HEALTH BENEFIT PLAN

FOR THE EMPLOYEES OF

PIGGLY WIGGLY ALABAMA DISTRIBUTING COMPANY, INC.

HIGH DEDUCTIBLE OPTION

SUMMARY PLAN DESCRIPTION

CLAIMS PROCESSOR

ALTERNATIVE INSURANCE RESOURCES, INC.
P.O. BOX 660787
BIRMINGHAM, AL 35266

March 1, 2017

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ARTICLE I – INTRODUCTION

A. Introduction

Piggly Wiggly Alabama Distributing Company, Inc. ("Plan Sponsor") has hereby established the Health Benefit Plan for the Employees of Piggly Wiggly Alabama Distributing Company, Inc. ("Plan") – High Deductible Option to provide health benefits to its eligible Employees and their eligible Dependents. The Plan is designed to protect Covered Persons against catastrophic health expenses. The Plan is a partially self-funded health plan, which is a type of welfare benefit plan subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

In general, an Employee's salary or wages pays his or her day-to-day living expenses. If a serious illness or injury occurs, the cost involved could cause significant financial burdens. The Plan may ease such burdens by providing reimbursement for the majority of Eligible Expenses. The Covered Person shall be responsible for sharing in the cost of such expenses through contributions toward Plan coverage, Coinsurance, Copayments, and Deductibles.

The Employer is responsible for at least a portion of the cost of an Employee's health care coverage. If an Employee elects to enroll Dependent(s) in the Plan, he or she may be responsible for a portion of that cost. The Employer shall pay costs in excess of the Employee's obligations. Contributions from the Employer and the Employees, if any, are used to provide the non-insured benefits under the Plan. A fund has been established pursuant to the Plan into which such contributions are made. Such contributions are deposited into a bank or similar financial institution. The fund is held in trust to be utilized for the purpose of providing benefits to Covered Persons and defraying the reasonable expenses of administering the Plan.

Contributions may also be used to purchase insurance or ancillary coverage to ensure that the Plan will meet its self-funded obligations. Contributions for such coverage, if any, shall be paid directly to the provider of the coverage. Any insurance policy or ancillary coverage purchased may be reviewed upon request submitted to the Plan Sponsor, which is also available to answer any questions about such policies and the coverage provided there under. The provisions of the Plan Document do not modify the terms of any insurance policy or ancillary coverage.

The Employer fully intends to maintain the Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies) at any time, and for any reason, upon prior written notice to all Employees.

B. The Purpose of the Plan

The purpose of the Plan is to provide certain health care benefits for eligible Employees of the participating Employer(s) and the eligible Dependents of such Employees.

C. The Purpose of the Plan Document

The Plan Sponsor is required under ERISA to provide to Employees a Plan Document or Summary Plan Description.

This Plan Document has been adopted and is being provided as the written description of the Plan and as a Summary Plan Description. This Plan Document supersedes any and all statements and/or amendments regarding healthcare coverage contained in any Plan Document or Summary Plan Description previously provided to Employees. The Plan Document is not a contract of employment between the Employer and the Employee, and does not give the Employee the right to be retained in the service of the Employer.

The Plan Document includes provisions that may result in an Employee being deemed ineligible for or being disqualified from coverage, or that may result in the denial, forfeiture, loss, offset, recovery, reduction, or suspension of benefits that a Covered Person might otherwise reasonably expect the Plan to provide. Covered Persons should review this Plan Document carefully so that they understand how its provisions affect payment of benefits under the Plan.

Provisions of the Plan Document may be modified from time to time, including those with respect to Copayments, Deductibles, Eligible Expenses, eligibility requirements, exclusions, limitations, Maximum Benefits, and other matters. The Plan Document will automatically be modified to comply with any federally-mandated provisions. The Plan shall notify Employees in writing of any material modification to the Plan in accordance with federal law. To the extent applicable, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, including USERRA, COBRA, HIPAA, NMHPA, WHCRA, FMLA, MHPA, MHPAEA, HITECH, GINA, and PPACA. Employees are required to keep the Plan Administrator informed of any changes in address with respect to themselves and any covered Dependents. Employees are encouraged to maintain a copy of any notices sent to the Employee by the Plan Administrator or to the Plan Administrator by the Employee.

ARTICLE II – GENERAL PLAN INFORMATION

A. General Information

Name of Plan:	Health Benefit Plan for the Employees of Piggly Wiggly Alabama Distributing Company, Inc. – High Deductible Option
Plan Sponsor/Plan Administrator:	Piggly Wiggly Alabama Distributing Company, Inc. 2400 J Terrell Wooten Drive Bessemer, Alabama 35020 (205) 481-2300 phone (205) 481-2383 fax
Participating Employer:	Piggly Wiggly Alabama Distributing Company, Inc.
Plan Sponsor ID Number (EIN):	63-0393676
Plan Number:	501
Plan Effective Date:	August 1, 1989
High Deductible Option Effective Date:	March 1, 2017
Plan Year:	January 1st through December 31st
Plan Benefits:	Medical, Prescription Drug and Disability Benefits
Named Fiduciary:	Piggly Wiggly Alabama Distributing Company, Inc. 2400 J Terrell Wooten Drive Bessemer, Alabama 35020 (205) 481-2300 phone (205) 481-2383 fax
Agent for Service of Legal Process:	Piggly Wiggly Alabama Distributing Company, Inc. 2400 J Terrell Wooten Drive Bessemer, Alabama 35020 (205) 481-2300 phone (205) 481-2383 fax

NOTE: Legal process may also be served upon the Plan Administrator or a Fiduciary.

Claims Processor:	Alternative Insurance Resources, Inc. P. O. Box 660787 Birmingham, AL 35266-0787 205-871-3229

B. Administration Expenses

In addition to being used to pay for benefits, contributions to the Plan may be used to pay reasonable administrative and operating expenses of the Plan, including but not limited to expenses incurred in accordance with the terms and conditions of any administration agreement between the Plan Sponsor and the Claims Processor; auditing fees incurred with respect to claims submitted by or on behalf of a Covered

Person; legal fees and costs associated with Plan-related issues, including those which may arise when a Claimant appeals an adverse benefit determination; and costs incident to securing or posting of any bond.

C. Taxes

Any premium or other taxes that may be imposed by any state or other taxing authority and that are applicable to the coverage under the Plan shall be paid by the Plan Sponsor.

NOTE: In providing benefits, purchasing insurance protection, and paying administrative expenses and any taxes required by law, the contributions made by Employees shall be used first. Any remaining Plan obligations shall be paid by Employer contributions. Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess shall be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at the Plan Sponsor's discretion, may be used in any other manner consistent with applicable law.

ARTICLE III – DEFINITIONS

A. Defined Terms

When capitalized herein, the following terms shall have the meanings set forth below:

1. **Accident**: An unforeseen and unavoidable event resulting in an Injury that is not due to any fault on the part of the Covered Person and that is not excluded under any provision of **ARTICLE XIV – MEDICAL LIMITATIONS AND GENERAL EXCLUSIONS**.

2. **Active Employee**: See **ARTICLE IV – ELIGIBILITY AND EFFECTIVE DATES**.

3. **Ambulatory Surgical Center**: A public or private institution or facility that:

    a. Complies with applicable licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

    b. Has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

    c. Provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and

    d. Does not provide services or other accommodations for patients to stay overnight.

    NOTE: An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, shall *not* be considered an Ambulatory Surgical Center for the purposes of this Plan.

4. **Amendment**: A formal document that changes the provisions of the Plan Document and that is duly signed by an authorized representative of the Plan.

5. **Benefit Percentage**: That portion of Eligible Expenses payable by the Plan in accordance with the coverage provisions as stated in the Plan Document, which provides the basis for determining any out-of-pocket expenses in excess of the annual Deductible payable by the Employee.

6. **Benefit Period**: The 12-month period in which medical benefits are calculated, the Calendar Year Deductible is assessed, and the annual Maximum Benefit and limits are based. A Benefit Period shall start on January 1st and end on December 31st; each successive January 1st shall be the start of a new Benefit Period.

7. **Birthing Center**: A special room in a Hospital that exists to provide prenatal, delivery, and postnatal care with minimum medical intervention, or a free-standing Outpatient facility that:

    a. Complies with applicable licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

    b. Is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;

c. Has organized facilities for obstetrical delivery and for short-term post-delivery recovery on its premises;

d. Provides birth services that are performed by or under the direction of a Physician specializing in obstetrics and gynecology and either a Registered Nurse ("RN") or a licensed Nurse midwife;

e. Has a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement; and

f. Maintains clinical records on each patient.

8. **Brand Name**: A trade name medication.

9. **Calendar Year**: The period of time commencing at 12:00 a.m. on January 1st of each year and ending at 11:59 p.m. on the next succeeding December 31st. Each succeeding like period shall be considered a new Calendar Year.

10. **Certificate of Creditable Coverage**: A written certificate provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of a person's previous coverage.

11. **CHIP**: The Children's Health Insurance Program (formerly the State Children's Health Insurance Program or "**SCHIP**").

12. **Chiropractic Care**: Skeletal adjustments, manipulations, or other treatments in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment must be performed by a chiropractor or by a Physician to remove nerve interference resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

13. **Claimant**: Any Covered Person on whose behalf a claim is submitted for benefits under the Plan, or any person or entity that submits a claim on behalf of a Covered Person.

14. **Claims Processor**: A company that performs all functions reasonably related to the general administration, management, and supervision of the Plan in accordance with the terms and conditions of an administration agreement between the Claims Processor and the Plan Administrator. The Claims Processor is not a Fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Claims Processor is not an insurer of Plan benefits, is not responsible for Plan financing, and does not guarantee the availability of benefits under the Plan.

15. **Close Relative**: A person who is the spouse, parent, sibling, child, or in-law of a Covered Person.

16. **CMS**: The Centers for Medicare and Medicaid Services.

17. **COBRA**: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

18. **COBRA Beneficiary or Qualified Beneficiary**: See **ARTICLE VII – COBRA CONTINUATION COVERAGE**.

19. **Company**: A corporation duly organized and existing under the laws of the State and all affiliates, divisions, and/or subsidiaries thereof that have adopted the Plan.

20. **Complications of Pregnancy**: When a Pregnancy has not been terminated by an elective abortion, conditions that are distinct from Pregnancy but that are adversely affected by Pregnancy or are caused by Pregnancy, including but not limited to acute nephritis or nephrosis, cardiac decompensation, and missed abortion. Complications of Pregnancy may also include:

    a. An ectoptic pregnancy which is terminated;

    b. Non-elective Cesarean section;

    c. Pernicious vomiting (hyperemesis gravidarum);

    d. Spontaneous termination of Pregnancy which occurs during a period of gestation when a viable birth is not possible; and

    e. Toxemia with convulsions (eclampsia of Pregnancy).

NOTE: Complications of Pregnancy do not include false labor, morning sickness, occasional spotting, Physician-prescribed rest during the Pregnancy, and similar conditions which, although associated with the management of a difficult Pregnancy, are not medically classified as distinct Complications of Pregnancy.

21. **Convalescent Nursing Facility or Skilled Nursing Facility**: A facility that:

    a. Complies with applicable licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

    b. Is duly licensed as a convalescent hospital, an extended care facility, an intermediate care facility, or a skilled nursing facility;

    c. Is primarily engaged in providing accommodations and skilled nursing care 24-hours-per-day for persons convalescing from Illness or Injury. Such care must be rendered by an RN or by a licensed practical nurse ("LPN") under the direction of an RN and must help restore patients to self-care in essential daily living activities;

    d. Is under the full-time supervision of a Physician or an RN;

    e. Admits patients only upon the recommendation of a Physician, maintains complete medical records, and has available at all times the services of a Physician;

    f. Has established methods and procedures for dispensing and administering drugs;

    g. Has an effective utilization review plan;

    h. Is approved and licensed by Medicare;

    i. Has a written transfer agreement in effect with one or more Hospitals; and

    j. Is not, other than incidentally:

        i. A place for rest;

ii. A place for care of the aged, the blind, or the deaf;

iii. A place for the care of the developmentally disabled or the mentally ill;

iv. A place for the care of persons suffering from tuberculosis;

v. A Substance Use Disorder Treatment Facility; or

vi. A hotel or motel.

22. **Convalescent Period**: The period of time beginning with the date of the confinement of a Covered Person to a Convalescent Nursing Facility. Such confinement must commence not more than 14 days of being discharged from an Inpatient Hospital confinement and must be for the care and treatment of the same Illness or Injury for which the patient was hospitalized.

23. **Copayment**: A fixed fee for specified services under the Plan paid by the Covered Person, typically at the time a service is rendered, to offset some of the cost of care. The size of the Copayment may vary depending on the service provided.

24. **Cosmetic Surgery**: A procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily functions, including but not limited to plastic surgery intended to preserve beauty or to minimize disfigurements or scars.

25. **Covered Person**: An Employee, a Dependent, or a Qualified Beneficiary under COBRA who is covered under the Plan. See **ARTICLE IV – ELIGIBILITY AND EFFECTIVE DATES** and **ARTICLE VII – COBRA CONTINUATION COVERAGE**.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits shall not be taken into account.

26. **Covered Provider**: A person who is licensed to perform certain health care services covered under the Plan and who is acting within the scope of his or her license or, in the absence of licensing requirements, who is certified by the appropriate regulatory agency or professional association. A "Covered Provider" may also be a health care facility or other entity that is appropriately licensed and providing services covered under the Plan, or any Nurse, Physician, or other provider who is employed by a Hospital or other covered facility and who is paid by such Hospital or covered facility for his or her services. Covered Providers include but are not limited to the following:

a. Audiologists;

b. Certified or Registered Nurse Midwives;

c. Chiropractors;

d. Dentists;

e. Licensed professional counselors;

f. Nurses, including RNs, LPNs, and Licensed Vocational Nurses ("LVNs");

g. Physician Assistants;

h. Physicians;

i. Podiatrists;

j. Psychologists; and

k. Speech language pathologists.

NOTE: A Covered Provider does not include a Covered Person treating himself or herself, any Close Relative, or any person who resides in the Covered Person's household (see **Relative or Resident Care** in **ARTICLE XIV – MEDICAL LIMITATIONS AND GENERAL EXCLUSIONS**).

27. **Creditable Coverage**: Includes coverage under a group health plan (including a governmental or church plan), individual health insurance coverage, Medicare (other than coverage solely under § 1928 of the Social Security Act, the program for distribution of pediatric vaccines), Medicaid, military-sponsored health care, a program of the Indian Health Services, a State health benefits risk pool, the Federal Employees Health Benefit Program, CHIP (or SCHIP, as it was formerly known), a public health plan as defined in regulations (that is, any plan established or maintained by a State, the United States government, or a foreign country, or any political subdivision of a State, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan), and a health benefit plan under the Peace Corps Act. Coverage can be Creditable Coverage even if such coverage remains in effect.

NOTE: Creditable Coverage does not include coverage consisting solely of dental or vision benefits or coverage that was in place before a significant break in coverage of 63 days or more. See also **Effect of the Trade Act** in **ARTICLE VII – COBRA CONTINUATION COVERAGE**.

28. **Custodial Care**: Care or confinement primarily for the purpose of meeting personal needs (for example, bathing, dressing, feeding, or walking) that could be rendered at home or by persons without professional skills or training, services or supplies that cannot reasonably be expected to lessen the patient's disability or enable him or her to live outside of an institution, or any type of maintenance care that is not reasonably expected to improve the patient's condition within a reasonable period of time, except that which may be included as part of a formal Hospice care program.

29. **Deductible**: A specified dollar amount with respect to an Eligible Expense that may have to be incurred during a Benefit Period before any other Eligible Expenses are considered for payment pursuant to the applicable Benefit Percentage.

30. **Dentist**: A Doctor of Dental Surgery or Doctor of Dental Medicine licensed by his or her state of practice to practice dentistry and render dental care services within the scope of his or her license for treatments covered under the Plan.

31. **Dependent**: See **ARTICLE IV– ELIGIBILITY AND EFFECTIVE DATES**.

32. **DOL**: The United States Department of Labor.

33. **Durable Medical Equipment**: Equipment which:

a. Can withstand repeated use;

b. Is primarily and customarily used to serve a medical purpose;

c. Generally is not useful to a person in the absence of an Illness or an Injury; and

d. Is appropriate for use in the home.

NOTE: Deluxe equipment or devices are not covered, nor is equipment ordered prior to a Covered Person's effective date of coverage, even if the equipment is delivered after such effective date.

34. **Effective Date**: See **ARTICLE IV – ELIGIBILITY AND EFFECTIVE DATES**.

35. **Elective Surgery**: A non-emergency surgical procedure that is scheduled at the Covered Person's convenience and that will not endanger such person's life or seriously impair his or her bodily functions if it is not performed.

36. **Eligible Expense**: An expense incurred by a Covered Person for services and/or supplies furnished to him or her that is covered by a specific benefit provision of the Plan Document. Eligible Expenses shall be considered to have been incurred on the date or at the time that the service or supply is actually furnished. Eligible Expenses include Deductibles, Coinsurance amounts, or other amounts not reimbursed by the Plan, but do not include any expense that is reimbursable by any other source.

37. **Emergency**: See **Medical Emergency**.

38. **Employee**: See **ARTICLE IV – ELIGIBILITY AND EFFECTIVE DATES**.

39. **Employer or Participating Employer**: The Employer(s) participating in the Plan as stated in **ARTICLE II – GENERAL PLAN INFORMATION**.

40. **ERISA**: The Employee Retirement Income Security Act of 1974, as amended.

41. **Essential Health Benefits**: Benefits for the following general categories and the items and services covered within the categories, as defined by the Patient Protections and Affordable Care Act. The Plan is not required to include all Essential Health Benefits, but if covered, must do so without annual limits.

    a. Ambulatory patient services;

    b. Emergency services;

    c. Hospitalization;

    d. Maternity and newborn care;

    e. Mental health condition and substance use disorder services, including behavioral health treatment;

    f. Prescription drugs;

    g. Rehabilitative and habilitative services and devices;

    h. Laboratory services;

    i. Preventive and wellness services and chronic disease management; and

j. Pediatric services, including oral and vision care.

42. **Experimental and/or Investigational**: Devices, drugs, procedures, services, supplies, or treatments that the Plan Administrator determines, in the exercise of its discretion and guided by a reasonable interpretation of Plan provisions, are experimental, investigational, or done primarily for research. The determinations shall be made in good faith and rendered following careful consideration of the claim and of the proposed course of care. The Plan Administrator shall be guided by the following principles:

a. Whether or not a device or a drug may be lawfully marketed without approval of the United States Food and Drug Administration ("FDA") if approval for marketing has not been given at the time that the device or device is furnished;

b. Whether or not the device, drug, procedure, service, supply, or treatment, or the patient "informed consent" document utilized therewith, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, if federal law requires such review and approval; and

c. Whether or not reliable evidence shows that a device, drug, procedure, service, supply, or treatment is the subject of ongoing phase I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of diagnosis or treatment. "Reliable evidence" shall include anything determined to be such by the Plan Administrator, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the CMS Medicare Coverage Issues Manual.

Notwithstanding any other provision of the Plan, coverage for clinical trials shall be provided pursuant to the requirements of the Patient Protection and Affordable Care Act.

NOTE: Drugs are considered Experimental if they are not commercially available for purchase and/or are not approved by the FDA for general use.

43. **Family Unit**: A covered Employee and his or her family members who are covered as Dependents under the Plan.

44. **FDA**: The United States Food and Drug Administration.

45. **Fiduciary**: Any entity having binding power to make decisions regarding Plan interpretation, policies, practices, or procedures.

46. **FMLA**: The Family and Medical Leave Act of 1993, as amended.

47. **Formulary**: A list of prescription medications compiled by the third-party payer of effective, safe, therapeutic drugs specifically covered by this Plan.

48. **Freestanding Emergency Medical Care Facility**: A facility that:

a. Complies with applicable licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

b. Is structurally separate and distinct from a Hospital; and

c. Provides medical care, services, or treatment to evaluate and stabilize a medical condition, Illness, or Injury of recent onset and of such severity that it could reasonably be expected to result in placing the patient's health or, with respect to a Pregnancy, the health of the woman or her unborn child, in serious jeopardy; serious impairment of bodily functions; serious dysfunction of a bodily organ or part; or serious disfigurement.

49. **General Anesthesia**: An agent introduced into the body that produces a loss of consciousness.

50. **Generic Drug**: A Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. The Plan considers a Generic Drug any FDA-approved generic pharmaceutical dispensed in accordance with the professional standards of licensed pharmacists and clearly designated by a pharmacist as being generic.

51. **Genetic Information**: Information about genes, gene products, and inherited characteristics that maybe derived from direct analysis of chromosomes or genes, from laboratory tests that identify mutations in specific genes or chromosomes, from family histories, or from physical examinations, including information regarding carrier status.

52. **HHS**: The United States Department of Health and Human Services.

53. **HIPAA**: The Health Insurance Portability and Accountability Act, as amended.

54. **HMO**: A health maintenance organization.

55. **Home Health Care**: A program for care and treatment of a Covered Person established and approved by such person's attending Physician in lieu of continued Inpatient Hospital confinement.

56. **Home Health Care Agency**: An agency or organization that:

a. Complies with applicable licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

b. Is primarily engaged in providing skilled nursing and other therapeutic services;

c. Has policies to govern the services provided that are established by a professional group associated with the agency or organization, which includes at least one RN;

d. Provides for full-time supervision of its services by a Physician or by an RN;

e. Maintains clinical records on each patient; and

f. Has a full-time administrator.

NOTE: In rural areas where there are no agencies which meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting Nurses may be substituted for the services of a Home Health Care Agency.

57. **Hospice**: A health care program that:

a. Complies with applicable licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

b. Provides a coordinated set of services rendered at home, in Outpatient settings, or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis;

c. Has an interdisciplinary group of personnel that includes at least one Physician and one RN;

d. Maintains clinical records on each patient; and

e. Meets the standards of the National Hospice Organization.

58. **Hospice Agency**: An agency the main function of which is to provide Hospice Care Services and Supplies and that is licensed by the state in which it is located, if licensing is required.

59. **Hospice Benefit Period**: A specified amount of time during which a Covered Person undergoes care by a Hospice, beginning on the date that a Covered Person is accepted into a Hospice program after having been diagnosed with a terminal Illness and ending six (6) months after such date or at the death of the Covered Person, whichever comes first. The Hospice Benefit Period may be extended if the attending Physician certifies that the Covered Person is still terminally ill; however, additional proof of such Illness may be required by the Plan Administrator before such extension becomes effective.

60. **Hospice Care Plan**: A plan of care for terminally ill patients that is established and conducted by a Hospice Agency and is supervised by a Physician.

61. **Hospice Care Services and Supplies**: Services and supplies provided through a Hospice Agency and under a Hospice Care Plan, including Inpatient care in a Hospice unit or other licensed facility, home care, and family counseling during the bereavement period.

62. **Hospital**: A facility that:

a. Complies with applicable licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

b. Is primarily and continuously engaged in providing on an Inpatient basis, for compensation from its patients, diagnostic, medical, surgical, and therapeutic facilities for the care and treatment of ill and/or injured persons;

c. Is operated by or under the supervision of a staff of Physicians and continuously provides 24-hour-per-day nursing services by an RN;

d. Is accredited as a Hospital by the Joint Commission and is approved as a Hospital by Medicare;

e. May include a psychiatric Hospital or residential treatment facility for mental health, *provided that* such Hospital or facility is licensed as such by the state in which it is located and is operating in accordance with applicable law, or a facility operating primarily for the treatment of Substance Use, *provided that* such facility:

i. Maintains full-time, permanent facilities for bed care and for confinement of at least 15 resident patients;

ii. Has a Physician in regular attendance;

iii. Continuously provides 24-hour-per-day nursing services by an RN;

iv. Has a full-time psychiatrist on the staff; and

v. Is primarily engaged in providing diagnostic and therapeutic services and facilities for Substance Use.

NOTE: A Hospital does *not* include a Christian Science hospital or facility.

63. **Hospital Room Charge**: The charge by a Hospital or other facility for room and board accommodations.

64. **Illness**: A disease, a bodily disorder, a Mental Health Condition, a Substance Use Disorder, or a physical sickness that has been diagnosed as such by a Physician or other appropriate Covered Provider. "Illness" also includes Pregnancy, Complications of Pregnancy, miscarriage, and childbirth.

65. **Infertility**: The inability to produce offspring.

66. **Injury**: A condition caused by an external force which results in damage to the Covered Person's body.

67. **Inpatient**: A person physically occupying a room and being charged for room and board in a Hospital or other covered facility to which the person has been assigned on a 24-hour-per-day basis without being issued pass(es) to leave the premises.

68. **Intensive Care Unit ("ICU"), Coronary Care Unit ("CCU"), Acute Care Unit, Burn Unit, or Intermediate Care Unit**: A Hospital area or accommodation that is exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician; that provides room and board, specialized registered nursing and other nursing care, and special equipment and supplies on a stand-by basis; and that is separate from the rest of the Hospital's facilities.

69. **IRS**: The United States Internal Revenue Service.

70. **Late Enrollee**: See **ARTICLE IV – ELIGIBILITY AND EFFECTIVE DATES**.

71. **Legal Guardian**: A person recognized by a court of law as being responsible for taking care of a person and/or managing the property and rights of a minor child.

72. **Lifetime**: All periods during which a person is covered under the Plan, including any prior statements of the Plan. It does not mean a Covered Person's entire lifetime.

73. **Maximum Benefit**: The maximum dollar value payable by the Plan on behalf of a Covered Person for a specified service during a Calendar Year or Plan Year (at the Plan's discretion), or the maximum non-monetary limit on a specified service during a Calendar Year or Plan Year (again, at the Plan's discretion). Once the maximum dollar value for a specified service has been paid or the maximum non-monetary limit for a specified service has been reached, the Covered Person shall not be entitled to any additional benefits for the specified service for the remainder of the time period in question.

74. **Medical Care Facility**: A Hospital, a facility that treats one or more specific ailments, or any type of Skilled Nursing Facility.

75. **Medical Emergency**: A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

    a. Placing the health of the person (or, with respect to a pregnant woman, the health of the woman and or her unborn child) in serious jeopardy;

    b. Serious impairment to bodily functions; or

    c. Serious dysfunction of any bodily organ or part.

76. **Medically Necessary:** Any health care treatment, service, or supply that the Plan Administrator determines is:

    a. Ordered by a Physician for the diagnosis or treatment of an Injury or an Illness;

    b. Safe and effective for its intended use, pursuant to the prevailing opinion within the appropriate specialty of the United States medical profession;

    c. Likely to adversely affect the patient's medical condition if not provided to the patient, pursuant to the prevailing opinion within the appropriate specialty of the United States medical profession;

    d. Furnished by a Covered Provider with appropriate training and experience, acting within the scope of his or her license;

    e. Provided at the most appropriate level of care needed to treat the particular condition; and

    f. Not provided solely for the convenience of the Covered Person or the Covered Provider.

    g. With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment which can only be provided on an Inpatient basis.

The Plan Administrator shall determine whether the above requirements have been met based upon published reports in authoritative medical and scientific literature; regulations, reports, publications, or evaluations issued by government agencies such as the National Institutes of Health, the FDA, and CMS; and listings in the following compendia: The American Hospital Formulary Service Drug Information and The United States Pharmacopoeia Dispensing Information. The Plan Administrator may also consider other authoritative medical resources to the extent that the Plan Administrator determines them to be necessary and appropriate. The fact that any particular provider individual may prescribe, order, recommend, or approve a service or supply, does not, of itself, make it Medically Necessary or make the charge a Covered Expense, even though it is not specifically listed in this Plan as an exclusion. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

77. **Medicare**: Health Insurance for the aged and disabled as established by Title I of Public Law 89-98, including parts A, B, and D and Title XVIII of the Social Security Act, as amended from time to time.

78. **Mental Health Condition**: Any diagnosis listed in the "Mental Disorders" section of the current edition of the International Classification of Diseases published by HHS or listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

79. **Mental Health Treatment Facility**: A facility that:

    a. Complies with applicable licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

    b. Provides a program for diagnosis, evaluation, and effective treatment of Mental Health Conditions;

    c. Provides nursing services by licensed professionals who are directed by a full-time RN;

    d. Has a Physician on staff or on call; and

    e. Prepares and maintains a written plan of treatment for each patient which is based on such person's medical, psychological, and social needs.

80. **Morbid Obesity**: A diagnosed condition in which a person's body weight either exceeds his or her medically-recommended weight by 100 pounds or is twice the medically-recommended weight for a person of the same age, height, and mobility.

81. **Name Brand Drug**: A proprietary drug protected by trademark.

82. **Newborn**: An infant from the date of his or her birth until he or she is initially discharged from the Hospital or until he or she is 14 days old, whichever occurs first.

83. **No-Fault Automobile Insurance**: The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

84. **Nurse**: A person who has received specialized nursing training, who is duly licensed by the state or regulatory agency responsible for such license in the state in which the individual performs the nursing services, and who is authorized to use the designation "RN" or "LPN."

85. **Occupational Therapy**: Treatment which consists primarily of instructing a Covered Person in the performance of the normal activities of daily living.

86. **Oral Surgery**: Necessary surgical procedures in the oral cavity, including pre- and postoperative care.

87. **Out of Pocket Maximum**: The maximum dollar amount of Medical Benefit Covered Expenses incurred during a Benefit Period, which a Covered Person must pay before certain benefits under the Plan are payable at a benefit percentage of 100%. This amount is stated in the Schedule of Benefits.

88. **Outpatient**: Services rendered on other than an Inpatient basis at a Hospital or at another covered facility.

89. **Outpatient Psychiatric Facility**: An administratively distinct governmental, public, private, or independent unit or part of such unit that provides for a psychiatrist who has regularly

scheduled hours in the facility and who assumes the overall responsibility for coordinating the care of all patients.

90. **Outpatient Substance Use Disorder Treatment Facility**: A facility that:

    a. Complies with applicable licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

    b. Provides a program for diagnosis, evaluation, and effective treatment of alcoholism and/or Substance Use Disorder;

    c. Provides detoxification services;

    d. Provides infirmary-level medical services or arranges with a Hospital in the area for any medical services that may be required;

    e. Is at all times supervised by a staff of Physicians;

    f. Provides at all times skilled nursing care by licensed Nurses who are directed by a full-time RN; and

    g. Prepares and maintains a written treatment plan established by a Physician for each patient based on his or her medical, psychological, and/or social needs.

91. **Partial Hospitalization**: Care provided in lieu of confinement in a Hospital or Medical Care Facility for the treatment of a Mental Health Condition or Substance Use Disorder. Treatment must last more than four hours but less than 24 hours per day and no charge must be made for room and board.

92. **Period of Confinement**: The time during which a Covered Person is confined as an Inpatient in a Hospital or other covered facility. If the Covered Person is discharged and is later readmitted, additional charges shall be payable as part of the original Period of Confinement unless more than 24 hours have elapsed since the time of discharge. An admission that occurs more than 24 hours after a discharge or that is due to an entirely different Illness, Injury, or medical condition shall be considered to be a new Period of Confinement.

93. **Pharmacy**: A licensed establishment where covered Prescription Drugs are dispensed by a pharmacist licensed under the laws of the state in which he or she is employed.

94. **Physically or Mentally Handicapped**: The inability of a person to engage in self-sustaining employment by reason of cerebral palsy, developmental disability, epilepsy, mental retardation, neurological disorder, physical handicap, or continuing disability due to congenital defect, Illness, or Injury.

95. **Physician**: A Doctor of Medicine or a Doctor of Osteopathy who is licensed by his or her state of practice to practice medicine and to render medical care services within the scope of his or her license for treatments covered under the Plan.

NOTE: "Physician" does not include the Covered Person himself or herself (see **ARTICLE XIV – MEDICAL LIMITATIONS AND GENERAL EXCLUSIONS**), his or her Close Relatives, or interns, residents, fellows, or others enrolled in a graduate medical education program.

96. **Plan**: The benefits described by the Plan Document or incorporated by reference therein and including any prior statement of the Plan. The name of the Plan is set forth in **ARTICLE II – GENERAL PLAN INFORMATION**.

97. **Plan Administrator**: See **Plan Sponsor**.

98. **Plan Document**: The formal written document, including any Amendments, which describes the plan of benefits and the provisions under which such benefits shall be paid to Covered Persons.

99. **Plan Sponsor**: The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **ARTICLE II – GENERAL PLAN INFORMATION**.

100. **Plan Year**: The period of time commencing at 12:00 a.m. on January 1st and ending at 11:59 p.m. on the next succeeding December 31st. Each succeeding like period shall be considered a new Plan Year.

101. **PPACA:** The Patient Protection and Affordable Care Act.

102. **Pre-Admission Testing**: Diagnostic laboratory and x-ray services that are rendered by a Hospital or other Covered Provider facility to a Covered Person on an Outpatient basis and that are Medically Necessary prior to a scheduled Inpatient confinement at the same facility.

103. **Preferred Provider Organization ("PPO")**: The network(s) of Physicians, Hospitals, and other Covered Providers with which the Plan has contracted to provide services and supplies to Covered Persons at a negotiated rate. Incentives for utilization of preferred providers in the PPO network(s) are set forth in **ARTICLE X – COMPREHENSIVE MEDICAL COVERAGE**. However, the Covered Person has the right to choose any Covered Provider, including one outside of the PPO network, to provide care, services, supplies, or treatment.

104. **Pregnancy**: Prenatal and postnatal care during Pregnancy, Complications of Pregnancy, miscarriage, and childbirth. See **Pregnancy Care in ARTICLE XIII – ELIGIBLE MEDICAL EXPENSES**.

NOTE: Coverage for Pregnancy under this Plan is limited to the Employee and a Dependent spouse. The Plan does *not* provide coverage for the Pregnancy of a Dependent child.

105. **Prescription Drug**: Any of the following:

    a. An FDA-approved drug or medicine that, under federal law, is required to bear the legend "Caution: federal law prohibits dispensing without prescription;"

    b. Injectable insulin; and

    c. Hypodermic needles or syringes, but only when dispensed upon the written prescription of a Physician.

106. **Primary Care Physician:** Any of the following:

    a. Family Practice Physician

    b. Internal Medicine Physician

    c. Pediatrician

d. Obstetrical/gynecology Physician

107. **QMCSO**: A Qualified Medical Child Support Order.

108. **Reasonable and Appropriate**: A charge made by a Covered Provider that is Medically Necessary for an Illness or an Injury and that does not exceed the general level of payments accepted by other providers in the same geographical area or community who have similar experience and training for the treatment of health conditions comparable in nature and severity to the health condition being treated. "Same geographical area or community" means the Physician Fee Reference ("PFR") five-digit zip code prefix adjustment factors (multipliers). The Plan Administrator has the discretionary authority to determine whether a charge is Reasonable and Appropriate. The Plan Administrator may consider the PPO fee schedule to be the Reasonable and Appropriate charge for PPO providers. However, it is within the sole discretion of the Plan Administrator to consider one or more of the following parameters in determining whether or not a charge is Reasonable and Appropriate, even if a PPO provider is used. The Plan Administrator is under no obligation to adhere to any of these parameters, and may consider other factors as well on a case-by-case basis to determine whether or not a charge is Reasonable and Appropriate:

a. Procedures: Charges for procedures may be compared with the charges billed by other providers rendering the same type of service in the same geographical area or community. If the billed procedure charge exceeds the 90th percentile for the same procedure performed by other providers in the same geographical area or community, then such procedure charge may be reduced to the 90th percentile, the highest percentile reflected in the PFR.

b. Pharmaceuticals: Charges for pharmaceuticals may be reimbursed by applying the Average Wholesale Price ("AWP"), as defined by REDBOOK, at 200% of AWP if AWP is $100 or less, or at 110% of AWP if AWP is over $100, provided that such pharmaceuticals are dispensed to a Covered Person:

i. Who is an Inpatient in a Hospital, Rehabilitation Facility, Skilled Nursing Facility, or other covered facility;

ii. Directly by the Covered Person's treating Physician, or by a representative of such Physician licensed to dispense pharmaceuticals and acting at the direction of the Physician, during an office visit; or

iii. By a Home Health Care Agency rendering services to the Covered Person.

c. Bundling/Unbundling/Upcoding and Other Errors: Charges may be reviewed to determine whether they contain errors as a result of bundling, unbundling, and/or upcoding. If it is determined that the charges contain any such error(s), the charges may be reduced based on the discovered errors. Charges that are determined to have been billed erroneously for services that were not rendered to the patient or for items that were not provided to the patient are not payable under the Plan.

d. Medical and Surgical Supplies: Charges for medical and surgical supplies may be reviewed for reasonableness based on 110% of list price (as reflected on cost lists, invoices, receipts, and other similar documents). Charges in excess of 110% of list price may be reduced to a reasonable amount.

e. Lab work, Imaging, Therapy, and Physicians: Charges for lab work, imaging, therapy, and Physicians may be compared with charges for the same type of service in the same geographical area or community. If the charges for such services

exceed 200% of the Medicare reimbursement rate for the same service by the provider, such charges may be reduced to 200% of the Medicare reimbursement rate for such provider.

f. **Implants**: Charges for implants may be reviewed for reasonableness based on 110% of list price (as reflected on cost lists, invoices, receipts, and other similar documents). Charges in excess of 110% of list price may be reduced to a Reasonable amount.

g. **Semi-Private Hospital Rooms**: Charges for Hospital rooms may be reviewed for reasonableness based on 110% of the Hospital's most recent cost-to-charge ratio as reported to CMS ("CMS-Cost"). Charges in excess of 110% of the CMS-Cost may be reduced to a reasonable amount; provided, however, that if there are extraordinary circumstances such as charges for specialized levels of care (for example, ICU or CCU charges), or if the Hospital does not charge for supplies, reimbursement may be increased incrementally to a maximum of 200% of the CMS-Cost for the indicated level.

h. **Operating Room, Recovery Room, and Anesthesia**: Charges for the operating room ("OR"), recovery room ("RR"), and anesthesia may be reviewed for reasonableness based on:

i. 200% of the Hospital's CMS-Cost for patients in a regular (not critical care) room. Charges in excess of this rate for a regular OR or for an RR may be reduced to a reasonable amount; and

ii. 110% of the Hospital's CMS-Cost for patients in the ICU or CCU. Charges in excess of this rate for the ICU or for the CCU may be reduced to a reasonable amount.

Charges in excess of 200% of the Hospital's CMS-Cost for a regular room and/or in excess of 110% of the Hospital's CMS-Cost for patients in an ICU or CCU room may be reduced to a reasonable amount.

i. **Emergency Room**: Charges for the emergency room ("ER") may be reviewed for reasonableness based on 200% of the Hospital's CMS-Cost. Charges for the ER in excess of 200% of the Hospital's CMS-Cost may be reduced to a reasonable amount.

NOTE: Reimbursement may be at the actual charge billed if such charge is equal to or less than the Reasonable and Appropriate charge, or may be at such other rate as the Plan may later specify.

109. **Rehabilitation Facility**: A facility or distinct part of a facility that:

a. Complies with applicable licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

b. Has a transfer agreement with one or more Hospitals; and

c. Is primarily engaged in providing comprehensive multi-disciplinary physical restorative services and post-acute Hospital or rehabilitative Inpatient care.

NOTE: "Rehabilitation Facility" does not include a facility that provides only ambulatory care, custodial care, minimal care, or part-time care, or a facility that primarily treats Mental Health

Conditions, Substance Use Disorders, or tuberculosis unless such facility is licensed, certified, or approved as a Rehabilitation Facility in the jurisdiction where it is located, or is accredited as such by the Joint Commission or by the Commission for the Accreditation of Rehabilitation Facilities.

110. **Specialist Physician**: Any Physician not meeting the definition of Primary Care Physician.

111. **Speech Therapist**: A person who has a Master's or a Doctoral degree in speech pathology, who has completed an internship, and who is duly licensed as a speech pathologist in his or her state of practice.

112. **Substance Use Disorder**: Physical and/or psychological dependence on alcohol, drugs, narcotics, toxic inhalants, or other addictive substances to a debilitating degree and/or any diagnosis related to such physical and/or psychological dependence listed in the "Mental Disorders" section of the current edition of the International Classification of Diseases published by HHS or listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine

113. **Substance Use Disorder Treatment Facility**: A facility that provides a program for the treatment of Substance Use Disorder pursuant to a written treatment plan approved and monitored by a Physician and that:

    a. Complies with applicable licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

    b. Is affiliated with a Hospital under a contractual agreement with an established system for patient referral; and

    c. Is accredited as such a facility by the Joint Commission.

114. **Surgery**: The performance of a generally-accepted operative or cutting procedure, identified by Current Procedural Terminology ("CPT") coding guidelines.

115. **Temporomandibular Joint Dysfunction ("TMJ")**: The abnormal, impaired, or inadequate function of the joint between the temporal and mandibular bones of the jaw.

116. **Totally Disabled**: A physical or mental state resulting from an Illness or an Injury which:

    a. In the case of a covered Employee, renders him or her incapable of performing any work for compensation or profit for which he or she is or becomes reasonably suited by education, experience, or training; and

    b. In the case of a Dependent or a COBRA Beneficiary, wholly prevents him or her from performing the normal activities for of a person that age and sex in good health and in similar circumstances.

117. **Urgent Care Facility**: A facility that is engaged primarily in providing minor emergency and episodic medical care and that has a board-certified Physician, an RN, and a registered x-ray technician in attendance at all times; laboratory and x-ray equipment; and a life support system.

NOTE: An "Urgent Care Facility" may include a clinic that is located at, operated in conjunction with, or is part of a Hospital.

118. **USERRA**: The Uniformed Services Employment and Reemployment Rights Act of 1994.

119. **Waiting Period**: See **ARTICLE IV – ELIGIBILITY AND EFFECTIVE DATES**.

120. **Well-Baby Care**: Medical treatment, services, or supplies rendered to a child or Newborn solely for the purpose of health maintenance and not for the treatment of an Illness or an Injury.

121. **WHCRA**: The Women's Health and Cancer Rights Act.

ARTICLE IV – ELIGIBILITY AND EFFECTIVE DATES

A. Choice of Coverage

An Employee may choose to enroll in the coverage for medical benefits under the Plan and to enroll his or her eligible Dependents as well. An Employee must be enrolled in the Plan in order to enroll his or her Dependents in the Plan.

If an Employee elects not to enroll himself or herself or his or her Dependents in the Plan, then the corresponding information contained in this Plan Document does not apply to such Employee or to his or her Dependents.

B. Eligibility Requirements – Employees

1. All Active Employees are eligible for coverage under the Plan. An Active Employee means an individual classified by the Employer as a common law employee of the Employer, determined in accordance with rules and regulations issued by the Internal Revenue Service, and who:

    a. Is a Full-time Active Employee for the Employer; that is, he or she must be employed an average of at least 130 hours of service per month, and

    b. Completes the employment Waiting Period that ends on the first day following 90 consecutive days as a Full-time Active Employee. A "Waiting Period" is the time between the first day of Full-time Active employment and the first day of coverage under the Plan.

An Employee shall be deemed in "active employment" on each day that he or she is actually performing services for the Employer, on each day of a regular paid vacation, and/or on a regular non-workday, *provided that* he or she was actively at work on the last preceding regular workday. An Employee shall also be deemed in active employment on any day on which he or she is absent from work during an approved leave pursuant to FMLA or solely due to his or her own health status. An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his or her first scheduled workday, he or she shall not be considered as having commenced active employment.

A person shall remain as an Active Employee, for the purposes of coverage under the Plan, for so long as he or she may be entitled to FMLA leave, to COBRA continuation coverage, or to weekly disability benefits**.** Eligibility for Medicaid or the receipt of Medicaid benefits shall not be taken into account in determining eligibility.

NOTE: An eligible Employee does not include one who is eligible for Medicare by reason of age, for TRICARE, or for another federal program and who has elected coverage under such program in lieu of Plan coverage.

The Employer will use the monthly measurement method to determine whether an Employee is a full-time Employee for purposes of Plan coverage. The monthly measurement method is based on Internal Revenue Service final regulations under the Affordable Care Act. The Employer intends to follow the IRS regulations (including any subsequent guidance issued by the IRS on the monthly measurement method when administering the monthly measurement method. The monthly measurement method applied to all Employees.

B-1. Effective Date – Employees

Coverage under the Plan is effective for an Employee, subject to timely enrollment, after completion of the Waiting Period. To enroll in the Plan, the Employee must submit a written application to the Employer not more than 31 days after completion of the Waiting Period. If an Employee fails to enroll within 31 days of completion of the Waiting Period, he or she shall be considered a "Late Enrollee" and his or her coverage can become effective only in accordance with the **Open Enrollment** or **Special Enrollment Rights** provisions below.

The first day of coverage under the Plan is the Employee's Effective Date.

C. Eligibility Requirements – Dependents

An eligible Dependent of an Employee includes any person who is:

1. A legally married spouse but only if such spouse is not eligible to enroll in another employer-sponsored health plan. "Legally married" means that the marriage meets all requirements of a valid marriage in the Employee's state of residence. The Employer may require documentation establishing a legal marriage relationship; and

   Spouses eligible for coverage under another group health plan are eligible for coverage under this Plan only if the Spouse must wait until an open or special enrollment period to enroll in that plan.

2. A child under the age 26 years. *A child whose coverage has been terminated because he or she no longer meets the eligibility requirements for Dependent children may regain eligibility for coverage if he or she again meets such requirements*. A "child" shall mean:

   a. A natural child;

   b. A stepchild; that is, a natural child of a covered Employee's spouse.

   c. A child who is adopted by the Employee or placed with him or her for adoption prior to the age of 18 years. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun. Placement ends when the legal support obligation ends;

   d. Notwithstanding any residency or main support and care requirements, a child for whom Plan coverage is required pursuant to a Medical Child Support Order that the Plan Sponsor determines to be a QMCSO in accordance with its written procedures. Such procedures are incorporated herein by reference and may be obtained by the Employee, without charge. A QMCSO also includes a judgment, decree, or order issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law under state law and that satisfies the QMCSO requirements of ERISA § 609(a);

   e. A foster child; that is, a child who has been raised as the child of the covered Employee. A "foster child" does not include a child who is or was temporarily living in such Employee's home, a child who is or was placed in such Employee's home by a social service agency which retains or retained control of the child, or a child whose natural parent(s) have exercised or shared parental control of and responsibility for the child; and

f. Any other child of whom the Employee is the Legal Guardian.

C-1. Proof of Dependency

The Plan may require proof (such as a copy of the Employee's marriage certificate, divorce decree, or legal adoption or legal guardianship papers) that a spouse or a child qualifies as a Dependent.

C-2. Ineligible Persons

The following persons are not eligible for coverage under the Plan:

1. Any person residing with the Employee who is not eligible for coverage as defined above;
2. A spouse following legal separation or a final decree of dissolution or divorce;
3. A person who is a domestic partner of the same sex as the Employee;
4. A person who is on active duty in military service, to the extent permitted by law; and
5. A person who is covered under the Plan as a Dependent of another Employee.

Also, a person who is already covered as an Employee may not be covered as a Dependent under the Plan.

See **ARTICLE VI – EXTENSION OF COVERAGE** for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits shall not be taken into account in determining a Dependent's eligibility.

C-3. Effective Date – Dependents

An Employee must submit a written application with the Employer to enroll his or her eligible Dependents in the Plan. A Dependent who is eligible and enrolled when the Employee enrolls shall have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within 31 days of their eligibility date (see **Special Enrollment Rights** for details, as well as for instances when the loss of other coverage and other circumstances may allow a Dependent to be enrolled).

The first day of coverage under the Plan is the Dependent's Effective Date.

Other than as set forth above, a Dependent may be enrolled only in accordance with the **Open Enrollment** provision.

NOTE: In no event shall a Dependent's coverage become effective prior to the Employee's Effective Date.

D. Newborn Children

A Newborn child of a covered Employee who has Dependent coverage is automatically enrolled in this Plan. If such Employee does not have Dependent coverage as of the date of birth of the Newborn, the Employee must enroll the Newborn as a Dependent within 31 days of such child's birth. If the Newborn is required to be enrolled in the Plan and is enrolled on a timely basis, Eligible Expenses for delivery and nursery care, for routine Physician services, and for treatment of Illness or Injury in the case of a sick Newborn shall be payable under the child's coverage. If the Newborn is required to be enrolled in the Plan and is not enrolled on a timely basis, the Newborn shall not be covered under the Plan and the Employee shall be responsible

for all charges in connection with delivery and nursery care, routine Physician services, and treatment of Illness or Injury in the case of a sick Newborn.

If a Newborn child is required to be enrolled and is not enrolled within 31 days of such child's birth, he or she shall be considered a "Late Enrollee" and his or her coverage can become effective only in accordance with the **Open Enrollment** or **Special Enrollment Rights** provisions below.

E. Special Enrollment Rights

A person who enrolls in accordance with this provision.

E-1. Entitlement Due to Loss of Other Coverage

A person who did not enroll in the Plan when previously eligible shall be allowed to apply for coverage under the Plan at a later date if he or she:

1. Was covered under another group health plan or other health insurance coverage at the time coverage was initially offered or previously available to him or her. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer;

2. Stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this provision only applies if the Plan Sponsor required such a written statement and provided the Employee with notice of the requirement and of the consequences of failure to comply with the requirement;

3. Lost the other coverage as a result of one or more of the following events:

    a. Loss of eligibility for coverage as the result of legal separation, divorce, cessation of Dependent status, death of an Employee, termination of employment, or reduction in the number of hours of employment, and loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

    b. Loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to persons who no longer reside or work in a service area, whether or not by choice of such person;

    c. Loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to persons who no longer reside or work in a service area, whether or not by choice of such person, and when no other benefit package is available to the person;

    d. Loss of eligibility when a person incurs expenses that would meet or exceed a Lifetime limit on all benefits. A person has a special enrollment right when a claim that would exceed a Lifetime limit on all benefits is incurred, and the right continues at least until 31 days after the earliest date that a claim is denied due to the operation of the Lifetime limit;

    e. Loss of eligibility when benefits are not offered to a class of similarly-situated individuals (for example, if health coverage for all part-time workers is terminated, such workers lose their eligibility, even if the Plan continues to provide coverage to other employees);

f. Loss of eligibility when the Employer's contributions toward the Employee's or Dependent's coverage terminate, even if a person continues the coverage by paying the amount previously paid by the Employer;

g. Loss of eligibility due to the exhaustion of COBRA Continuation Coverage; or

h. Loss of eligibility for coverage under Medicaid or CHIP, and

4. The Employee requested Plan enrollment not more than 31 days after termination of the other coverage, or in the case of Medicaid or CHIP coverage, not more than 60 days after the loss of coverage.

If the above conditions are met, Plan coverage shall be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application. For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

NOTE: Loss of other coverage due to failure on the part of the Employee to make contributions on a timely basis toward his or her coverage or toward coverage for his or her Dependents, or loss of coverage for cause (for example, making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to other coverage) shall not be a valid loss of coverage for purposes of this provision.

E-2. Enrollment Under CHIP

If an Employee has declined enrollment in the Plan for himself or herself or for his or her Dependents, including a spouse, because of coverage under Medicaid or CHIP, such Employee may be entitled to enroll in the Plan if there is a loss of eligibility for Medicaid or CHIP. However, a request for enrollment must be made no later than 60 days after coverage under Medicaid or CHIP ends. Any change in enrollment status shall be on a prospective basis only.

In addition, if an Employee has declined enrollment in the Plan for himself or herself or for his or her Dependents, including a spouse, and later becomes eligible for state assistance through Medicaid or CHIP to pay for Plan coverage, such Employee may be entitled to enroll in the Plan. However, a request for enrollment must be made no later than 60 days after the determination of eligibility for assistance through Medicaid or CHIP is made. Any change in enrollment status shall be on a prospective basis only.

E-3. Entitlement Due to Acquiring New Dependent(s)

If an Employee acquires one or more new eligible Dependents through marriage, birth, adoption, or placement for adoption (as defined by federal law and herein referred to as a "triggering event"), application for their coverage may be made within 31 days of the date that the new Dependents are acquired, and Plan coverage shall be effective as follows:

1. When the Employee's marriage is the triggering event, the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) shall be effective on the date of the marriage if application for coverage is made not later than 31 days after the marriage; and/or

2. When acquisition of a child is the triggering event, the child's coverage shall be effective on the date of the event (that is, on the child's date of birth, date of adoption, or date of placement) if application for coverage is made not later than 31 days after the event. The triggering event date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within 31 days of birth.

NOTE: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (that is, must have satisfied any Waiting Period requirement) and must enroll with such Dependent.

E-4. Court-Ordered Coverage

In accordance with state and federal law, if the Plan receives a Medical Child Support Order from a state court or agency and such order is determined by the Plan to be a QMCSO, the child shall be enrolled at the earliest possible date following such determination.

If the Employee is not enrolled when the Plan is presented with a QMCSO and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer may withhold any applicable payroll contributions for coverage from such Employee's pay.

E-5. Change in Status, Cost, or Coverage

An Employee shall be permitted to make Plan election changes when such changes are consistent with and made concurrently with changes allowed under the Plan Sponsor's § 125 cafeteria plan due to a qualified change as permitted under federal law. The effective date of the Plan changes shall be concurrent with the effective date of the cafeteria plan changes, unless an earlier effective date would be allowed under the terms of one of the other subsections of this Special Enrollment Rights provision.

F. Open Enrollment

If a person does not enroll when he or she is first eligible to do so or if he or she allows coverage to lapse, he or she may later enroll during an "Open Enrollment" period, which shall be held annually. The Plan Administrator for the Health Benefit Plan for the Employees of Piggly Wiggly Alabama Distributing Company, Inc. reserves the right to annually decide the open enrollment month(s),

NOTE: See **Special Enrollment Rights** for exceptions to this provision.

G. Reinstatement/Rehire

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and FMLA, and during the leave the Employee stopped paying his or her share of the cost of coverage causing coverage to terminate, such Employee may have coverage reinstated for himself or herself and for any Dependents who were covered at the point contributions ceased as if there had been no lapse. The Employer shall have the right to require that unpaid coverage contribution costs be repaid.

In accordance with USERRA, certain Employees who return to active employment following active duty service as a member of the United States armed forces shall be reinstated to coverage under the Plan immediately upon returning from military service. Additional information concerning USERRA may be obtained from the Plan Sponsor.

An Employee who has been terminated and who is rehired immediately after a period of time during which he or she was a COBRA Beneficiary shall not be required to complete the Waiting Period. All other terminated Employees who are rehired shall be treated as newly-hired and shall be required to satisfy all eligibility and enrollment requirements.

Benefits for any Employee or Dependent who is covered under the Plan, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time shall be limited to the Maximum Benefits that would have been payable had there been no interruption of employment or coverage.

H. Transfer of Coverage

If a husband and wife are both covered as Employees under the Plan, their children, if any, shall be covered as Dependents of the husband or the wife, but not of both. If a husband and wife are both covered as Employees under the Plan and one of them terminates coverage, the terminated spouse and any of his or her eligible and enrolled Dependents shall be permitted to immediately enroll under the remaining spouse's coverage. Application to enroll must be made not more than 31 days after the status change. Such new coverage shall be deemed an uninterrupted continuation of prior coverage and shall not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or as the Dependent of the terminated spouse.

If a Covered Person changes status from Employee to Dependent or vice versa and such person remains eligible and covered without interruption, Plan benefits shall not be affected by the change in status.

I. Adjustments for Prior Plan Sponsor Coverage

The coverage set forth in this Plan Document replaces prior coverage offered by the Plan Sponsor, but this Plan is not a new plan. Except to the extent that benefits are expressly added, deleted, or modified, any benefits paid with respect to such Covered Persons under the prior coverage shall be deemed to be benefits paid under this Plan Document for a person who is eligible as an Active Employee or a COBRA enrollee under this Plan Document on its effective date. Any continuous periods that a Covered Person was covered under prior coverage of the Plan Sponsor shall be deemed to be time covered under this Plan Document.

ARTICLE V- TERMINATION OF COVERAGE

A. Employee Coverage Termination

An Employee's coverage under the Plan shall terminate upon the earliest of the following:

1. The date on which the Employer terminates the Plan and offers no other group health plan;

2. The date on which the Employee's participation in the Plan terminates;

3. The date on which the Employee begins active duty service in the armed services of any country or organization, except for reserve duty of less than 30 days. See **Extension of Coverage During United States Military Service** in **ARTICLE VI – EXTENSION OF COVERAGE**;

4. The end of the period for which the Employee last made the required contribution, if coverage is provided on a contributory basis (that is, if the Employee shares in the cost);

5. At 11:59 p.m. on the last day the covered Employee retires, leaves, or is dismissed from the employment of the Employer; elects to terminate coverage; ceases to be eligible; ceases to be in an eligible class; or ceases to be engaged in active employment for the required number of hours as specified in **ARTICLE IV – ELIGIBILITY AND EFFECTIVE DATES**, except when coverage is extended pursuant to any provision of **ARTICLE VI – EXTENSION OF COVERAGE**; or

6. The date on which the Employee dies.

Unused vacation days or severance pay following cessation of active work shall not count as extending the period of time coverage shall remain in effect.

NOTE: An Employee otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his or her health status or need for health services.

B. Dependent Coverage Termination

A Dependent's coverage under the Plan shall terminate upon the earliest of the following:

1. The date on which the Employer terminates the Plan and offers no other group health plan;

2. The date on which the Employee's coverage terminates;

3. The date on which Dependent coverage under the Plan is discontinued for any and all Dependents;

4. At 11:59 p.m. on the last day on which the Dependent ceases to meet the eligibility requirements of the Plan, except when coverage is extended under the terms of any provision in **ARTICLE VI – EXTENSION OF COVERAGE**. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;

5. The end of the period for which the Employee last made the required contribution for such coverage, if the Dependent's coverage is provided on a contributory basis (that is, if the Employee shares in the cost). However, in the case of a child covered pursuant to a QMCSO, the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage that shall take effect immediately upon termination; or

6. The date on which the Dependent becomes eligible for coverage as an Employee.

NOTE: A Dependent otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his or her health status or need for health services.

C. Certificate of Creditable Coverage

When coverage under the Plan terminates, Employees and Dependents who were covered shall automatically receive a Certificate of Creditable Coverage showing the period of coverage under the Plan. Employees and Dependents have the right to request a Certificate of Creditable Coverage from the Claims Processor at any time while covered under the Plan and up to 24 months after coverage ceases. The Claims Processor may be reached at (800) 451-4318 to request the Certificate of Creditable Coverage.

ARTICLE VI – EXTENSION OF COVERAGE

A. General Information

Coverage may be continued beyond the dates set forth in **ARTICLE V - TERMINATION OF COVERAGE** under the circumstances identified below. However, unless expressly stated otherwise, coverage for a Dependent shall not extend beyond the date that the Employee's coverage ceases.

B. Extension of Coverage During Absence from Work

An Employee who fails to continue in eligible active status due to employer sponsored disability, a layoff, or an approved leave of absence may remain eligible for coverage under the Plan. With respect to an employer sponsored disability, such person shall remain as an Active Employee, for purposes of coverage under the Plan, as set forth in **ARTICLE XV - WEEKLY DISABILITY BENEFITS**. With respect to an employer sponsored layoff or an approved leave of absence, such person shall remain as an Active Employee, for purposes of coverage under the Plan, for six months following the date of the layoff or approved leave of absence. Should the layoff or approved leave of absence exceed six months, the Employee shall no longer be considered an Active Employee for purposes of coverage under the Plan, but shall instead be eligible for COBRA Continuation Coverage due to a Qualifying Event. During the period of COBRA Continuation Coverage, the Employee shall be responsible for making his or her contribution for the cost of Plan coverage. This provision shall not affect any of the COBRA provisions mandated under this Plan and does not apply to terminated Employees electing COBRA Continuation Coverage.

Any extended coverage allowances under this provision shall be provided on a non-discriminatory basis.

C. Extension of Coverage for Physically or Mentally Handicapped Dependent Children

The status of a Dependent child who attains the age of 26 years shall not terminate solely by reason of his or her having attained that age if:

1. On the day immediately before his or her 26th birthday, such child was covered under the Plan;

2. At the time such child attains the age of 26 years, he or she is Physically or Mentally Handicapped;

3. Such child's condition has been diagnosed by a Physician or other appropriate Covered Provider as a permanent or long-term dysfunction or condition;

4. Such child is primarily dependent upon the Employee for maintenance and support; and

5. Such child is unmarried.

A child who meets the above stated criteria shall continue to be covered under the Plan for as long as he or she remains in such condition and otherwise meets the requirements for a Dependent set forth in **ARTICLE IV – ELIGIBILITY AND EFFECTIVE DATES**.

The Employee must submit proof of the child's Physical or Mental Handicap to the Plan Administrator not more than 31 days after the child has attained the age of 26 years and thereafter at reasonable intervals as may be required, but not more frequently than once per year after the two-year period immediately following the child's 26th birthday. The Plan may require that a Physician chosen by the Plan examine the child before a determination is made regarding the child's eligibility for coverage pursuant to this provision and thereafter

at reasonable intervals as may be required, but not more frequently than once per year after the two-year period immediately following the child's 26th birthday.

The Plan Administrator shall have the right to require satisfactory proof of continued incapacity and dependence upon the Employee, the right to inquire into changes in the child's marital status, and the right to request that the child be examined by a Physician chosen by the Plan.

C-1. Termination of Extension of Coverage for Physically or Mentally Handicapped Dependent Children

Coverage for a Dependent child of an Employee pursuant to the above provision shall terminate if:

1. The Employee fails to submit required proof of the child's physical or mental handicap, as requested by the Plan Administrator;

2. A Physician of the Plan's choosing is not permitted to examine the child, as requested by the Plan Administrator;

3. The child ceases to be physically or mentally handicapped;

4. The child ceases to be dependent upon the Employee for maintenance or support; or

5. The child marries.

D. Extension of Coverage under FMLA

To the extent that the Employer is subject to FMLA, it intends to comply with FMLA. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs 50 or more Employees for each working day during each of 20 or more calendar workweeks in the current or preceding Calendar Year.

In accordance with FMLA, an Employee is entitled to continued coverage if he or she has worked for the Employer for at least 12 months, has worked at least 1,250 hours in the year preceding the start of the leave, and is employed at a worksite where the Employer employs at least 50 employees within a 75-mile radius.

Except as noted, continued coverage under FMLA provides for up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

1. The birth of an Employee's child and in order to care for the child;

2. The placement of a child with the Employee for adoption or foster care;

3. To care for a spouse, child, or parent of the Employee where such relative has a serious health condition;

4. The Employee's own serious health condition leaves him or her unable to perform the functions of his or her job; and/or

5. The Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, child, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (that is, a specified military operation) or occurring during the deployment of the spouse, child, or parent to a foreign country.

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee may obtain a more complete description of his or her FMLA rights from the Plan Sponsor's Human Resources or Personnel department(s). Any Plan provisions found to conflict with FMLA are modified to comply with at least the minimum requirements of FMLA.

NOTE: An eligible Employee shall be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, child, parent, or next of kin (that is, nearest blood relative) of a covered service member. A "covered service member" is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy; is an Outpatient; or is on the temporary disability retired list, for a "serious injury or illness" (that is, an injury or illness incurred in line of duty while on active duty in the Armed Forces that may render the service member medically unfit to perform his or her duties). A covered service member also includes a veteran of the Armed Forces who is undergoing medical treatment, recuperation, or therapy for a serious Injury or Illness that was sustained or aggravated while he or she was on active duty in the Armed Forces (whether or not the Injury or Illness manifested itself before or after he or she became a veteran) and who was a member of the Armed Forces at any time during the five-year period before he or she began the treatment, recuperation, or therapy.

In addition to the mandated FMLA coverage specified above, an Employee who qualifies for a maximum of 12 weeks of FMLA, and exhausts that maximum, shall be offered COBRA coverage. Such COBRA coverage shall count toward the maximum coverage period allowed for COBRA Continuation Coverage.

E. Extension of Coverage During United States Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan shall at all times comply with USERRA and its regulations for an Employee entering military service.

USERRA provides for the continuation of health benefits for Employees who are on military leave. If an Employee was covered under the Plan immediately prior to being ordered to active military duty, coverage may continue up to 24 months for elections made on or after December 10, 2004 or the duration of active military service, whichever is shorter. The Employee must pay the cost of coverage. The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost if the military leave is less than 31 days.

Regardless of whether an Employee elects continuation coverage under USERRA, coverage shall be reinstated on the first day that the Employee returns to active employment if the Employee was discharged or released under honorable conditions.

The Employee must return to employment on the first full business day following completion of military service for military leave of 30 days or less, within 14 days of completion of military service for military leave of 31 to 180 days, or within 90 days of completion of military service for military leave of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan shall apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period may be imposed on a returning Employee or on his or her Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

An Employee who is ordered to active military service and his or her eligible Dependents are considered to have experienced a COBRA-qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the above provisions.

ARTICLE VII – COBRA CONTINUATION COVERAGE

A. General Information

In order to comply with COBRA, the Plan includes a continuation of coverage option, which is available to certain Covered Persons whose health care coverage under the Plan would otherwise terminate. This Article is intended to comply with COBRA, but it is only a summary of the major features of the law. In any individual situation, the law, its applicable regulations, and its clarifications and intent shall prevail over this Article.

B. Defined Terms

When capitalized herein, the following items shall have the meanings set forth below:

1. **COBRA Beneficiary or Qualified Beneficiary:** A person who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee or the covered Dependent spouse or child of a covered Employee. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA Continuation Coverage is also a Qualified Beneficiary. Such child has the right to immediately elect, under the COBRA Continuation Coverage the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

NOTE: A person who is not covered under the Plan on the day before a Qualifying Event because he or she was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law may be considered to have had the Plan coverage and shall be a Qualified Beneficiary if that individual experiences a Qualifying Event; provided, however, that individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he or she was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

2. **Qualifying Event**: Any of the following events that would result in the loss of coverage under the Plan in the absence of COBRA Continuation Coverage:

   a. Voluntary or involuntary termination of an Employee's employment for any reason other than the Employee's gross misconduct;

   b. Reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not the Employee actually works and may include absence from work due to a disability, a temporary layoff, or a leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his or her portion of the cost of Plan coverage during the FMLA leave;

   c. For an Employee's spouse or child, the Employee's entitlement to Medicare. "Entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect. In accordance with IRS Revenue Ruling 2004-22, it is not the Plan's intent to recognize a terminated Employee's Medicare

entitlement as a second Qualifying Event for a spouse or child who is covered under the Plan as a COBRA-Qualified Beneficiary;

d. For an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;

e. For an Employee's spouse or child, the death of the covered Employee; and/or

f. For an Employee's child, the child's loss of Dependent status (for example, a Dependent child's reaching the maximum age limit).

3. **Non-COBRA Beneficiary**: A person who is covered under the Plan on an "active" basis (that is, an individual to whom a Qualifying Event has not occurred).

C. COBRA Notification Procedures for Employees

It is the responsibility of an Employee to provide the following written notices as they relate to COBRA Continuation Coverage:

1. **Notice of Divorce or Separation**: Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his or her spouse;

2. **Notice of Child's Loss of Dependent Status**: Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (for example, a Dependent child reaching the maximum age limit);

3. **Notice of a Second Qualifying Event**: Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;

4. **Notice Regarding Disability**: Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months and determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage has subsequently been determined by the Social Security Administration to no longer be disabled; and

5. **Notice Regarding Address Changes**: Notice of the current addresses of all Employees or Dependents who are or may become Qualified Beneficiaries.

Notification of a Qualifying Event must be made in writing to the Plan Administrator.

Notification must include an adequate description of the Qualifying Event or disability determination. In the case of a disability determination by the Social Security Administration, a copy such determination must be included. The Qualified Beneficiary must also provide any additional information deemed necessary by the Plan for making the appropriate determination with regard to the Notice, such as a divorce decree or a child's birth certificate.

Notification must be received by the Plan Administrator at the following address:

Piggly Wiggly Alabama Distributing Company, Inc.
2400 J Terrell Wooten Drive
Bessemer, Alabama 35020

The telephone number for assistance with COBRA questions is (205) 871-3229.

C-1. Time Requirements for Notification

Should an event occur as described above, the Employee or family member must provide notice to the designated recipient within the following time frames. The notice must be received in the Plan Administrator's office no more than 60 days after the occurring event.

In the case of a divorce or legal separation or of a child losing Dependent status, notice must be delivered no more than 60 days after the latest of the date of the Qualifying Event, the date health plan coverage is lost due to the event, or the date the Qualified Beneficiary is notified of the obligation to provide notice through the Plan Document or a General COBRA Notice. If notice is not received within the 60-day period, COBRA Continuation Coverage shall not be available, except in the case of a loss of coverage due to foreign competition, where a second COBRA election period may be available.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, notice must be delivered no more than 60 days after the latest of:

1. The date of the determination;

2. The date of the Qualifying Event;

3. The date that coverage is lost as a result of the Qualifying Event; or

4. The date that the covered Employee or Qualified Beneficiary is advised of the notice obligation through the Plan Document or a General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide notice no more than 30 days after the date that he or she is subsequently determined by the Social Security Administration to no longer be disabled.

Any person who is the covered Employee, a Qualified Beneficiary with respect to a Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary, may provide the notice. Notice by one person shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

The Plan shall not reject an incomplete notice as long as the notice identifies the Plan, the covered Employee and Qualified Beneficiaries, the Qualifying Event/disability determination, and the date on which such event occurred or such determination was made. However, the Plan is not prevented from rejecting an incomplete notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following such request.

D. Notification

If the Employer is the Plan Administrator and if the Qualifying Event is the Employee's termination, reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA Continuation Coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must

provide Qualified Beneficiaries with their COBRA rights Notice within 14 days thereafter. Notice to Qualified Beneficiaries must be in writing and must be sent by first-class mail.

If COBRA Continuation Coverage terminates early (for example, if the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiaries with notification of such early termination. Notice must include the reason for early termination, the date of termination, and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA Continuation Coverage, has a separate right to receive a written election Notice when a Qualifying Event has occurred that permits him or her to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement shall be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those Qualified Beneficiaries who have separate and independent rights to COBRA Continuation Coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that results in a Dependent child's ceasing to be eligible under the requirements of the Plan, or of the divorce or legal separation of the Employee from his or her spouse. A Qualified Beneficiary is also responsible for other notifications. See **COBRA Notification Procedures** in **ARTICLE VIII – SPECIAL NOTICES** and the Employer's "COBRA General Notice" or "Initial Notice" for further details and time limits imposed on such notifications. Upon receipt of a Notice, the Plan Administrator must notify the Qualified Beneficiaries of their continuation rights within 14 days.

E. Election and Election Period

COBRA Continuation Coverage may be elected during the period beginning on the date that Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following:

1. 60 days after coverage ends due to a Qualifying Event; or

2. 60 days after the Notice of COBRA Continuation Coverage rights is provided to the Qualified Beneficiary. Failure to make a COBRA election within the 60-day period shall result in the inability to elect COBRA Continuation Coverage.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA Continuation Coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary may be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA Continuation Coverage rights, the waiver may be revoked at any time before the end of the election period. Revocation of the waiver shall be an election of COBRA Continuation Coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date that they are sent to the Employer or Plan Administrator.

Open enrollment rights which allow Non-COBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" under HIPAA extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he or she does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a health care provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See **Effect of the Trade Act** for information regarding a second 60-day election period allowance.

F. Effective Date of Coverage

COBRA Continuation Coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary shall be charged for coverage in this retroactive period.

See **Election and Election Period** for an exception to the above when a Qualified Beneficiary initially waives COBRA Continuation Coverage and then revokes his waiver. In that instance, COBRA Continuation Coverage is effective on the date the waiver is revoked.

G. Level of Benefits

COBRA Continuation Coverage shall be equivalent to coverage provided to similarly situated Non-COBRA Beneficiaries. If coverage is modified for similarly situated Non-COBRA Beneficiaries, the same modification shall apply to Qualified Beneficiaries.

If the Plan includes a Deductible requirement, a Qualified Beneficiary's Deductible amount at the beginning of the COBRA continuation period must be equal to his or her Deductible amount immediately before that date. If the Deductible is computed on a family basis, only the expenses of those family members electing COBRA Continuation Coverage are carried forward to the COBRA Continuation Coverage. If more than one family unit results from a Qualifying Event, the family Deductibles are computed separately, based on the members in each unit. Other Plan limits are treated in the same manner as Deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that shall not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

H. Cost of Continuation Coverage

The cost of COBRA Continuation Coverage is fixed in advance for a 12-month determination period and shall not exceed 102% of the Plan's full cost of coverage during the period for similarly situated Non-COBRA Beneficiaries. The "full cost" includes any part of the cost which is paid by the Employer for Non-COBRA Beneficiaries. Qualified Beneficiaries shall be charged 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial premium payment (that is, for the cost of coverage) must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. If payment is not made within such time period, the COBRA election is null and void. The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Payment is considered to be made on the date that it is sent to the Plan or the Plan Sponsor.

The Plan must allow the payment for COBRA Continuation Coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA Continuation Coverage can only increase during the Plan's 12-month determination period if:

1. The cost previously charged was less than the maximum permitted by law;

2. The increase occurs due to a disability extension (that is, the 11-month disability extension) and does not exceed the maximum permitted by law, which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

3. The Qualified Beneficiary changes his coverage option(s) which results in a different coverage cost.

Timely payments which are less than the required amount but are not significantly less (an "insignificant shortfall") shall be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment shall be considered an insignificant shortfall if it is not greater than $50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and to then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTE: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the state may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the state through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices may be contacted for additional information.

See **Effect of the Trade Act** for additional cost of coverage information.

I. Maximum Coverage Periods

The maximum coverage periods for COBRA Continuation Coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

1. If the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see **Disability Extension** below), the 18 months is extended to 29 months;

2. If the Qualifying Event occurs to a Dependent due to an Employee's enrollment in the Medicare program before the Employee himself or herself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare; and

3. For any other Qualifying Event, the maximum coverage period ends 36 months after the Qualifying Event.

If a Qualifying Event occurs which provides for an 18- or 29- month maximum coverage period and is followed by a second Qualifying Event that provides for a 36-month maximum coverage period, the original period shall be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of

hours of employment shall not expand the maximum COBRA continuation period. In no event may the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event.

Also, COBRA coverage shall run concurrently with medical continuation of coverage under USERRA. If an Employee on military leave continues coverage under USERRA, equivalent months of COBRA entitlement shall be exhausted, unless there was another Qualifying Event.

J. Disability Extension

An 11-month disability extension (an extension from a maximum 18 months of COBRA Continuation Coverage to a maximum 29 months) shall be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA Continuation Coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination and the date of onset of such disability must fall within the allowable periods described. The Notice must be provided within 60 days of the disability determination and prior to the expiration of the initial 18-month COBRA Continuation Coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by the Social Security Administration to no longer be disabled.

If a person who is eligible for the 11-month disability extension has family members who are entitled to COBRA Continuation Coverage, those family members are also entitled to the 29-month COBRA Continuation Coverage period. This provision applies even if the disabled person does not elect the extension himself or herself.

K. Termination of Continuation Coverage

Except for an initial interruption of Plan coverage in connection with a waiver (see **Election and Election Period** above), COBRA Continuation Coverage that has been elected by or for a Qualified Beneficiary shall extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

1. The last day of the applicable maximum coverage period (see **Maximum Coverage Periods** above);

2. The date on which the Employer ceases to provide any group health plan to any Employee;

3. The date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan.

4. The date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. "Entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;

5. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

    a. 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

b. The end of the maximum coverage period that applies to the Qualified Beneficiary, without regard to the disability extension; or

6. The end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (that is, coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). *The Plan is required to make a complete response to any inquiry from a health care provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment*.

The Plan Sponsor may terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated Non-COBRA Beneficiaries for cause (for example, for the submission of a fraudulent claim).

If a person is receiving COBRA Continuation Coverage solely because of the person's relationship to a Qualified Beneficiary (for example, a Newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA Continuation Coverage available shall cease when the Plan is no longer obligated to make COBRA Continuation Coverage available to the Qualified Beneficiary.

L. Effect of the Trade Act

Pursuant to Public Law 107-210, referred to as the Trade Act of 2002 ("Trade Act"), the Plan is deemed to be "Qualified Health Insurance," because the Plan provides COBRA Continuation Coverage in the manner required of the Plan by the Trade Act for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the United States International Trade Commission and the DOL under the Trade Act of 1974, as amended.

L-1. Eligible Individuals

The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to the Trade Act as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of Trade Act benefits, including but not limited to a government certificate of Trade Act eligibility, a PBGC benefit statement, and federal income tax filings. The Plan need not require every available document to establish evidence of Trade Act eligibility. The burden for evidencing Trade Act eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

L-2. Temporary Extension of the COBRA Election Period

The following definitions shall apply:

1. **Non-Electing Trade Act-Eligible Individual**: A Trade Act-Eligible Individual who has a Trade Act related loss of coverage and who did not elect COBRA Continuation Coverage during the Trade Act-Related Election Period;

2. **Trade Act-Eligible Individual**: An eligible Trade Act recipient and an eligible alternative Trade Act recipient;

3. **Trade Act-Related Election Period**: With respect to a Trade Act-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a Trade Act-Eligible Individual; and

4. **Trade-Act Related Loss of Coverage**: With respect to an individual whose separation from employment gives rise to being a Trade Act-Eligible Individual, the loss of health benefits coverage associated with such separation. In the case of an otherwise COBRA Qualified Beneficiary who is a Non-Electing Trade Act-Eligible Individual, such individual may elect COBRA Continuation Coverage during the Trade Act-Related Election Period, but only if such election is made not later than six months after the date of the Trade Act-Related Loss of Coverage. Any continuation of coverage elected by a Trade Act-Eligible Individual shall commence at the beginning of the Trade Act-Related Election Period, and shall not include any period prior to the such individual's Trade Act-Related Election..

L-4. Applicable Cost of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a Trade Act-Eligible Individual pursuant to the Trade Act shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS Regulations 54.4980B-8, A-5(b), the Plan shall notify such individual of the deficient payment and allow 30 days to make full payment. Otherwise, the Plan shall return such payment to the individual and coverage shall terminate as of the original cost of coverage due date.

ARTICLE VIII– SPECIAL NOTICES

A. COBRA Notification Procedures

It is the responsibility of an Employee to provide the following notices as they relate to COBRA Continuation Coverage:

1. Notice of Divorce or Separation: Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his or her spouse;

2. Notice of Child's Loss of Dependent Status: Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (for example, a Dependent child reaching the maximum age limit);

3. Notice of a Second Qualifying Event: Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;

4. Notice Regarding Disability: Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months and determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage has subsequently been determined by the Social Security Administration to no longer be disabled; and

5. Notice Regarding Address Changes: Notice of the current addresses of all Employees or Dependents who are or may become Qualified Beneficiaries.

Notification of a Qualifying Event must be made in writing to the Plan Administrator.

Notification must include an adequate description of the Qualifying Event or disability determination. In the case of a disability determination by the Social Security Administration, a copy such determination must be included. The Qualified Beneficiary must also provide any additional information deemed necessary by the Plan for making the appropriate determination with regard to the Notice, such as a divorce decree or a child's birth certificate.

Notification must be received by the Plan Administrator at the following address:

Piggly Wiggly Alabama Distributing Company, Inc.
2400 J Terrell Wooten Drive
Bessemer, Alabama 35020

The telephone number for assistance with COBRA questions is (205) 871-3229.

B. Time Requirements for Notification

Should an event occur as described above, the Employee or family member must provide notice to the designated recipient within the following time frames. The notice must be received in the Plan Administrator's office no more than 60 days after the occurring event.

In the case of a divorce or legal separation or of a child losing Dependent status, notice must be delivered no more than 60 days after the latest of the date of the Qualifying Event, the date health plan coverage is lost

due to the event, or the date the Qualified Beneficiary is notified of the obligation to provide notice through the Plan Document or a General COBRA Notice. If notice is not received within the 60-day period, COBRA Continuation Coverage shall not be available, except in the case of a loss of coverage due to foreign competition, where a second COBRA election period may be available (see **Effect of the Trade Act** in **ARTICLE VII – COBRA CONTINUATION COVERAGE**).

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, notice must be delivered no more than 60 days after the latest of:

1. The date of the determination;

2. The date of the Qualifying Event;

3. The date that coverage is lost as a result of the Qualifying Event; or

4. The date that the covered Employee or Qualified Beneficiary is advised of the notice obligation through the Plan Document or a General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide notice no more than 30 days after the date that he or she is subsequently determined by the Social Security Administration to no longer be disabled.

Any person who is the covered Employee, a Qualified Beneficiary with respect to a Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary, may provide the notice. Notice by one person shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

The Plan shall not reject an incomplete notice as long as the notice identifies the Plan, the covered Employee and Qualified Beneficiaries, the Qualifying Event/disability determination, and the date on which such event occurred or such determination was made. However, the Plan is not prevented from rejecting an incomplete notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following such request.

C. Special Enrollment Rights under CHIP

If an Employee or a Covered Person has declined enrollment in the Plan for himself or herself or for his or her Dependents, including a spouse, because of coverage under Medicaid or CHIP, such Employee or Covered Person may be entitled to enroll in the Plan if there is a loss of eligibility for Medicaid or CHIP. However, a request for enrollment must be made within 60 days after coverage under Medicaid or CHIP ends. Any change in enrollment status shall be on a prospective basis only.

In addition, if an Employee or a Covered Person has declined enrollment in the Plan for himself or herself or for his or her Dependents, including a spouse, and later becomes eligible for state assistance through Medicaid or CHIP to pay for Plan coverage, such Employee or Covered Person may be entitled to enroll in the Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for assistance through Medicaid or CHIP is made. Any change in enrollment status shall be on a prospective basis only.

D. Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, federal law generally does not prohibit the mother's or Newborn's attending provider, after consulting with the mother, from discharging the mother or her Newborn earlier than 48 hours (or 96 hours as applicable). In any case,

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

E. WHCRA

Under federal law, the health benefits of most plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending Physician and the patient:

1. Reconstruction of the breast on which a mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce symmetrical appearance;

3. Breast prostheses; and

4. Physical complications of all stages of mastectomy, including lymphedemas.

Employees must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the WHCRA.

ARTICLE IX – COST MANAGEMENT SERVICES

A. General Information

The Plan includes Cost Management Services as described below. The purpose of such program is to encourage Covered Persons to obtain quality medical care while utilizing the most cost-efficient sources.

The Plan Sponsor has contracted with an independent Utilization Management Organizations to provide precertification services. For treatment of any Illness or Injury (except Mental Health conditions or Substance Use Disorders), precertification services are provided by:

Bay Care Management.
1-866-966-9221

For treatment of Mental Health Conditions or Substance Use Disorders, precertification services are provided by:

Behavioral Health Systems
(800) 245-1150

The procedures outlined below must be followed to avoid a penalty for non-compliance.

B. Services Requiring Precertification

The following services require precertification:

1. All Inpatient Hospital admissions;

2. All Inpatient Hospital admissions for a Mental Health Condition or for a Substance Use Disorder; and

3. All Outpatient Surgeries

C. Precertification Requirements

It is the Covered Person's responsibility to initiate the process to satisfy the precertification requirements. The Utilization Management Organizations with which the Plan has contracted shall review the Medical Necessity of a Surgery or of a Covered Person's Inpatient admission to a Hospital or to another covered facility and shall further review the appropriateness of care and/or the length of the Covered Person's Hospital stay. In addition, the Plan reserves the right to retrospectively review any procedure that requires precertification.

The Utilization Management Organizations require that the Employee or Covered Person, his or her attending Physician, or a member of his or her family contact such organizations as follows:

1. **For an Non-Emergency Hospital Admission**: At least seven days prior to admission;

2. **For an Emergency Hospital Admission**: Not more than two business days after admission;

3. **For a Maternity Hospital Admission**: Not more than two business days after admission if the admission is expected to exceed 48 hours following a normal vaginal delivery, or 96

hours following a cesarean section delivery. Precertification shall not be required for a maternity hospital admission that does not exceed 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section delivery. However, if/when the Pregnancy confinement for the mother or Newborn is expected to exceed these limits, precertification for such extended confinement is required.

D. Precertification Process

The following information must be provided to a Utilization Management Organization:

1. The Employee's or Covered Person's name, address, and Social Security number;

2. The patient's name, address, telephone number, date of birth, sex, and relationship to the Employee;

3. The name, address, and telephone number of the attending Physician and the Hospital or other covered facility;

4. The reason for the confinement in the Hospital or covered facility (that is, the patient's diagnosis and prognosis);

5. The expected (or, if an emergency, the actual) date of admission; and

6. The name of the Plan; that is, the "Health Benefit Plan for the Employees of Piggly Wiggly Alabama Distributing Company, Inc. – High Deductible Option"

If, in the opinion of the patient's Physician, it is necessary for the patient to be confined for a longer time than initially authorized, the Physician may request that additional days be authorized by contacting the Utilization Management Organization no later than the last authorized day.

It is the Employee's or Covered Person's responsibility to see to it that the precertification procedures required by the Utilization Management Organization have been completed. To minimize the risk of reduced benefits, the Employee or Covered Person should contact the Utilization Management Organization to make certain that the facility or attending Physician has initiated the necessary processes.

Precertification is not a guarantee of coverage. Cost Management Services are only intended to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan shall depend upon the patient's eligibility for coverage and the Plan's limitations and exclusions. Benefits shall not be paid for any confinement or service that is not Medically Necessary or that is not otherwise covered under the Plan.

See provisions regarding the filing of a Pre-Service Claim in **ARTICLE XVIII – CLAIMS PROCEDURES**, which include information about appealing an adverse decision (that is, a benefit denial or reduction) under the Utilization Management Program.

E. Precertification for Mental Health Conditions and Substance Use Disorders

Precertification is required for Mental Health Condition and Substance Use Disorder Hospital admissions. All Mental Health Conditions and Substance Use Disorders must be deemed Medically Necessary, either before, during, or after treatment by Behavioral Health Systems (BHS) at (800) 245-1150. The Employer encourages all Covered Persons to contact BHS prior to receiving treatment.

F. Penalty for Non-Compliance with Precertification Requirements

If the precertification requirements are not completed for services set forth in **Services Requiring Pre-certification** above, Coinsurance benefits payable for all expenses associated therewith shall be reduced to 50%. Any additional share of expenses that becomes the Employee's or Covered Person's responsibility as a penalty for failure to comply with these requirements shall not be considered Eligible Expenses and shall not apply to any Deductibles, Coinsurance, or Out-of-Pocket Maximums of the Plan.

NOTE: The Plan shall not reduce or deny a claim for failure to obtain precertification under circumstances that would make obtaining precertification impossible or where application of the precertification process could seriously jeopardize the life or health of the patient (for example, if the patient is unconscious and is in need of immediate care at the time that medical treatment is rendered).

G. Case Management Services

In situations where extensive or ongoing medical care is needed, the Utilization Management Organization may, with the consent of the patient or Covered Person and the Plan Sponsor, provide case management services. Such services may include contacts with the patient, his or her family, the primary treating Physician, other caregivers and care consultants, and the Hospital staff, as necessary.

The Utilization Management Organization shall evaluate and summarize the patient's continuing medical needs, assess the quality of current treatments, coordinate alternative care when appropriate and approved by the Physician and Plan Sponsor, review the progress of alternative treatment after implementation, and make appropriate recommendations to the Plan Sponsor.

The Plan Sponsor expressly reserves the right to make modifications to Plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services.

NOTE: *Case Management is a voluntary service. There are no reductions in benefits or penalties if the patient and family choose not to participate. Also, each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.*

ARTICLE X – COMPREHENSIVE MEDICAL COVERAGE

A. Choice of Providers

The Plan Sponsor has entered into agreements with one or more PPO's which have a network of health care providers. For the current Plan Year, the Plan has selected the following PPO's:

1. St. Vincent's Network, Dial A Nurse 205-939-7878
   www.stvphysicianalliance.com

2. Health Choice of Alabama, 866-508-4800, 205-715-4802 fax,
   www.healthchoiceofalabama.com;

3. Behavioral Health Systems (BHS) – Mental Health Conditions or Substance Use Disorders – 800- 245-1150

NOTE: SERVICES MUST BE RENDERED BY A ST. VINCENT'S NETWORK PROVIDER, A HEALTH CHOICE OF ALABAMA PROVIDER OR A BEHAVIORAL HEALTH SYSTEMS PROVIDER UNLESS OTHERWISE INDICATED IN THE SCHEDULE OF BENEFITS. SERVICES PROVIDED BY PROVIDERS THAT ARE NOT IN THESE NETWORKS WILL NOT BE CONSIDERED ELIGIBLE EXPENSES UNDER THE PLAN.

However, the choice of a health care provider is entirely up to the Covered Person, and each Covered Person, along with his or her health care provider(s), is ultimately responsible for determining his or her course of medical treatment. .

Any agreement between the Plan and the PPO's is subordinate to the provisions of this Plan Document. Contractual arrangements entered into by the Plan are for the exclusive benefit of the Plan, Employees, and Dependents. If the Plan Administrator, in its capacity as a Fiduciary of the Plan and in accordance with ERISA, determines, in its sole discretion, that the contractual arrangements are not in the best interests of the Plan, Employees, or Dependents in any particular case or that such provisions violate applicable laws, the Plan Administrator shall pay benefits in accordance with its Fiduciary duties and this Plan Document, regardless of any contractual arrangements to the contrary. In no event shall a PPO provider or a Non-PPO provider be paid more than the amount deemed by the Plan Administrator to be Reasonable and Appropriate under the terms of this Plan Document.

PPO providers are independent contractors; neither the Plan nor the Plan Administrator makes any representation as to the quality of care that may be rendered by any PPO provider.

A directory of PPO providers shall be furnished to all Employees, without charge, and shall be updated as needed. Since certain covered services and supplies may not be available through the PPO, Covered Persons are encouraged to refer to the PPO directory to determine if a particular specialty is included. Covered Persons are also encouraged to refer to this directory before scheduling appointments or elective procedures to verify that the provider from whom health care services are sought is a PPO provider.

B. Eligible Expenses

Eligible Expenses are payable if they are Reasonable and Appropriate and they:

1. Are incurred with respect to services ordered by a Physician or other Covered Provider;

2. Are Medically Necessary for the treatment of an Illness or an Injury, except as otherwise specified in the Schedule of Benefits;

3. Are not of a luxury or personal nature; and

4. Are not excluded under **ARTICLE XIV – MEDICAL LIMITATIONS AND GENERAL EXCLUSIONS**.

C. Deductibles, Copayments, and Coinsurance

Deductibles, Copayments, and Coinsurance are out-of-pocket amounts that a Covered Person must pay before the Plan pays benefits. An explanation of each follows:

1. **Deductibles**: Except as specified otherwise, Eligible Expenses are subject to a Calendar Year Deductible that must be met before benefits are payable. The following provisions apply to Calendar Year Deductibles:

   a. An Individual Deductible is satisfied once a Covered Person has paid the Individual Deductible amount;

   b. A Family Deductible is satisfied once amounts credited toward the Individual Deductibles of a Family Unit total the Family Deductible amount set forth in **ARTICLE XI – SCHEDULE OF BENEFITS**.

   c. Once the Family Deductible is satisfied, all Individual Deductibles for that family are considered to be satisfied for the remainder of that Calendar Year;

   d. There is a three-month carryover for Deductibles; that is, Eligible Expenses incurred in and applied toward the Deductible in October, November, and December of each year shall be applied toward the Deductible in the next Calendar Year.

   e. There is a Common-Accident Deductible; that is, when two or more Covered Persons in a Family Unit are injured in the same Accident, only one Deductible must be met before the Plan will consider payment of Eligible Expenses incurred as a result of the Accident.

   f. Each Hospital admission is subject to a separate Hospital Deductible.

2. **Copayments**: For certain specified services covered under the Plan, a Covered Person must pay a fixed fee, otherwise known as a “Copayment.” Such payment is typically made at the time the service is rendered to offset some of the cost of care. The size of the Copayment may vary depending on the service provided; and

3. **Coinsurance**: Most Eligible Expenses are payable by the Plan at less than 100%. After the Deductible is satisfied, a percentage of the Eligible Expense, known as “Coinsurance,” must be paid by the Covered Person, except with respect to those expenses subject to a Copayment. The Coinsurance amounts for PPO and Non-PPO providers are set forth in **ARTICLE XI– SCHEDULE OF BENEFITS**.

D. Out-of-Pocket Maximum

The maximum dollar amount of Medical Benefit Covered Expenses incurred during a Benefit Period, which a Covered Person must pay before certain benefits under the Plan are payable at a benefit percentage of 100%.This amount is stated in the Schedule of Benefits.

The St. Vincent's and Health Choice/Behavioral Health PPO Out-of-Pocket Maximum includes:

1. Coinsurance
2. Copays
3. Deductibles

The St Vincent's and Health Choice/Behavioral Health PPO Out-of-Pocket Maximum does not include:

1. Penalties resulting from non-compliance with the Utilization Management Program
3. Expenses not covered under the Plan
4. Claims that exceed reasonable and appropriate

E. Allocation and Apportionment of Benefits

Deductibles may be allocated to any Eligible Expense and benefits may be apportioned to the Covered Person and/or to any assignees. Such allocation and apportionment shall be conclusive and binding upon the Covered Person and all assignees.

ARTICLE XI– SCHEDULE OF BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully in the Summary Plan Description (SPD) including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Reasonable and Appropriate; and that services, supplies and care are not Experimental and/or Investigational.

Verification of Eligibility: Toll Free (outside Birmingham, Alabama area) 800-451-4318 or local (Birmingham, Alabama) 205-871-3229 or go to www.yourtpa.com. Call this number to verify eligibility for Plan benefits before the charge is incurred.

Precertification through the utilization management organization is required prior to services being rendered for all inpatient admissions and outpatient surgeries. Although not required for childbirth as outlined by Federal Legislation, pre-notification is recommended and penalty for failure to pre-notify a hospitalization may apply should a hospitalization result in an extended stay beyond that mandated by Federal Legislation**.**

For Inpatient admissions (other than mental health or substance abuse disorders) and outpatient surgeries:

Bay Care Management, Inc.
(866) 966-9221

For treatment of Mental Health Conditions or Substance Use Disorder, precertification services are provided by:

Behavioral Health Systems
(800) 245-1150

PPO Provider Network:

1. St. Vincent's Network
   www.stvphysicianalliance.com
   St. Vincent Dial a Nurse 205-939-7878

2. Health Choice of Alabama
   205-939-7030
   www.healthchoiceofalabama.com

3. BHS – Mental Health Conditions or Substance Use Disorders
   (800) 245-1150

Where to File Claims:

Alternative Insurance Resources/Global Care, Inc.
EDI Payor ID: 07689
P.O. Box 247
Alpharetta, GA 30009-0247

A. MEDICAL BENEFITS

BENEFIT MAXIMUMS	
Once a Maximum Benefit for a specified service is met, no additional benefits for that service are available for the remainder of the time period specified. The Maximum Benefits specified below are per Covered Person**.**	
Lifetime Maximum Benefit	Unlimited
Calendar Year Maximum Benefit for Essential Health Benefits,	Unlimited
Chiropractic Care	No more than four visits per 30 day period
Hospital Room and Board for Private or Semi-Private Room	Average semi-private room rate for the Hospital, provided such rate is Reasonable and Appropriate
ICU, CCU, and Burn Unit	Actual Hospital charge, provided that such charge is Reasonable and Appropriate

DEDUCTIBLES Expenses applied to the St. Vincent's Deductible will be applied to the Health Choice Deductible and expenses applied to the Health Choice Deductible will be applied to the St. Vincent's Deductible**.**		
Calendar Year Deductible	**St. Vincent's**	**Health Choice**
Per Covered Person	$1,500	$3,000
Per Family	Maximum 3 per family	Maximum 3 per family

COINSURANCE		
	St. Vincent's	**Health Choice**
Plan/Covered Person Percentage	90%/10%	70%/30%

OUT-OF-POCKET Expenses applied to the St. Vincent's Out-of-Pocket will be applied to the Health Choice Out-of-Pocket and expenses applied to the Health Choice Out-of-Pocket will be applied to the St. Vincent's Out-of-Pocket		
	St. Vincent's	**Health Choice**
Maximum Out-of-Pocket per Covered Person including deductibles, coinsurance and copays	$7,150	$10,000
Maximum Out-of-Pocket per Family including deductibles, coinsurance and copays	$14,300	$20,000

ELIGIBLE EXPENSES – MEDICAL		
This schedule shows the percentage that may be payable by the Plan for an Eligible Expense after any Copayment, Deductible, and/or Coinsurance, if applicable, has been satisfied. The percentages shown may be applied to the Reasonable and Appropriate charge for an Eligible Expense. For PPO providers, that charge may be based on the discounted rate. However, at the discretion of the Plan Sponsor/Administrator, PPO provider charges may be reviewed to determine if they are Reasonable and Appropriate, in lieu of using the PPO discounted rate**.**		
	St. Vincent's	**Health Choice**
Chiropractic Care (Limited to No More Than Four Visits Every 30-Day Period)	90% after Calendar Year Deductible	70% after Calendar Year Deductible
Colorectal Screening • **Age 50 to age 75** • **Fecal occult blood testing – one per calendar year** • **Sigmoidoscopy – one every five years** • **Colonoscopy – one every ten years**	100% with Calendar Year Deductible Waived	Not Covered
HOSPITAL SERVICES		
ER Services	90% after Calendar Year Deductible	90% after Calendar Year Deductible
Inpatient (Must Be Precertified)	90% after Calendar Year Deductible	70% after Calendar Year Deductible
Outpatient Services (Not Including Outpatient Surgery)	90% after Calendar Year Deductible	70% after Calendar Year Deductible
Outpatient Surgery (Must Be Precertified)	90% after Calendar Year Deductible	70% after Calendar Year Deductible
PHYSICIAN SERVICES		
Primary Care Physician Office Visit	100% after $15 copay after the Calendar Year Deductible	70% after Calendar Year Deductible
Specialist Physician Office Visit	100% after $25 copay after the Calendar Year Deductible	70% after Calendar Year Deductible
Emergency Room Physician/Emergency Room Radiology-Pathology	90% after Calendar Year Deductible	90% after Calendar Year Deductible
Pregnancy	Same as for any other illness	Same as for any other illness
Radiology/Pathology	90% after Calendar Year Deductible	70% after Calendar Year Deductible
Renal Dialysis	90% after Calendar Year Deductible	70% after Calendar Year Deductible

ELIGIBLE EXPENSES – MEDICAL		
This schedule shows the percentage that may be payable by the Plan for an Eligible Expense after any Copayment, Deductible, and/or Coinsurance, if applicable, has been satisfied. The percentages shown may be applied to the Reasonable and Appropriate charge for an Eligible Expense. For PPO providers, that charge may be based on the discounted rate. However, at the discretion of the Plan Sponsor/Administrator, PPO provider charges may be reviewed to determine if they are Reasonable and Appropriate, in lieu of using the PPO discounted rate.		
	St. Vincent's	**Health Choice**
Therapy Services, Outpatient (Including Cardiac Rehabilitation, Chemotherapy, Occupational/Physical Therapy, Radiation Therapy, Respiratory Therapy, and Speech Therapy)	90% after Calendar Year Deductible	70% after Calendar Year Deductible
Preventative Adult Care – (limited to services required by the Patient Protection and Affordable Care Act – services not available from a Preferred Provider will be reimbursed at 100%-go to www.yourtpa.com for link to covered services)	100% with Calendar Year Deductible Waived	Not covered
Preventative Child Care – (limited to services required by the Patient Protection and Affordable Care Act – services not available from a Preferred Provider will be reimbursed at 100%-go to www.yourtpa.com for link to covered services)	100% with Calendar Year Deductible Waived	Not covered
All Other Eligible Medical Expenses (Excluding Mental Health Conditions and/or Substance Use Disorders)	90% after Calendar Year Deductible	70% after Calendar Year Deductible

ONLY SERVICES PROVIDED BY ST. VINCENT'S OR HEALTH CHOICE PROVIDERS WILL BE COVERED. THERE WILL BE NO BENEFITS FOR SERVICES PROVIDED BY PROVIDERS OUTSIDE OF THE ST. VINCENT'S OR HEALTH CHOICE NETWORKS OF PROVIDERS WITH THE FOLLOWING EXCEPTIONS:

Services provided by Non-PPO Providers will be processed under the St. Vincent's Provider benefit subject to Reasonable and Appropriate under the following circumstances:

1. Services are not available in the PPO Service Area and treatment is referred by a St. Vincent's Provider to a Non-PPO Provider.
2. Lab work is referred to a Non-PPO provider by a St. Vincent's PPO provider.
3. Treatment is provided by a Non-PPO provider at a St. Vincent's PPO facility.

Services provided by Non-PPO Providers will be processed under the Health Choice Provider benefit subject to Reasonable and Appropriate under the following circumstances:

1. A PPO Provider is not available in the St. Vincent's or Health Choice PPO Service Area.
2. Services are not available in the PPO Service Area and treatment is referred by a Health Choice Provider to a Non-PPO Provider.
3. Lab work is referred to a Non-PPO provider by a Health Choice PPO provider.
4. Treatment is provided by a Non-PPO provider at a Health Choice PPO facility.
5. A Covered Participant is out of the St. Vincent's or Health Choice Service Area and has a Medical Emergency requiring immediate care.
6. Treatment is received by Participants living outside and receiving treatment outside the PPO Service.

B. MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE DISORDERS

ELIGIBLE EXPENSES – MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS		
Behavioral Health Services ("BHS") shall provide a PPO network for providers of treatment for Mental Health Conditions and Substance Use Disorders ("BHS PPO"). All Mental Health Conditions and Substance Use Disorders must be deemed Medically Necessary, either before, during, or after treatment, by BHS at (800) 245-1150. The Employer encourages all Covered Persons to contact BHS prior to receiving treatment. Inpatient treatment of Mental Health Conditions and/or Substance Use Disorders must be precertified. BHS shall provide precertification services for Inpatient treatment and an initial assessment if contacted prior to treatment. All BHS PPO payments are based on current BHS PPO fee schedules as determined by BHS.		
	BHS PPO	**BHS Non-PPO**
ER Services		
Hospital, Mental Health Condition Treatment Facility, or Substance Use Disorder Treatment Facility	90% after $100 copayment	Not Covered
Physician	90%	Not Covered
Inpatient Services		
Hospital, Mental Health Condition Treatment Facility, or Substance Use Disorder Treatment Facility	70%	Not Covered
Partial Hospitalization Program/ Intensive Outpatient Program	70%	Not Covered
Structured Substance Use Disorder/Intensive Outpatient Program	70%	Not Covered
Electroconvulsive Therapy		
Facility and Anesthesia	70%	Not Covered
Physician	70%	Not Covered
Psychiatrist Visit and/or Consultation	70%	Not Covered
Outpatient Services		
Assessment	70%	Not Covered
Physician Office Visit	70%	Not Covered
Psychological Testing	70%	Not Covered
Therapy (at PhD or MS Level)	70%	Not Covered
Other Services		
Ambulance	70%	Not Covered

Home Health Visit	70%	Not Covered
Laboratory	70%	Not Covered
All Other Eligible Expenses for Mental Health Conditions and/or Substance Use Disorders	70%	Not Covered

NOTE: Treatment for a Mental Health Condition provided by a Covered Provider who is not a psychiatrist, psychologist, or licensed professional counselor shall be deemed a claim for medical benefits and shall be payable as for any other Illness.

C. PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG BENEFITS		
The Plan shall pay 100% of the cost of Eligible Expenses for Prescription Drugs remaining after the Copayments stated herein. **Variable Copay Program™**: Piggly Wiggly Alabama Distributing has adopted the Southern Scripts Variable Copay Program™ to help members who utilize manufacturer copay programs save money on prescription drugs. Please refer to **PRESCRIPTION DRUG BENEFITS** for more information. Important Note: If you are eligible for a manufacturer copay subsidy for a drug but fail to obtain the subsidy, your copay obligation – and the out-of-pocket cost you may be required to pay – will be the maximum manufacturer copay subsidy for that drug.		
	PPO	**Non-PPO**
	Pharmacy Option (30-Day Supply Purchased with Pharmacy Drug Card)	
Tier 0 – Over-the-Counter ("OTC") (Limited to the Following Classes of Drugs with a Written Prescription for the Generic or Brand Equivalent of the Drug): **Acid-Reducing Products Such as Prilosec OTC, Tagamet, or Zantac, But Excluding Rolaids, Tums, or Similar Antacids** **Loratadine Products Such as Alavert or Claritin**	$0 copayment	N/A
Tier I – Generic Drugs	$15 copayment	N/A
Tier 2 – Preferred Brand Drugs (No Generic Available)	40% of cost of drug – maximum $100	N/A
Tier 3 – Non-Preferred Brand Drugs	40% cost of drug – maximum $150	N/A
Specialty Drugs - limited to Retail 30 day supply only	40% cost of drug – maximum $150	N/A
Contraceptives – prescription required – RX and OTC – FDA Approved – Name brand only if no generic equivalent available	$0 copayment	N/A

	Retail Option (31-90 Day Supply Purchased with Pharmacy Drug Card)	
Tier 1 – Generic Drugs	$30 copayment	N/A
Tier 2 – Preferred Brand Drugs (No Generic Available)	40% of cost of drug – maximum $200	N/A
Tier 3 – Non-Preferred Brand Drugs	40% cost of drug – maximum $300	N/A
Contraceptives – prescription required – RX only – Name brand only if no generic equivalent available	$0 copayment	N/A
	Mail Order Option (up to a 30-Day Supply Purchased with Pharmacy Drug Card)	
Tier 1 – Generic Drugs	$15 copayment	N/A
Tier 2 – Preferred Brand Drugs (No Generic Available)	30% of cost of drug – maximum $100	N/A
Tier 3 – Non-Preferred Brand Drugs	30% cost of drug – maximum $150	N/A
Contraceptives – prescription required – RX only – Name brand only if no generic equivalent available	$0 copayment	N/A
	Mail Order Option (31-90 Day Supply Purchased with Pharmacy Drug Card)	
Tier 1 – Generic Drugs	$30 copayment	N/A
Tier 2 – Preferred Brand Drugs (No Generic Available)	30% of cost of drug – maximum $200	N/A
Tier 3 – Non-Preferred Brand Drugs	30% cost of drug – maximum $300	N/A
Contraceptives – prescription required – RX only – Name brand only if no generic equivalent available	$0 copayment	N/A

ARTICLE XII – PHARMACY DRUG CARD BENEFITS

A. General Information

The Piggly Wiggly Alabama Distributing Company, Inc. Pharmacy Drug Card Program ("Pharmacy Drug Card Program") is designed to provide Employees and their eligible Dependents with a convenient way to purchase Prescription Drugs. Drugs covered under the Pharmacy Drug Card Program are subject to the Plan exclusions and limitations.

From time to time, certain drugs otherwise covered under this Plan may not be available under the Pharmacy Drug Card Program. Questions or concerns about obtaining a Prescription Drug may be directed to the Pharmacy Benefit Manager listed on the Pharmacy Drug Card issued to each Employee.

This Article only provides a summary of the Prescription Drug coverage offered by the Plan. The actual controlling provisions and lists of covered and excluded drugs, devices, items, and services must be obtained directly from the Plan Sponsor or from the Pharmacy Benefit Manager.

B. Pharmacy Option

Participating Pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. A list of participating Pharmacies may be obtained from the Pharmacy Benefit Manager listed on the Pharmacy Drug Card issued to each Employee.

NOTE: Except as otherwise provided in this Plan Document, only prescriptions purchased at a participating Pharmacy with the Pharmacy Drug Card shall be covered.

B-1. Copayment

A Copayment is applied to each covered Pharmacy drug charge, as shown in **ARTICLE XI – SCHEDULE OF BENEFITS**. The Copayment amount is not an Eligible Expense under the Plan.

C. Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (that is, those taken for long periods of time, such as drugs prescribed for asthma, heart disease, and high blood pressure). Because of volume buying, the mail order Pharmacy is able to offer Covered Persons significant savings on their Prescriptions Drugs.

C-1. Copayment

A Copayment is applied to each covered mail order prescription charge, as shown in **ARTICLE XI – SCHEDULE OF BENEFITS**. The Copayment is not an Eligible Expense under the Plan.

D. Covered Prescription Drugs

The following is a list of Prescription Drugs and non-prescription drugs and supplies covered by this Plan:

1. All drugs prescribed by a Physician or other Covered Provider licensed to prescribe that require a prescription, either by federal or state law, and drugs not set forth in **Expenses Not Covered** below;

2. **ADD** Medications covered through age 25;

3. **Anaphylaxis Kits (**Epinephrine);

4. **Acne Medication** covered through age 25;

5. All **compounded drugs** containing at least one prescription ingredient in a therapeutic quantity;

6. **Contraceptives**: Oral, Patch, Cervical Cap, Injectables, Spermicide, Sponge, Vaginal Ring – generic and name brand with no generic equivalent available without cost sharing under PPACA guidelines.

7. **Diabetic needs**: Insulin, Lancets, Test Strips, Glucagon, Urine Test Strips, Insulin Needles and Syringes.

8. **Migraine Medications**: Oral, Injectable, Nasal Spray;

9. **Smoking Cessation:** Prescription and over-the-counter as mandated by PPACA

10. **Vaccines/Immunizations: PPACA** mandated covered vaccines and immunizations

11. **Vitamins**: Prenatal

NOTE: The Prescription Drug benefit only applies when a Covered Person incurs an expense for a covered Prescription Drug. Coverage for expenses for any single prescription is limited to refills not exceeding the number specified by the prescribing Physician or other Covered Provider, or refills up to one year from the date of order by such Physician or Covered Provider.

E. Expenses Not Covered

Prescription Drug coverage shall not be provided for any of the following:

1. **Administration**: Charges for the administration of a covered Prescription Drug.

2. **Anti-Obesity** Medications

3. **Blood Products**

4. **Contraceptive Devices or Implants**

5. **Cosmetic:** Hair Products, Anti-Wrinkle Agents

6. **Devices**: Charges for devices of any type, even if such devices may require a prescription, including but not limited to artificial appliances, braces, support garments, and therapeutic devices.

7. **Diabetic Needs**: Alcohol Swabs, Glucagon, Glucose Monitors, Lancet Devices

8. **Experimental Drugs**: Charges for an Experimental drug, even if a charge is made to the Covered Person, including any drugs that is not commercially available for purchase in the United States and/or is not approved by the FDA for general use unless required under PPACA .

9. **Growth Hormones**

10. **Impotency Drug**

11. **Infertility Medications**

12. **Injectables** (Other Than Insulin and Imitrex): Charges for injectable drugs and for hypodermic needles and/or syringes.

13. **No Charge:** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

14. **Over-the-Counter Medications** except as mandated by the Patient Protection and Affordable Care Act or listed in the Schedule of Benefits as covered.

15. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

The Plan Administrator, in its sole discretion, reserves the right to authorize coverage under the Prescription Drug Card Program for a prescription drug not covered under the drug card program if the prescription drug is otherwise considered a covered expense under the medical plan.

ARTICLE XIII – ELIGIBLE MEDICAL EXPENSES

A. General Information

This Article lists those medical conditions, services, and supplies that are covered by the Plan, and must be read in conjunction with **ARTICLE XI – SCHEDULE OF BENEFITS** to understand how Plan benefits are determined. All medical care, services, and supplies must be approved by a Physician or other appropriate Covered Provider, must be received from or ordered by a Covered Provider, and must be Medically Necessary for the care and treatment of an Injury, an Illness, Pregnancy, another covered medical condition.

Except as otherwise noted below, benefits are payable based on the Reasonable and Appropriate charge for the expense incurred by a Covered Person, and are subject to **ARTICLE III – DEFINITIONS, ARTICLE XIV – MEDICAL LIMITATIONS AND GENERAL EXCLUSIONS,** and all other terms and conditions of the Plan.

ARTICLE XI – SCHEDULE OF BENEFITS should be referred to in determining what percentage of each Eligible Expense is payable by the Plan.

B. Eligible Expenses

The following are covered by the Plan:

1. **Ambulance**: Charges for professional ambulance service via air or ground transportation to the nearest facility equipped to render required treatment or between medical facilities when Medically Necessary. In no event will coverage be provided for a trip in excess of 50 miles from the place of pickup, unless the Plan Administrator finds a longer trip to be Medically Necessary.

2. **Ambulatory Surgical Center**: Charges for services and supplies provided by an Ambulatory Surgical Center (see **ARTICLE III – DEFINITIONS**) in connection with a covered Outpatient Surgery.

3. **Anesthesia**: Charges for anesthetics and services of a Physician or a Certified Registered Nurse Anesthetist for the administration of Anesthesia in connection with a surgical procedure.

4. **Assistant Surgeon**: Charges for the services of an Assistant Surgeon when Medically Necessary to render assistance during a surgical procedure. Eligible Expenses for an Assistant Surgeon shall be payable at 25% of the Reasonable and Appropriate charge for the major surgical procedure only.

   NOTE: If the assistance is rendered by a Physician Assistant or a Surgical Assistant, Eligible Expenses for such assistance shall be limited to 15% of the Reasonable and Appropriate charge for the major surgical procedure only.

5. **Birthing Center**: Charges for services and supplies provided by a Birthing Center (see **ARTICLE III – DEFINITIONS**) in connection with a covered Pregnancy.

6. **Blood/Plasma**: Charges for blood and blood derivatives that have not been donated or replaced and for intravenous injections and solutions, including administration services.

7. **Cardiac Rehabilitation**: Charges for cardiopulmonary rehabilitation programs under the direct supervision of a Physician in a facility which primarily provides medical care for Illness or Injury.

8. **Chemotherapy**: Charges for professional services and supplies related to the administration of chemical agents in the treatment or control of an Illness.

9. **Chiropractic Care**. Limited to 4 visits per 30-day period.

10. **Colonoscopies –** Limited to one every 10 years, age 50 -75 as mandated by PPACA.

11. **Cosmetic and Reconstructive Surgery**: Eligible Expenses are limited to the following:

    a. Charges for coverage required by the WHCRA (that is, reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage shall be provided for such care as determined by the attending Physician in consultation with the patient;

    b. Charges for treatment or Surgery to correct a congenital anomaly in a Dependent child; and

    c. Charges for treatment or Surgery necessitated by an Accident, *provided that* the treatment is received not more than 12 months after the date of the Accident.

12. **Dental Care**: Eligible Expenses are limited to the Reasonable and Appropriate charge for following:

    a. Emergency repair of Injury to sound natural teeth caused by an Accident, *provided that* all treatment is rendered within 12 months of the date of such Accident and all treatment is rendered while the patient is covered under the Plan;

    b. Excision of:

        i. Benign bony growths of the jaw and hard palate;

        ii. Cysts and tumors of the jaws, cheeks, lips, tongue, and/or roof and floor of the mouth; and

        iii. Wholly or partly unerupted bony impacted teeth;

    c. External incision and drainage of cellulitis;

    d. Incision of sensory sinuses, salivary glands, or ducts;

    e. Reduction of dislocations; and

    f. Surgery needed to correct Injury to the jaws, cheeks, lips, tongue, and/or floor and roof of the mouth caused by an Accident, *provided that* all treatment is rendered within 12 months of the date of such Accident and all while the patient is covered under the Plan.

NOTE: Coverage shall not be provided for Oral Surgery or other procedures involving orthodontic care of the teeth, periodontal disease, and/or preparation of the mouth for the fitting or continued use of dentures.

13. **Diagnostic Laboratory and X-ray**: Charges for:

    a. Basal metabolism tests, electrocardiograms, electroencephalograms, pneumo-encephalograms, or similar well-established diagnostic tests generally approved by Physicians throughout the United States; and

    b. Laboratory studies, including but not limited to include laboratory and/or microscopic tests necessary for the diagnosis or treatment of a covered Illness or Injury. Hospital Pre-Admission testing must occur no more than seven days prior to a scheduled Inpatient Hospital confinement.

NOTE: Amniocentesis and/or ultrasound during Pregnancy is covered only when the attending Physician certifies that such procedure is Medically Necessary.

14. **Durable Medical Equipment**: Charges for rental and maintenance of durable medical equipment required for therapeutic use or for the purchase of durable medical equipment when purchase is more cost-effective due to a long-term need for such equipment. Charges for the repair or replacement of durable medical equipment shall be covered if due to a change in the patient's medical condition, if economically justified, and if the Covered Person has taken proper care of such equipment.

NOTE: Insulin infusion pumps are limited to one per Calendar Year, and Jobst garments are limited to two per Calendar Year.

15. **Educational:** Diet counseling for adults at higher risk for chronic disease in accordance with PPACA Preventative Care guidelines.

16. **Freestanding Emergency Medical Care Facility**: Charges for services and supplies provided by a Freestanding Emergency Medical Care Facility (see **ARTICLE III – DEFINITIONS**)

17. **Home Health Care**: Charges for services and supplies furnished to a Covered Person by a Home Health Care Agency for care and treatment of an Illness or an Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care, and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan established and approved in writing by the Covered Person's attending Physician and reviewed by such Physician at least every two months during the period of Home Health Care. Eligible Expenses for services and supplies are limited to:

    a. Part-time or intermittent services of an RN, an LPN, or a public health Nurse under the direct supervision of an RN;

    b. Part-time or intermittent services of home health aides for a Covered Person who is receiving covered nursing or therapy services;

    c. Medical equipment and supplies routinely furnished by the Home Health Care Agency;

    d. Drugs that require a Physician's prescription; and

e. Laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under the Plan if the Covered Person had remained hospitalized.

A "Home Health Care Visit" means a visit by a member of a Home Health Care team. Each such visit that lasts for a period of four hours or less is treated as one Home Health Care Visit. If the visit exceeds four hours, each four-hour period shall be treated as one visit, as shall any period of time less than four hours.

NOTE: Home Health Care does not include the following:

- Custodial care and housekeeping;
- Services and supplies not included in the Home Health Care Plan;
- Services of a Close Relative or of any person who ordinarily resides in the home of the Covered Person;
- Services of any social worker; and/or
- Transportation services.

18. **Hospice Care**: Charges for the care of a Covered Person with a terminal prognosis (that is, a life expectancy of six months or less) who has been admitted to a formal program of Hospice care established and approved in writing by the Covered Person's attending Physician, reviewed by such Physician at least every two months during the period of Hospice care, and certified as Medically Necessary by such Physician. Eligible Expenses include:

    a. Inpatient care in a Hospice facility, including:

        i. Room, board, routine services and supplies, and rental of DME furnished by the Hospice facility and used solely for treating an Illness or an Injury;

        ii. Physician services and/or nursing care provided by an RN or an LPN; and

        iii. Drugs prescribed by the attending Physician, but only to the extent that such drugs are necessary for pain control and management of the terminal condition;

    b. Home care, including:

        i. Routine services, supplies, and rental of durable medical equipment furnished by the Hospice;

        ii. Care furnished by a Hospital or Home Health Care Agency under the direction of a Hospice, including custodial care if it is provided during a regular visit by an RN, an LPN, or a home health aide;

        iii. Respite care; and

        iv. Drugs and medical supplies prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition; and

c. Bereavement counseling and other support services provided to the family of the dying person.

19. **Hospital Services**: Charges for services and supplies furnished by a Hospital, Ambulatory Surgical Center, Birthing Center, Freestanding Emergency Medical Care Facility, or other covered facility provided on an Outpatient basis, and for Inpatient care, including daily room and board and ancillary services and supplies. Eligible Expenses for Inpatient room and board are limited to the Reasonable and Appropriate charge for a room or, if Medically Necessary, the Reasonable and Appropriate charge for confinement in an ICU, CCU, or Burn Unit. Room charges made by a Hospital having only "private rooms" shall be payable at 80% of the average private room rate.

NOTE: A confinement shall be considered an Inpatient confinement after 23 hours of observation.

20. **Mental Health Conditions**: Charges for the treatment of Mental Health Conditions are covered as any other Illness.

21. **Midwife**: Charges for the services of a Certified or Registered Nurse Midwife when provided in conjunction with a covered Pregnancy. See Pregnancy Care.

22. **Morbid Obesity**: Charges for:

a. Medically Necessary, Physician-supervised weight loss or weight management programs, including supplies or services but not including food items, when a Covered Person is Morbidly Obese; and

b. Medically Necessary Surgery for Morbid Obesity if in compliance with the National Institutes of Health Consensus 1991 guidelines, as set forth below. Benefits shall only be provided for one surgical procedure for Morbid Obesity per Covered Person under this Plan. Benefits shall be provided for a subsequent Surgery for complications related to a covered surgical procedure for Morbid Obesity, but only if Medically Necessary and in compliance with the aforementioned guidelines. However, no benefits shall be provided for subsequent Surgery for complications related to a covered surgical procedure for Morbid Obesity (including but not limited to revisions or adjustments to a covered surgical procedure or conversion to another covered bariatric procedure, weight gain, or failure to lose weight) if the complications arise from non-compliance with medical recommendations regarding patient activity and lifestyle following the procedure. This exclusion for subsequent Surgery for complications that arise from non-compliance with medical recommendations applies even if the subsequent Surgery would otherwise be Medically Necessary and/or would otherwise be in compliance with the guidelines.

The National Institutes of Health Consensus 1991 guideline for Morbid Obesity are as follows:

- Patients seeking treatment for severe obesity for the first time should be considered for treatment in a nonsurgical program with integrated components of a dietary regimen, appropriate exercise, and behavioral modification and support;

- Gastric restrictive or bypass procedures could be considered for well-informed and motivated patients with acceptable operative risks;

- Patients who are candidates for surgical procedures should be selected carefully after evaluation by a multidisciplinary team with medical, surgical, psychiatric, and nutritional expertise;

- The operation must be performed by a surgeon substantially experienced with the appropriate procedures and working in a clinical setting with adequate support for all aspects of management and assessment; and

- Lifelong medical surveillance after surgical therapy is a necessity.

23. **Multiple Surgical Procedures**: Charges for the services of a Covered Provider when a Covered Person undergoes two or more procedures during the same Anesthesia period and each procedure is clearly identified and defined as a separate procedure. When two or more surgical procedures occur during the same Anesthesia period, the Eligible Expenses shall be as follows:

    a. When Multiple Surgical Procedures that increase the time and amount of patient care are performed, Eligible Expenses are limited to the Reasonable and Appropriate charge for the primary Surgery, 50% of the Reasonable and Appropriate charge for the secondary Surgery, and 25% of the Reasonable and Appropriate charge for each additional Surgery; and

    b. When an incidental procedure is performed through the same incision, Eligible Expenses are limited to the Reasonable and Appropriate charge for the primary Surgery only.

24. **Newborn Care**: Charges for routine nursery care for up to the first five days after birth while the mother is Hospital-confined, including room, board, Physician Services, and other services and supplies for which the Hospital usually charges, *provided that* a parent is covered under the Plan at the time of delivery. Charges for routine nursery care and for Physician Services shall be covered under the newborn's Plan benefits. Charges for a covered Newborn who is ill or injured are payable to the same extent as any other Covered Person.

NOTE: In accordance with the Newborns' and Mothers' Health Protection Act, the Plan shall not restrict benefits for a Hospital stay for a mother and her newborn to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean delivery. Also, the Utilization Management Program requirements for Inpatient Hospital admissions shall not apply for this minimum length of stay, and early discharge shall only be only permitted if the decision is made between the attending Physician and the mother.

25. **Nursing Services, Private Duty**: Charges for private duty nursing care that is Medically Necessary and that is provided by an RN, an LPN, or an LVN as follows:

    a. **Inpatient Nursing Care**: Charges for care that is not custodial in nature when there are no available rooms in the Hospital's ICU for the patient or when the Hospital has no ICU; and

    b. **Outpatient Nursing Care**: Charges for care that is not custodial in nature, *provided that* the Nurse rendering such care does not ordinarily reside in the Covered Person's home and/or is not a Close Relative.

26. **Occupational Therapy**: Charges for treatment or services, including supplies, rendered by a licensed Occupational Therapist under the direct supervision of a Physician in a home setting or at a facility which primarily provides medical care for Illness or Injury. Such therapy must be in accordance with a Physician's exact orders as to type, frequency, and duration and must be intended to improve body function.

27. **Orthotics**: Charges for orthopedic or corrective shoes, orthotics, and other supportive appliances or devices for the feet which have been prescribed by a Physician who certifies that they are Medically Necessary.

NOTE: Splints or braces for non-medical purposes (such as supports worn primarily during participation in sports or similar physical activities) are not covered.

28. **Oxygen**: Charges for Oxygen and other gases and the durable medical equipment required for administration, *provided that* rental costs for such equipment may not exceed the purchase price.

29. **Physical Therapy**: Charges for treatment or services rendered by a licensed Physical Therapist under the direct supervision of a Physician in a home setting or at a facility which primarily provides medical care for Illness or Injury. Such therapy must be in accordance with a Physician's exact orders as to type, frequency, and duration and must be intended to improve body function.

30. **Physician Services**: Charges for the services of a Physician for diagnostic, medical, and surgical treatment, including office, home, or Hospital visits; clinic care; and consultations.

31. **Pregnancy Care**: Charges for maternity care, and for the treatment of Complications of Pregnancy, for an Employee or a covered spouse on the same basis as any Illness covered under the Plan. Pregnancy coverage does not include Lamaze and other charges for education related to prenatal care and birthing procedures, adoption expenses, expenses of a surrogate mother, or any charges related to or resulting from the Pregnancy of a Dependent child.

NOTE: Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for a Hospital stay for a mother and her newborn to less than 48 hours following a normal vaginal delivery or to less than 96 hours following a cesarean delivery. However, the Plan may pay for a shorter stay if the attending Covered Provider (that is, the Physician, Physician Assistant, or Certified or Registered Nurse Midwife), after consultation with the mother, discharges her or her newborn earlier. Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48- or 96-hour stay is treated in a manner less favorable to the mother or her newborn than any earlier portion of the stay. In addition, group health plans and health insurance issuers may not require that a Physician or other Covered Provider obtain authorization for prescribing a length of stay up to 48 or 96 hours. However, to use certain providers or facilities, or to reduce out-of-pocket costs, precertification may be required. The Covered Person should contact the Plan Administrator for information regarding precertification.

32. **Prescription Drugs**: Charges for drugs that are dispensed by a licensed pharmacist, Physician, or Dentist; that are Medically Necessary for the treatment of an Illness or an Injury; and that are not considered Experimental unless mandated by PPACA, including insulin and insulin needles or syringes.

33. **Preventative Care:** Services as mandated by the Patient Protection and Affordable Care Act.

34. **Prosthetics**: Charges for:

    a. Artificial eyes, larynx, or limbs. Replacement of such artificial appliances is covered only if the replacement is Medically Necessary due to a change in the physical condition of the Covered Person and is less expensive than repair of the existing appliance; and

    b. Braces, casts, cervical collars, crutches, dressings, head halters, splints, sutures, traction devices, trusses, or other prosthetic devices to replace lost body parts or to aid in their function when impaired. Replacement of such devices is covered only if the replacement is Medically Necessary due to a change in the physical condition of the Covered Person.

NOTE: Excess charges for deluxe prostheses, for prostheses that are not prescribed by a Physician, or for dental prostheses are not covered.

35. **Radiation Therapy**: Charges for radium and radioactive isotope therapy.

36. **Renal Dialysis Services**: Charges for renal dialysis in a Hospital or other covered facility or in the patient's home. Eligible Expenses include but are not limited to the purchase or rental of Hospital-type equipment for the personal and exclusive use of the patient. Coverage for the total purchase price of such equipment shall be pro-rated on a monthly basis during the first 24 months of ownership, *provided that* dialysis treatment continues to be Medically Necessary and the patient continues to be a covered under the Plan. Eligible Expenses shall also include the Reasonable and Appropriate charge for all materials, supplies, and repairs necessary for the proper operation of such equipment.

37. **Respiratory Therapy**: Charges for the services of a licensed Respiratory Therapist or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type, frequency, and duration, but only to the extent that the therapy is for improvement of respiratory function.

38. **Second Surgical Opinions**: Charges for a second surgical opinion consultation following a surgeon's recommendation for Surgery. The Physician rendering a second opinion regarding the Medical Necessity of the proposed Surgery must be qualified to render such opinion, either through experience, specialist training, education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual Surgery.

39. **Skilled Nursing Facility**: Charges for room and board and nursing care furnished by a Skilled Nursing Facility when:

    a. The patient is confined to bed in such facility;

    b. The confinement starts within 14 days of a Hospital confinement of at least three days;

    c. The attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

    d. The attending Physician completes a treatment plan that includes a diagnosis, the proposed plan of treatment, and the projected date of discharge from the Skilled Nursing Facility.

40. **Sleep Disorders:** Charges for care and treatment for Sleep Disorders if deemed to be Medically Necessary.

41. **Speech Therapy**: Charges for Medically Necessary services rendered by a licensed Speech Therapist under the direct supervision of a Physician to restore speech lost or impaired due to an Illness or an Injury or to Surgery performed on account of an Illness or an Injury, other than a functional nervous disorder. If the speech loss or impairment is due to a congenital anomaly, Surgery to correct the anomaly must be performed prior to Speech Therapy. Continuing measurable progress must be demonstrated at regular intervals.

42. **Sterilization Procedures**: Charges for a surgical procedure for the purpose of sterilization of man or woman.

NOTE: Reconstruction (reversal) of a prior elective sterilization procedure is *not* covered.

43. **Substance Use Disorder Treatment**: Charges for the treatment of Substance Use Disorders are covered as any other Illness.

44. **Total Parenteral Nutrition/Hyperalimentation**: Charges for Total Parenteral Nutrition or Hyperalimentation for Covered Persons recovering from or preparing for Surgery.

45. **Transplant-Related Procedures**: Eligible Expenses otherwise covered under the Plan for care and treatment due to a bone marrow, an organ, or tissue transplant are subject to the following limitations:

    a. The transplant must be performed to replace an organ or tissue of the Covered Person;

    b. Pre-authorization by the Utilization Management Organization is required as soon as the Covered Person is identified by a Physician as an organ transplant candidate. If pre-authorization is not obtained from the Utilization Manager, no benefits will be payable including related services or complication;

    c. Charges for obtaining donor organs or tissue are covered charges under the Plan when the recipient is a Covered Person. If the donor has medical coverage, his or her plan shall pay such charges first, and the benefits available under this Plan shall be reduced by those payable under the donor's plan;

    d. Donor charges include those for evaluating the organ or tissue, removing the organ or tissue from the donor, and transporting the organ or tissue from within the United States or Canada to the place where the transplant is to take place;

    e. For donor costs to be covered, the recipient must be a Covered Person under this Plan; and

    f. In certain bone marrow transplant cases (that is, those involving autologous bone marrow transplantation), extremely high doses of Chemotherapy or Radiation are administered, which could eradicate any normal bone marrow production. Therefore, it is necessary to preserve and subsequently transplant the marrow in order for the patient to regain normal function. Charges for bone marrow transplants, both with respect to autologous and allogeneic marrow, may be covered for a variety of diagnoses, but are subject to Plan limitations and must be Medically Necessary.

NOTE: Any organ or tissue transplant involving the use of artificial or mechanical organs or tissue, or organs or tissue removed from an animal, is not covered.

46. **Vision Care**: Charges for the initial prescription contact lenses or eyeglasses required following cataract Surgery.

ARTICLE XIV – MEDICAL LIMITATIONS AND GENERAL EXCLUSIONS

A. Expenses Not Covered by the Plan

Except as specifically stated otherwise, no benefits shall be payable for:

1. **Acupuncture and Acupressure**

2. **Adoption Expenses**

3. **Air Purification Units**: Charges for air conditioners, air purifications units, electric heating units, and humidifiers.

4. **Air Travel**: Charges for care and treatment of any Illness or Injury related to an Air Travel Accident unless the Covered Person was a fare-paying passenger on a scheduled flight of a licensed airline at the time the Accident occurred.

5. **Alcohol:** Services, supplies, care or treatment to a Covered Person for Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Use Disorder treatment as specified in the Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

6. **Biofeedback**: Charges for biofeedback, diversional or educational therapy, or other forms of self-care or self-help training and any related diagnostic testing.

7. **Complications of Non-Covered Treatment**: Charges for services rendered as a result of (or due to complications resulting from) any service, supply, Surgery, or treatment specifically excluded from coverage under this Plan.

8. **Corrective shoes**: Except as specifically stated otherwise in **ARTICLE XIII – ELIGIBLE MEDICAL EXPENSES**, charges for corrective shoes or other corrective appliances or devices that may be inserted into shoes.

9. **Court Appearance**: Charges related to any court appearance, hearing, or proceeding.

10. **Court-Ordered Care, Confinement, or Treatment**: Charges for any care, confinement, or treatment of a Covered Person in a public or private facility as the result of a court order, unless such expenses would have been covered under the Plan in the absence of a court order.

11. **Cosmetic Surgery**: Except as specifically stated otherwise in **ARTICLE XIII – ELIGIBLE MEDICAL EXPENSES**, charges for any drug, service, supply, or Surgery primarily to improve the appearance of a person by alteration of a physical characteristic that is within the broad range of normal but that may be considered displeasing or unsightly.

12. **Criminal Activities**: Charges for any Illness or Injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation. This exclusion does not apply when such Illness or Injury results from a physical or mental medical condition (such as depression) or from an act of domestic violence.

13. **Custodial, Domiciliary, and/or Maintenance Care**: Charges for services and supplies intended primarily to maintain a level of physical or mental function, including:

    a. Custodial, rest, or sanitarium care; and

    b. Hospitalizations primarily for diagnostic study, hydrotherapy, laboratory, medical observation, physiotherapy, x-rays, or any medical examination or test not connected with an Illness or an Injury.

14. **Deductibles and Copays:** Expenses used to satisfy Deductibles, Copayments, non-covered expenses or those resulting from non-compliance penalties.

15. **Dental Care**: Except as specifically stated otherwise in **ARTICLE XIII – ELIGIBLE MEDICAL EXPENSES** charges for care or treatment on or to the teeth, alveolar processes, or gingival tissue, or for malocclusion.

16. **Dependent Pregnancy**: Charges for care and treatment in connection with prenatal and postnatal care during Pregnancy, Complications of Pregnancy, miscarriage, and childbirth for any person other than an Employee or a Dependent spouse.

17. **Diagnostic Hospital Admission**: Charges for confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Out-patient setting.

18. **Drugs in Testing Phases**: Charges for drugs or medications that are in the FDA Phases I, II, or III testing, and drugs that are not commercially available for purchase or are not approved by the FDA for general use, unless required by the **Patient Protection and Affordable Care Act.**

19. **Ecological or Environmental Medicine**: Charges for chelation or chelation therapy (except for acute metal poisoning); orthomolecular substances; the use of substances of animal, vegetable, chemical, or mineral origin that are not specifically approved by the FDA as effective for treatment; or environmental sensitivity treatments (that is, Inpatient or Outpatient treatment of allergic symptoms by controlling the environment, sanitizing the surroundings, removing toxic materials, or using special nonorganic, no repetitive diet techniques).

20. **Educational or Vocational Testing or Training:** Except as specifically stated otherwise in **ARTICLE XIII – ELIGIBLE MEDICAL EXPENSES or services mandated by the Patient Protection and Affordable Care Act,** charges for services, supplies, and/or treatment that is primarily educational in nature or for vocational testing or training.

21. **Elective Abortion:** Charges for an elective abortion, except where the life of the mother would be threatened if the fetus were carried to term.

22. **Excess Charges**: Charges in excess of the Reasonable and Appropriate charge for the services or supplies provided.

23. **Exercise Equipment/Health Clubs**: Charges for aerobic and strength conditioning, exercise equipment, vibratory equipment, swimming or therapy pools, work-hardening programs, or enrollment in health, athletic, or similar clubs, except for Physician-supervised Occupational Therapy, Physical Therapy, or rehabilitation covered by this Plan.

24. **Experimental/Investigational Treatment**: See **Experimental and/or Investigational** in **ARTICLE III – DEFINITIONS**. Expenses for clinical trials as mandated by the Patient Protection and Affordable Care Act will be considered a covered benefit.

25. **Financial Counseling**

26. **Damages, Fines, and/or Judgments and Other Penalties Imposed by Law**

27. **Foot Care**: Charges for the treatment of flat, strained, unbalanced, unstable, or weak feet; for bunions or metatarsalgia (except for open cutting operation); and for callouses, corns, or toenails unless Medically Necessary in the treatment of a metabolic or peripheral-vascular disease.

28. **Forms Completion or Reports**: Charges for the completion of forms or for providing supplemental information or reports.

29. **Government-Operated Facilities**: Charges for services furnished to the Covered Person in any institution, military hospital, veterans hospital, or facility operated by the United States government, by any state government, or by any agency or instrumentality of such governments.

NOTE: This exclusion does not apply to treatment of non-service related disabilities, to Inpatient care provided in a military or other United States government hospital to Dependents of active duty armed service personnel or to armed service retirees and their Dependents, to Medicaid recipients, or when otherwise prohibited by law.

30. **Hair Loss**: Charges for treatment of hair loss, including but not limited to hair transplants, wigs, or any drug relating to baldness or hair replacement, whether or not prescribed by a Physician, except for the initial wig after chemotherapy.

31. **Hearing Aids and Examinations**: Charges for services or supplies in connection with hearing aids or examinations for their fitting.

32. **Holistic, Homeopathic, or Naturopathic Medicine**: Charges for services, supplies, drugs, or accommodations provided in connection with holistic, homeopathic, or naturopathic treatment.

33. **Hospital Employees**: Charges for professional services of a Nurse or a Physician who is an employee of a Hospital or Skilled Nursing Facility and is paid by such Hospital or facility for the services.

34. **Hypnotherapy**: Charges for treatment by hypnosis.

35. **Illegal drugs or medications**: Charges for care, services, supplies, or treatment provided to a Covered Person for an Illness or an Injury resulting from such person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician. Any Covered Person injured by the acts of another Covered Person who has voluntarily taken or is under the influence of a controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician shall be eligible for benefits. This exclusion does not apply if the Illness or Injury resulted from a medical condition (physical or mental), including a medical condition resulting from domestic violence (for example, depression).

36. **Impotence**: Charges for care, drugs, services, or supplies connection with treatment for impotence or sexual dysfunction.

37. **Impregnation and Infertility Testing or Treatment**: Charges for services and supplies related to the diagnosis and treatment of infertility and artificial reproductive procedures, including but not limited to artificial insemination, embryo implantation, fertility drugs when used for the treatment of infertility, gamete intrafallopian transfer, in-vitro fertilization, or surrogacy.

38. **Late-Filed Claims**: Charges for claims that are not filed with the Claims Processor for handling within the required time periods as included in **ARTICLE XVIII – CLAIMS PROCEDURES**.

39. **Legal Fees and Expenses**

40. **Mailing and/or Shipping and Handling Expenses**

41. **Marriage and Family Counseling**

42. **Massage Therapy or Rolfing**

43. **Medical and Dental:** Expenses eligible for consideration under any other plan of the Company; when an expense occurs which is eligible under both the Medical and Dental coverages, the Dental Plan will be considered primary.

44. **Military Service**: Charges for conditions that are determined by the Veterans Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

45. **Missed Appointments**: Charges for failure to keep or for cancellation of a scheduled appointment.

46. **No Charge/No Legal Requirement to Pay**: Charges for services for which no charge is made or which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan provides "secondary" coverage, this exclusion shall apply to those amounts a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

NOTE: This exclusion does not apply to any benefit or coverage that is available through the Medical Assistance Act (Medicaid).

47. **Non-Compliance**: Charges in connection with drugs or treatments when the patient either is non-compliant with the recommendations of his or her Physician or other Covered Provider or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

48. **Non-Human Transplants**: Charges for any organ or tissue transplant involving the use of artificial or mechanical organs or tissue, or organs or tissue removed from a non-human animal, is not covered.

49. **Not Medically Necessary/Not Physician Prescribed**: Charges for services or supplies that are not Medically Necessary or for any treatment that is not prescribed by, rendered by, or provided under the supervision of a Physician and are not incurred on the advice of a Physician, unless expressly included herein, and for Inpatient room and board when

hospitalization is for services that could have been performed safely on an Outpatient basis, including but not limited to convalescent care, preliminary diagnostic tests, medical observation, Physical Therapy, or treatment of chronic pain.

50. **Not Specified as Covered**: Charges for services, supplies, and treatments that are not specified as covered under this Plan.

51. **Nuclear Reaction**: Charges for Illness or Injury sustained as a result of nuclear reaction or the release of nuclear energy.

NOTE: This exclusion shall not apply if the Illness begins or the Injury is sustained within 90 days after the nuclear incident. To be covered under the Plan, the loss must be caused by explosion, fire, heat, or other physical trauma that is a result of the release of nuclear energy. The Covered Person must be within a 25-mile radius of the site of the nuclear incident at the time of such incident or within 24 hours thereafter.

52. **Obesity**: Charges for weight loss or weight management programs or for any other services or supplies for or related to obesity or weight control, including drugs and surgery, except as specifically stated otherwise in **ARTICLE XIII – ELIGIBLE MEDICAL EXPENSES** and as required by PPACA guidelines for preventative care. This exclusion applies even when weight loss is included as part of the treatment plan for another Illness.

53. **Other Coverage**: Charges for services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by:

    a. Any plan, authority, law of any government, or governmental agency (federal or state, dominion or province, or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payer or Medicaid Priority rule;

    b. A health care department maintained by or on behalf of an Employer, mutual benefit association, labor union, trustees, or similar person(s) or group;

    c. Any school system that is required to provide services or items under public law; and/or

    d. Medical coverage provided by or available through any applicable No-Fault Automobile Insurance law provision, uninsured motorist provision, underinsured motorist provision, or other first-party or no-fault provision of any automobile law or coverage, or any other automobile, homeowners, aircraft, boat owners, or other similar policy of insurance.

54. **Outside of Scope of Professional License**: Charges for services, supplies, or treatment that have been rendered beyond the scope of the Covered Provider's professional license or that have not been recommended or furnished by an appropriate provider.

55. **Outside of the United States**: Charges incurred outside of the United States for services or supplies, if the Covered Person traveled to the foreign location for the primary purpose of obtaining such services or supplies.

56. **Pastoral Counseling**

57. **Penile Prosthetic Implant**: Charges related to a penile prosthetic implant.

58. **Personal Comfort or Convenience Items and Deluxe Equipment**: Charges for services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician), including but not limited to:

    a. Air conditioners, air purifiers, or vacuum cleaners;

    b. Cervical pillows;

    c. Deluxe equipment or items, such as motorized equipment when manually-operated equipment can be used or wheelchair sidecars;

    d. Elastic bandages;

    e. Food liquidizers;

    f. Hypoallergenic mattresses, pillows, blankets, or mattress covers;

    g. Motorized transportation equipment, escalators, elevators, handrails, or wheelchair ramps;

    h. Personal computers and related equipment, televisions, telephones, or other similar items or equipment;

    i. Personal hygiene items;

    j. Scales;

    k. Structural changes to homes or autos;

    l. Swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs; and

    m. Waterbeds or non-hospital adjustable beds.

59. **Prior Coverage**: Charges for services or supplies for which the Covered Person is eligible for benefits under the plan that this Plan replaces.

60. **Prior to Effective Date/After Termination Date**: Charges incurred prior to a Covered Person's Effective Date of coverage under the Plan or after coverage is terminated, except as may be expressly stated.

61. **Relative or Resident Care**: Charges for any service rendered to a Covered Person by a Close Relative or by anyone who customarily lives in the Covered Person's household.

62. **Replacement Braces**: Charges for replacement of braces of the arm, leg, neck, or artificial arm(s) or leg(s), unless there is sufficient change in the Covered Person's physical condition rendering the original brace no longer functional.

63. **Sales or Other Taxes**: Charges for sales or other taxes or charges imposed by any government or entity. However, this exclusion shall not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

64. **Self-Inflicted Injury**: Charges for any expenses resulting from voluntary self-inflicted Illness or Injury or voluntary attempted self-destruction, except that this exclusion shall not apply where such self-inflicted injury results from a physical or mental medical condition (such as depression) or from an act of domestic violence.

65. **Self-Procured Services**: Charges for services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies, or treatment, including any periods of Hospital confinement, that are not recommended, approved, and certified as Medically Necessary and reasonable by a Physician, except as specifically stated otherwise under **ARTICLE XIII – ELIGIBLE MEDICAL EXPENSES**.

66. **Sex Counseling** unless mandated by the Patient Protection and Affordable Care Act.

67. **Sex-Related Disorders**: Charges for sex therapy and for services rendered with respect to transsexualism, gender dysphoria, sexual reassignment or change, or other sexual dysfunctions or inadequacies. Excluded services and supplies include but are not limited to therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment. This exclusion applies whether or not treatment is Medically Necessary or follows Surgery.

68. **Surgical Sterilization Reversal**: Charges related to reversal of any reproductive sterilization procedure.

69. **Telecommunications**: Charges for advice or consultation given by or through any form of telecommunication.

70. **Travel or Accommodations**: Charges for travel expenses, including but not limited to accommodations, of a Covered Person or a Physician, except for Ambulance charges as provided in **ARTICLE XIII – ELIGIBLE MEDICAL EXPENSES**.

71. **Vision Care**: Except as specifically stated otherwise in **ARTICLE XIII – ELIGIBLE MEDICAL EXPENSES** charges for routine eye examinations and examinations with respect to refractions, lenses for the eyes and examinations for their fitting, and radial keratotomy or other eye surgery to correct refractive disorders. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the Preventative Benefits of this Plan.

NOTE: This exclusion does not apply to aphakic patients and to soft lenses or sclera shells intended for use as corneal bandages.

72. **War or Active Duty**: Charges for health conditions resulting from insurrection; war (declared or undeclared); act of war or complications therefrom, including armed aggression resisted by the forces of any country or combination of countries, civil war, insurrection, rebellion, revolution, or riot; or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

73. **Weekend Hospital Admissions**: Charges for Hospital expenses incurred in connection with an admission on Friday, Saturday, Sunday, or a holiday, unless the admission occurs not more than 24 hours prior to a scheduled Surgery, the Covered Person is admitted on an Emergency basis, or the admission is for Pregnancy delivery.

74. **Work-Related Conditions**: Charges that the Covered Person has recovered or could recover from any other source, including but not limited to any benefit plan, or that arise out of, or in the course of, any occupation or self-employment for wage or profit for which the Covered Person is entitled to benefits pursuant to or under any federal, state, or

governmental law, regulation, or program, including but not limited to Workers' Compensation law, occupational disease law, occupational disability law, no-fault automobile law, or any similar law. If the Plan elects to provide benefits for any such condition, the Plan shall be entitled to establish a lien upon such other benefits up to the amount paid.

NOTE: With respect to any Injury that is otherwise covered by the Plan, the Plan will not deny benefits for treatment of such Injury if it results from an act of domestic violence or from a physical condition or a Mental Health Condition.

ARTICLE XV – WEEKLY DISABILITY BENEFITS

A. General Information

The Company shall pay the benefits set forth below to an Employee who becomes disabled while covered under the Plan. The disability must require treatment by Physician or other appropriate Covered Provider.

For the purposes of this Article, "disabled" shall mean any physical condition arising from any material and substantial duties of his or her occupation on a full- or part-time basis and in not receiving any earnings for performing any work or service.

B. Eligibility for Disability Benefits

An Employee shall become eligible for weekly disability benefits on the Effective Date of his or her coverage (see **ELIGIBILITY AND EFFECTIVE DATES**). An Employee's disability benefits shall terminate on the earliest of the following dates:

1. The date on which the Employee is no longer disabled;

2. The date on which benefits have been paid for the maximum period covered; or

3. The date on which the Employee returns to active employment.

Multiple periods of disability may be treated as one if they are due to the same Accident, Illness, Injury, or Pregnancy or to a related cause and if they are separated by less than two weeks of active full-time work.

C. Disability Benefits Payable

All eligible Employees shall be entitled to disability benefits in the amount of $225 per week. Payment shall begin on the first day of disability due to Injury and on the eighth day of disability due to Illness. The Maximum Benefit period is 26 weeks. In no event shall payment from all sources exceed two-thirds of the Employee's basic weekly salary.

D. Exclusions

Benefits under this Article shall not be payable for disability caused by:

1. Any attempted suicide or self-inflicted Injury, including a self-inflicted Injury which is the result of willful intoxication;

2. The ingestion of any poison or poisonous substances, or the inhalation of gas of any kind unless administered by or on the advice of a Physician or a Dentist;

3. Any Accident, Illness, or Injury that arises out of or in the course of the Employee's usual occupation or any self-employment for wage or profit for which the Employee is entitled to benefits pursuant to or under any federal, state, or governmental law, regulation, or program, including but not limited to Workers' Compensation law, occupational disease law, occupational disability law, No-Fault Automobile Insurance law, or any similar law;

4. Any Mental Health Condition or Substance Use Disorder;

5. Participation in any riot or act of civil disobedience/strife;

6. Active service in the military of the United States, except to the extent prohibited or modified by law; or

7. War (declared or undeclared), act of war, or insurrection.

ARTICLE XVI– COORDINATION OF BENEFITS

A. Coordination of the Benefits Plans

Coordination of Benefits ("COB") sets out rules for order of payment of Eligible Expenses when two or more plans (or Medicare) is/are responsible for paying. When a Covered Person is covered by this Plan and another plan or plans, the plans will coordinate benefits when a claim is received.

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 remaining balance of the Eligible Expenses up to 100%, subject to the limitations as outlined below.

B. Defined Terms

All health care benefits provided under the Plan are subject to COB as described below, unless specifically stated otherwise.

As used in this Article, the following terms shall have the meanings indicated:

1. **Benefit Plan**: Any of the following that provides health care benefits or services:

    a. Group, blanket, or franchise coverage provided through HMOs and other pre-payment group or individual practice plans;

    b. Blue Cross and Blue Shield group plans;

    c. Plans or programs sponsored by the federal government, including Medicare;

    d. Other plans or programs provided or required by law, not including Medicaid or any plan like it that, by its terms, does not permit COB;

    e. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;

    f. No-Fault Automobile Insurance when not prohibited by law; and/or

    g. Any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.

NOTE: A Benefit Plan includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them. If a Benefit Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

2. **This Plan**: The coverage of the Health Benefit Plan for the Employees of Piggly Wiggly Alabama Distributing Company, Inc..- High Deductible Option.

3. **Allowable Expense**: A health care service or expense, including Deductibles and Copayments, that is covered at least in part by any of the plans (that is, by This Plan or by a Benefit Plan) covering the Claimant. When a plan provides benefits in the form of services, the reasonable cash value of each service shall be considered an Allowable Expense and a benefit shall be paid. An expense or service that is not covered by any of the plans is not an

Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

a. If a Covered Person is confined in a private Hospital room, the difference in cost between a semi-private room in the Hospital and a private room shall not be an Allowable Expense unless the private room accommodation is Medically Necessary in terms of generally accepted medical practice or unless one of the plans routinely provides coverage for private rooms.

b. If, in addition to This Plan, a person is covered by one or more Benefit Plan(s) that compute benefits on the basis of "usual and customary" allowances, any amount in excess of a Reasonable and Appropriate charge as defined in **ARTICLE III – DEFINITIONS**, shall not be an Allowable Expense, even if it is a usual and customary expense under the other plan(s).

c. If, in addition to This Plan, a person is covered by one or more Benefit Plan(s) that provide benefits or services on the basis of negotiated or discounted fees, any charge in excess of a Reasonable and Appropriate charge as defined in **ARTICLE III – DEFINITIONS**, shall not be an Allowable Expense, even if it is based on a negotiated or discounted fee under the other plan(s).

d. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary allowances and another plan that provides its benefits or services on the basis of negotiated or discounted fees, the lesser of those amounts shall be the Allowable Expense for This Plan, unless the lesser of those amounts exceeds a Reasonable or Appropriate charge as defined in **ARTICLE III – DEFINITIONS**, in which case the Reasonable and Appropriate charge shall be the Allowable Expense.

NOTE: Any expense not payable by a primary plan due to the Covered Person's failure to comply with any utilization review requirements (for example, precertification of admissions) shall not be considered an Allowable Expense.

4. **Claim Determination Period**: A period that commences each January 1st at 12:00 a.m. and ends on the next succeeding December 31st at 11:59 p.m., or that portion of such period during which a Covered Person is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see **Effect on Benefits under This Plan**).

5. **Custodial Parent**: A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than 50% of the Calendar Year without regard to any temporary visitation.

C. Effect on Benefits Under This Plan

The following provisions must be considered in determining the COB.

C-1 When the Other Benefit Plan Does Not Contain a COB Provision

If another Benefit Plan does not contain a COB provision that is consistent with the National Association of Insurance Commissioners Model COB Contract Provisions, then such other Benefit Plan shall be "primary" and This Plan shall pay its benefits after such other Benefit Plan.

C-2. When the Other Plan Contains a COB Provision

When another Benefit Plan contains a COB provision similar to this one, This Plan shall determine its benefits using the **Order of Benefit Determination Rules** below. If, in accordance with such rules, This Plan is to pay benefits before another Benefit Plan, This Plan shall pay its normal liability without regard to the benefits of the other Benefit Plan. However, if This Plan is to pay its benefits after another Benefit Plan, it shall pay the lesser of its normal liability or the total Allowable Expenses minus benefits paid or payable by the other Benefit Plan.

C-3. Maintenance of Benefits

If a covered Employee's Dependents are covered under this Plan and under another group plan (such as a plan sponsored by a spouse's employer), the Dependents' coverage under this Plan will be affected by a provision called "Maintenance of Benefits." When this Plan pays second (that is, after the other or primary plan has paid benefits), then this Plan shall pay the difference of the Dependents' claims up to the amount that the Plan would normally pay if it had been the primary plan.

For example, suppose that a Dependent is covered under another group plan (the primary plan) as well as under this Plan (the secondary plan), and the Dependent incurs $1,000 in allowable expenses, of which the primary plan pays $750. If this Plan (the secondary plan) would have paid more than $750, it shall pay the difference between the amount the primary plan paid and the amount it would have paid had there been no other group plan; that is, if the primary plan paid $750 and this Plan (the secondary plan) would have paid $900, then this Plan shall pay the difference between $900 and $750 ($150). If the primary plan paid $750 and this Plan (the secondary plan) would have paid $650, then this Plan shall not make an additional payment.

D. Order of Benefit Determination Rules

Whether This Plan is the primary plan or a secondary plan is determined in accordance with the following rules.

D-1. Medicare as Another "Benefit Plan"

If a Covered Person is an active Employee age 65 or over, he or she must either:

1. Elect This Plan as his or her primary medical coverage and Medicare as his or her secondary medical coverage; or

2. Elect Medicare as his or her medical coverage.

If the Covered Employee elects This Plan as his or her primary medical coverage, his or her covered Dependent spouse may elect Medicare as his or her medical coverage or may continue coverage under the Plan. If the Covered Employee elects Medicare as his or her medical coverage, his or her covered Dependent spouse shall also have Medicare as his or her medical coverage, and coverage under This Plan shall terminate. If no election is made, coverage shall continue under This Plan by default, and This Plan's benefits shall be primary.

Medicare shall be considered a Benefit Plan for purposes of COB. This Plan shall coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare benefits.

Medicare shall be the primary, secondary, or last payer in accordance with federal law. When Medicare is the primary payer, This Plan shall determine its benefits based on Medicare Part A and Part B benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits.

NOTE: Medicare may be primary and this Plan may be secondary for a Covered Person who is under age 65 and is eligible for Medicare by reason of a disability other than kidney failure. This Plan is primary and Medicare shall be secondary for a Covered Person during the first 30 months in which the he or she is eligible for Medicare solely because of permanent kidney failure. After the first 30 months, Medicare is primary and the Plan shall be secondary for such Covered Person.

D-2. Non-Dependent vs. Dependent

The benefits of a plan which covers the Covered Person *other than* as a Dependent (that is, as an Employee, a member, a retiree, or a subscriber) shall be determined before the benefits of a plan which covers such person as a Dependent. However, if the Covered Person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering such person as a Dependent and primary to the plan covering the person as other than a Dependent (for example, a retired Employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee, a member, a retiree, or a subscriber is secondary and the other Benefit Plan is primary.

D-3. Child Covered Under More Than One Plan

When the Covered Person is a Dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if the child's parents are married or are not separated (whether or not they have ever been married), or a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the Covered Person is a Dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

When the Covered Person is a Dependent child whose father and mother are not married, are separated (whether or not they have ever been married), or are divorced, the order of benefits is:

1. The plan of the Custodial Parent;

2. The plan of the spouse of the Custodial Parent;

3. The plan of the noncustodial parent; and then

4. The plan of the spouse of the noncustodial parent.

D-4. Active vs. Inactive Employee

The plan that covers the Covered Person as an Employee who is neither laid off nor retired is primary. The plan that covers a person as a Dependent of an Employee who is neither laid off nor retired is primary. 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 shall not apply.

D-5. COBRA Continuation Coverage Enrollee

If a Covered Person is a COBRA enrollee under This Plan, the other Benefit Plan covering the person as an Employee, a member, a retiree, or a subscriber (or as that person's Dependent) is primary and This Plan is secondary. 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 shall not apply.

D-6. Coordination with Automobile Insurance Coverage

This Plan's liability for expenses arising out of an automobile Accident is based on the type of automobile insurance law enacted by the state in which the Covered Person resides (or, if a pedestrian, by the state in which the accident occurred). There are currently three types of state automobile laws: No-Fault Automobile Insurance laws, financial responsibility laws, and other automobile liability insurance laws.

NOTE: It is This Plan's general intent not to pay medical expenses resulting from automobile Accidents, and the Plan should be so interpreted.

D-6.01. Coordination Under No-Fault Automobile Insurance Laws

Except as required by law, This Plan is secondary to any No-Fault Automobile Insurance coverage. This Plan is not intended to reduce the level of coverage that would otherwise be available through a No-Fault Automobile Insurance policy, nor is it intended to be the primary payer in order to reduce the premiums or costs of No-Fault Automobile Insurance coverage.

If a Covered Person incurs Eligible Expenses as a result of an automobile Accident (either as a driver, a passenger, or a pedestrian), the amount of covered expenses that This Plan shall pay is limited to:

1. Any Deductible under the automobile coverage;

2. Any Copayment under the automobile coverage;

3. Any expense properly excluded by the automobile coverage that is an Eligible Expense under this Plan; and

4. Any expense that This Plan is required to pay by law.

A person is considered to be covered under an automobile insurance policy if he or she is the owner or principal named insured under the policy, a family member of a person insured under the policy, or a person who would be eligible for medical expense benefits under an automobile insurance policy if This Plan did not exist.

D-6.02. Coordination Under Financial Responsibility Law

This Plan is secondary to automobile insurance coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from an automobile Accident.

If the state in which the Covered Person resides has a financial responsibility law which will not allow This Plan to pay benefits as secondary or will not allow This Plan to advance payments with the intent of subrogating or recovering the payment, This Plan will not pay any benefits related to an automobile Accident for the Covered Person.

D-6.03. Coordination Under Other Automobile Liability Insurance

If the state in which the Covered Person resides does not have a No-Fault Automobile Insurance law or a financial responsibility law, This Plan is secondary to his or her automobile insurance coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from an automobile Accident.

D-7. Longer vs. Shorter Length of Coverage

If none of the above rules establish which plan is primary, the benefits of the plan which has covered the Covered Person for the longer period of time shall be determined before those of the plan which has covered such person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the other Benefit Plan(s). However, This Plan shall not pay more than it would have paid had it been primary.

E. Excess Coverage

This provision applies when a Covered Person incurs medical or dental expenses that are eligible for coverage under a policy of liability insurance, property insurance, casualty insurance, or property-casualty insurance, including but not limited to a motor vehicle policy, a boat owner's policy, a homeowner's policy, or a renter's policy. When such expenses are incurred, This Plan will pay the lesser of:

1. The benefits under This Plan; or

2. 100% of Eligible Expenses under This Plan less the amount that the Covered person is eligible to receive for the same expenses from the liability insurance, property insurance, casualty insurance, or property-casualty insurance.

F. Other Information About COB

The following information pertains to COB determinations.

F-1. Right to Receive and Release Necessary Information

For the purpose of enforcing or determining the applicability of the terms of this COB provision or any similar provision of any other Benefit Plan, the Claims Processor may, without the consent of any person, release to or obtain from any insurance company, organization, or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan shall furnish to the Claims Processor such information as may be necessary to enforce this provision.

F-2. Facility of Payment

A payment made under another Benefit Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made such payment. That amount shall then be treated as though it were a benefit paid under This Plan. This Plan shall not have to pay such amount again.

F-3. Right of Recovery

If the amount of the payments made by This Plan is more than it should have paid under this COB section, This Plan may recover the excess from one or more of the persons it has paid or for whom it has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

ARTICLE XVII – SUBROGATION AND REIMBURSEMENT, THIRD-PARTY RECOVERY

A. Benefits Subject to This Article

This Article shall apply to all benefits provided under this Plan.

B. Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Illness, an Injury, or a disability is caused by or results from, in whole or in part, the acts or omissions of a Covered Person or his or her Dependents, beneficiaries, estate, heirs, guardians, personal representatives, or assigns (collectively, "Plan Beneficiary") or the acts or omissions of a third-party when other insurance is available, including but not limited to No-Fault Automobile Insurance, uninsured or underinsured motorist, and/or medical payment coverage (collectively, "Coverage").

The Plan Beneficiary, his or her attorney, and/or the legal guardian of a minor or an incapacitated person hereby agree that acceptance of the Plan's payment of medical benefits is constructive notice of these provisions in their entirety and agree to maintain 100% of the Plan's payment of benefits or the full extent of payment from any one or a combination of first- and third-party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee(s). By accepting benefits, the Plan Beneficiary agrees that the Plan shall have an equitable lien on any funds received by the Plan Beneficiary and/or his or her attorney from any source and that said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Beneficiary agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event that a Plan Beneficiary settles, recovers, or is reimbursed by any third-party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits that have or shall be paid. If the Plan Beneficiary fails to reimburse the Plan out of any judgment or settlement received, the Plan Beneficiary shall be responsible for any and all expenses (that is, attorneys' fees and costs) associated with the Plan's attempt to recover benefits paid by the Plan from such judgment or settlement.

C. Subrogation

As a condition to participating in and receiving benefits under this Plan, the Plan Beneficiary agrees to subrogate the Plan to any and all claims, causes of action, or rights which may arise against any person, corporation, and/or entity and to any Coverage to which the Plan Beneficiary is entitled, regardless of how classified or characterized.

If a Plan Beneficiary receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Plan Beneficiary may have against any party causing the injury or Sickness to the extent of such payment by the Plan, plus reasonable costs of collection.

The Plan may, in its own name or in the name of the Plan Beneficiary, commence a proceeding or pursue a claim against any third-party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.

If the Plan Beneficiary fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of such party;

2. Any first-party insurance through medical payment coverage, personal injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;

3. Any policy of insurance from any insurance company or guarantor of a third-party;

4. Worker's Compensation or other liability insurance company; or

5. Any other source, including but not limited to crime victim restitution funds; any medical, disability, or other benefit payments; and school insurance coverage,

then the Plan Beneficiary authorizes the Plan to pursue, sue, compromise, or settle any such claims in the Plan Beneficiary's and/or the Plan's name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Beneficiary assigns all rights to the Plan or its assignee(s) to pursue a claim and the recovery of all expenses from any sources listed above.

D. Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction of attorneys' fees and costs or application of the common fund doctrine, the make-whole doctrine, or any other similar legal theory, and without regard to whether the Plan Beneficiary is fully compensated by his or her recovery from all sources. The Plan has the right of first dollar recovery the Plan Beneficiary obtains even if the Plan Beneficiary is not made whole. The Plan shall have an equitable lien that supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which may interfere with or compromise in any way the Plan's equitable subrogation lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how any judgment or settlement is classified or characterized by the parties, the courts or any other entity and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Beneficiary's recovery is less than the benefits paid, then the Plan is entitled to be paid 100% of such recovery.

No court costs, expert witness fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior written consent of the Plan.

The Plan's right of subrogation and reimbursement shall not be reduced or affected as a result of any fault or claim on the part of the Plan Beneficiary, whether under the doctrines of causation, comparative fault, or contributory negligence or any other similar doctrine in law. Accordingly, any lien-reduction statutes that attempt to apply such doctrines and reduce a subrogating plan's recovery shall not be applicable to this Plan and shall not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, or disability, and without regard to whether any separate written acknowledgement of these rights is required by the Plan and/or is signed by the Plan Beneficiary.

This provision shall not limit other remedies of the Plan provided by law.

E. Excess Insurance

If, at the time of any Illness, Injury, or disability, there is available or potentially available any Coverage, including but not limited to Coverage resulting from a judgment at law or a settlement, the benefits under the Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of such party;

2. Any first-party insurance through medical payment coverage, personal injury protection, No-Fault Automobile Insurance coverage, or uninsured or underinsured motorist coverage;

3. Any policy of insurance from any insurance company or guarantor of a third-party;

4. Worker's Compensation or other liability insurance company; or

5. Any other source, including but not limited to crime victim restitution funds; any medical, disability, or other benefit payments; and school insurance coverage.

F. No-fault COB Provision

If all plans have a coordinating provision the following will apply:

No-fault coverage, personal injury protection and medical payment coverage are always primary and the Plan is always secondary to those types of plans.

G. Wrongful Death Claims

In the event that the Plan Beneficiary dies as a result of his or her Illness, Injury, or disability and a wrongful death or survivor claim is asserted against a third-party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

H. Obligations

It is the Plan Beneficiary's obligation to:

1. Cooperate with the Plan, or with any representative thereof, in protecting the Plan's rights, including discovery, attending depositions, and/or cooperating at trial;

2. Provide the Plan with pertinent information regarding the injury, Sickness, disease, or disability that gave rise to the claim for benefits, including accident reports, settlement information, and other documents or information requested by the Plan;

3. Take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

4. Do nothing to prejudice the Plan's rights of subrogation and reimbursement;

5. Promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received; and

6. Not settle or release, without the prior written consent of the Plan, any claim that the Plan Beneficiary may have against any responsible party or Coverage.

If the Plan Beneficiary and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid as a result of the Illness, Injury, or disability that gave rise to the claim for benefits out of the proceeds, judgment, or settlement received, the Plan Beneficiary shall be responsible for any and all expenses, fees, and costs associated with the Plan's attempts to recover such monies from the Plan Beneficiary.

I. Right of Offset

The Plan requires all covered persons and their representatives to cooperate in order to guarantee reimbursement to the Plan from third party benefits. Failure to comply with this request will entitle the Plan to withhold benefits due to Covered Persons under the Plan.

J. Minor Status

In the event that the Plan Beneficiary is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned. If the minor's parents and/or court-appointed guardian fail to so cooperate, the Plan shall have no obligation to advance payment of the medical benefits on behalf of the minor. Any court costs or legal fees associated with seeking and obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

K. Language Interpretation

The Plan Administrator retains sole, full, and final discretionary authority to construe and interpret the language of this Article, to determine all questions of fact and law arising under this Article, and to administer the Plan subrogation and reimbursement rights. The Plan Administrator may amend this Article at any time without prior notice.

L. Severability

This Article, and any provision contained herein, shall be fully severable. In the event that any provision of this Article is deemed invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this Article and this Plan, and the Plan shall be construed and enforced as if such invalid or illegal provisions had never been set forth herein.

ARTICLE XVIII – CLAIMS PROCEDURES

A. Submitting a Claim

A claim is a request for a benefit determination that is made in accordance with the Plan's procedures by a Claimant or his or her authorized representative. A claim must be received by the person or organizational unit customarily responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must set forth:

1. The name of the Plan;
2. The name of the Claimant;
3. The patient's health condition(s), symptom(s), or diagnostic code(s);
4. The specific treatment, service, or supply (or procedure/revenue code) for which a benefit or benefit determination is requested;
5. The date(s) of service;
6. The amount of charges;
7. The address or location at which services are or were provided; and
8. The provider's name, address, telephone number, and tax identification number.

A claim must be in English. Any request for a benefit determination that is in a language other than English shall not be considered a claim for the purposes of the Plan. The Claimant is responsible for any and all costs associated with translation. Such translation must be obtained by the Claimant prior to submission of a request for benefit determination.

The Plan Administrator has contracted with other entities to handle claims communications and benefit determinations for the Plan. Contact information for such entities ("claims offices") is provided below.

B. Type of Claims

There are two types of health claims – Pre-Service Claims and Post-Service Claims:

1. **Pre-Service Claim**: The Plan conditions benefits, in whole or in part, on prior approval of the proposed care. See **ARTICLE IX – COST MANAGEMENT SERVICES**. A Pre-Service Claim is made for the purposes of assessing the Medical Necessity and appropriateness of care and where it is to be delivered. *A determination on a Pre-Service Claim is not a guarantee of benefits. Plan benefits with respect to a Pre-Service Claim are subject to review after medical services have been rendered, and are subject to all Plan provisions, exclusions, and limitations.*
2. **Post-Service Claim**: A written request for a benefit determination after medical services have been rendered and expenses have been incurred. A Post-Service Claim must be submitted to the claims office within 365 days after charges are incurred. Upon termination of the Plan, final claims must be received within 90 days of termination. A Post-Service Claim should be submitted to:

Alternative Insurance Resources, Inc./Global Care, Inc.
EDI Payor: 07689
P. O. Box 247
Alpharetta, GA 30009-0247

NOTE: In accordance with federal law, CMS has three years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

It is the Claimant's obligation to cooperate with the Plan, or any representatives of the Plan, in handling claims; to provide the Plan with pertinent information regarding the injury, Sickness, disease, or disability and any other requested additional information relating to the claim; and to take such action and provide such information as the Plan may require to process a claim.

C. Assignments to Providers

All Eligible Expenses reimbursable under the Plan shall be paid to the covered Employee except that assignments of benefits to Hospitals, Physicians, or other providers of service shall be honored; the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss; and the Plan may make benefit payments for a child covered by a QMCSO directly to the custodial parent or legal guardian of such child.

Benefits due to any network provider shall be considered "assigned" to such provider and shall be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his or her right to sue to recover benefits under the Plan or to enforce rights due under the Plan or any other causes of action that he or she may have against the Plan or its Fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program shall be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary that may be required by the state Medicaid plan. Furthermore, the Plan shall honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

D. Claim Time Limits and Allowances

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration, and benefit determinations (that is, how quickly the Plan shall respond to claims notices, filings, and claims appeals and how much time shall be allowed for Claimants to respond). It is the Claimant's obligation to cooperate with the Plan, or any representatives of the Plan, in handling claims; to provide the Plan with pertinent information regarding the Illness, Injury, or disability, and any other requested additional information relating to the claim; and to take such action and provide such information as the Plan may require to process a claim.

NOTE: *These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval.*

PRE-SERVICE CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Urgent Claim (defined below)	
Claimant Submits Initial *Incomplete* Claim	Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice. Claimant shall have a reasonable period of time, but not less than 48 hours, to provide the required information to complete the claim.
Plan Receives Information Necessary to Complete Claim	Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of receipt of the completing information, or the period of time Claimant was allowed to provide the completing information. Oral notice may be given in addition to written or electronic notice. Written or electronic notice of a benefit denial or reduction (an "adverse benefit determination") must be provided to Claimant not later than three days after an oral notification.
Claimant Submits Initial *Complete* Claim	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), Plan responds with written or electronic benefit determination. Oral notice may be given in addition to written or electronic notice. Written or electronic notice of a benefit denial or reduction (an "adverse benefit determination") must be provided to Claimant not later than three days after an oral notification.
Claimant Appeals	See **Appeal Procedures**. An appeal for an urgent claim may be made orally or in writing.
Plan Responds to Appeal	Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation) after receipt of Claimant's appeal.

An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: serious jeopardy to the patient's life, health, or ability to regain maximum function, or in the judgment of a Physician knowledgeable about the patient's condition, severe pain that could not be adequately managed without the care or treatment being claimed.

All necessary information, including the Plan's handling of an appeal, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available and similarly expeditious methods. Whether a claim is urgent shall generally be decided by an individual acting on behalf of the Plan and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if

a Physician familiar with the patient's condition decides that the claim involves urgent care, the Plan must defer to the Physician's judgment.

NOTE: The benefit determination time frame stated above shall begin at a time a claim is filed in accordance with the procedures of the Plan, without regard to whether all of the information necessary to make a benefit determination accompanies the filing.

Where the **Time Limit or Allowance** stated above reflects "or sooner if possible," this phrase means that an earlier response may be required, considering the urgency of the medical situation.

PRE-SERVICE CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Concurrent Claim (defined below)	
Plan Wants to Reduce or Terminate Already Approved Care	Plan notifies Claimant of intent to reduce or deny benefits *before* any reduction or termination of benefits is made and provides enough time to allow Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary is subject to the urgent claim rules.
Claimant Requests Extension for Urgent Care	Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), *provided that* Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment. Otherwise, Plan's notification must be made in accordance with the time allowances for appeal of an urgent, pre-service, or post-service claim, as appropriate.

A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.

PRE-SERVICE CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Non-Urgent Claim	
Claimant Submits Initial *Incomplete* Claim	Within 15 days of receipt of an incomplete claim, Plan notifies Claimant, in writing or electronically, that Plan Administrator has determined that a 15-day extension of the deadline to respond to such claim is necessary due to Claimant's failure to submit the information necessary to decide the claim. Such notice specifically describes the information necessary to decide the claim, affords Claimant 45 days from receipt of the notice within which to submit the necessary information, and informs Claimant that the benefit determination shall be made within 15 days of the date on which Claimant responds to the request for additional information. The period for making the benefit determination shall be tolled (that is, suspended) from the date on which the notice of the extension is sent to Claimant until the date on which Claimant responds to the request for additional information.
Plan Receives Information Necessary to Complete Claim	Plan notifies Claimant, in writing or electronically, within 15 days of receipt of the information necessary to complete the claim of Plan's benefit determination.
Claimant Submits Initial *Complete* Claim	Within 15 days of receipt of a complete claim, Plan notifies Claimant, in writing or electronically, of Plan's benefit determination. The time within which to notify Claimant of Plan's benefit determination may be extended once for 15 days, if Plan Administrator determines that such extension is necessary for reasons beyond the control of Plan and notifies Claimant, within the initial 15-day period, of the circumstances requiring the extension of time and the date by which Plan expects to decide the claim.
Claimant Appeals	See **Appeal Procedures.**
Plan Responds to Appeal	Plan responds to a properly-submitted notice of appeal within 15 days in connection with a first-level appeal, and within 15 days in connection with a second-level appeal.

POST-SERVICE CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Submits Initial *Incomplete* Claim	Within 30 days of receipt of an incomplete claim, Plan notifies Claimant, in writing or electronically, that Plan Administrator has determined that a 15-day extension of the deadline to respond to such claim is necessary due to Claimant's failure to submit the information necessary to decide the claim. Such notice specifically describes the information necessary to decide the claim, affords Claimant 45 days from receipt of the notice within which to submit the necessary information, and informs Claimant that the benefit determination shall be made within 15 days of the date on which Claimant responds to the request for additional information. The period for making the benefit determination shall be tolled (that is, suspended) from the date on which the notice of the extension is sent to Claimant until the date on which Claimant responds to the request for additional information.
Plan Receives Information Necessary to Complete Claim	Plan notifies Claimant, in writing or electronically, within 15 days of receipt of the information necessary to complete the claim of Plan's benefit determination.
Claimant Submits Initial *Complete* Claim	Within 30 days of receipt of a complete claim, Plan notifies Claimant, in writing or electronically, of Plan's benefit determination. The time within which to notify Claimant of Plan's benefit determination may be extended once for 15 days, if Plan Administrator determines that such extension is necessary for reasons beyond the control of Plan and notifies Claimant, within the initial 30-day period, of the circumstances requiring the extension of time and the date by which Plan expects to decide the claim.
Claimant Appeals	See **Appeal Procedures**
Plan Responds to Appeal	Plan shall respond to a properly-submitted notice of appeal within 30 days in connection with a first-level appeal, and within 30 days in connection with a second-level appeal.

E. Authorized Representative May Act for Claimant

Any of the above actions that may be done by the Claimant may also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a patient's medical condition, shall be permitted to act as the authorized representative of the Claimant. "Health care professional" means a Physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with the state law.

F. Written or Electronic Notices

The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an *approved* benefit must be provided only for Pre-Service benefit determinations.

G. Denial of Claims

If a claim for benefits is denied, in whole or in part, the Claimant shall be given written or electronic notice of such denial. The notice shall include the following and shall be provided in a manner intended to be understood by the Claimant:

1. The specific reason(s) for the denial of benefits;

2. Reference to the specific provision(s) of this Plan Document on which the denial of benefits is based;

3. A description of any additional material or information necessary for the Claimant to submit in connection with any review of the claim and an explanation of why such material or information is necessary;

4. Reference to any internal rule(s), guideline(s), protocol(s), or other similar criteria that were relied upon in denying benefits or a statement that a copy of such rule(s), guideline(s), protocol(s), or other criteria will be provided, free of charge, to the Claimant upon request;

5. If the denial of benefits is based on medical necessity, experimental treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of this Plan Document to the patient's medical circumstances, or a statement that such explanation shall be provided, free of charge, to the Claimant upon request;

6. A description of the Plan's appeal procedures and the time limits applicable to such procedures;

7. If the denial of benefits involves an urgent care claim, a description of the expedited appeal procedures applicable to such claims; and

8. A statement that the Claimant has the right to bring a civil action under § 502(a) of ERISA following an adverse benefit decision on appeal.

H. Appeal Procedures

A Claimant must adhere to the following procedures in appealing a claim for medical benefits that has been denied, in whole or in part.

H-1. Filing a First-Level Appeal

When a Claimant believes that a claim has been wrongly denied, in whole or in part, such Claimant is entitled to a reasonable opportunity for a full and fair review of the claim and of the denial of benefits. The Plan provides for a two-level appeal process.

The Plan Administrator has delegated to a First-Level Appeal Committee the power, duty, and authority to decide a first-level appeal. Within 180 days of receipt of the notice that a claim for benefits has been denied,

in whole or in part, the Claimant may submit a first-level appeal of such denial. The first-level appeal must be in writing and must be sent or hand-delivered to:

First-Level Appeal Committee
c/o Alternative Insurance Resources, Inc.
P. O. Box 660787
Birmingham, Alabama 35266-0787

If the denial of benefits involves an urgent care claim, the Claimant is entitled to an expedited review pursuant to which the request for an expedited appeal may be submitted orally or in writing by the Claimant and all necessary information, including the benefit decision on appeal, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available expeditious method.

The first-level appeal shall not be conducted by a person or persons who made the initial determination to deny benefits or by anyone who is a subordinate of such person or persons, nor shall the first-level appeal afford deference to the initial determination to deny benefits.

A first-level appeal of a denial of benefits shall include the following information:

1. The name of the Claimant;

2. The Employee's member identification number, if applicable;

3. The group name or group number, if applicable;

4. A statement in clear and concise terms as to why the Claimant disagrees with the denial of benefits; and

5. All facts and theories supporting the appeal and the claim for benefits. Failure to include any facts or theories in support of the appeal and the claim for benefits shall constitute a waiver of the right to have such facts or theories considered by the First-Level Appeal Committee.

The Claimant may submit written comments, documents, records, and other information in support of the first-level appeal. All such comments, documents, and information shall be considered by the First-Level Appeal Committee, regardless of whether they were submitted in connection with the initial benefit determination.

Upon request, the Claimant shall be provided, free of charge, with reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits.

In deciding an appeal of a denial of benefits that is based, in whole or in part, on a medical judgment (for example, whether a particular treatment, drug, or item is experimental, investigational, or not Medically Necessary), the First-Level Appeal Committee shall consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment and who is neither a person who was consulted in connection with the initial determination to deny benefits nor a subordinate of such person. The First-Level Appeal Committee shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of benefits and/or the appeal, regardless of whether the advice was relied upon in denying the benefits or deciding the appeal.

H-2. Decision on a First-Level Appeal

A decision with regard to a first-level appeal of a denial of benefits shall be made within the time allowed (see **Claim Time Limits and Allowances**).

The Claimant shall be notified in writing or electronically of the decision with regard to the first-level appeal. If the decision on appeal upholds the denial of benefits, the notice shall be provided in a manner calculated to be understood by the Claimant and shall include the following:

1. The specific reason(s) for the decision on appeal;

2. Reference to the specific provision(s) of this Plan Document on which the decision on appeal is based;

3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;

4. Reference to any internal rule(s), guideline(s), protocol(s), or other similar criteria that were relied upon in deciding the appeal or a statement that a copy of such rule(s), guideline(s), protocol(s), or other criteria will be provided, free of charge, to the Claimant upon request;

5. If the decision on appeal is based on medical necessity, experimental treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of this Plan Document to the patient's medical circumstances, or a statement that such explanation shall be provided, free of charge, to the Claimant upon request;

6. The identity of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the first-level appeal, regardless of whether the advice was relied upon in deciding the appeal;

7. A description of the Plan's second-level appeal procedures and the time limits applicable to such procedures;

8. If the decision on appeal involves an urgent care claim, a statement that the Claimant is entitled to an expedited review pursuant to which the request for an expedited second-level appeal may be submitted orally or in writing by the Claimant and all necessary information, including the benefit decision on appeal, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available expeditious method;

9. A statement to the effect that the Claimant may have other voluntary alternative dispute resolution options, such as mediation, and that the Claimant may contact his or her local DOL Office to find out what options are available; and

10. A statement that the Claimant has the right to bring a civil action under § 502(a) of ERISA following an adverse benefit decision on appeal, once the Claimant has exhausted all administrative remedies.

H-3. Filing a Second-Level Appeal

When a Claimant believes that a first-level appeal has been wrongly decided, such Claimant is entitled to a reasonable opportunity for a full and fair review of the claim and of the first-level appeal decision to uphold the denial of benefits, in whole or in part.

The Plan Administrator has delegated to a Second-Level Appeal Committee the power, duty, and authority to decide a second-level appeal. Within 60 days of receipt of the notice of an adverse decision on the first-level appeal, the Claimant may submit a second-level appeal of such decision. The second-level appeal must be in writing and must be sent or hand-delivered to:

Second-Level Appeal Committee
c/o Alternative Insurance Resources, Inc.
P.O. Box 660787
Birmingham, Alabama 35266-0787

If the denial of benefits involves an urgent care claim, the Claimant is entitled to an expedited review pursuant to which the request for an expedited appeal may be submitted orally or in writing by the Claimant and all necessary information, including the benefit decision on appeal, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available expeditious method.

The second-level appeal shall not be conducted by a person or persons who made the initial determination to deny benefits or the decision on the first-level appeal, or by anyone who is a subordinate of such person or persons, nor shall the second-level appeal afford deference to the initial determination to deny benefits or to the decision on the first-level appeal.

A second-level appeal of a denial of benefits shall include the following information:

1. The name of the Claimant;

2. The Employee's member identification number, if applicable;

3. The group name or group number, if applicable;

4. A statement in clear and concise terms as to why the Claimant disagrees with the denial of benefits and the decision on the first-level appeal; and

5. All facts and theories supporting the appeal and the claim for benefits. Failure to include any facts or theories in support of the appeal and the claim for benefits shall constitute a waiver of the right to have such facts or theories considered by the Second-Level Appeal Committee.

The Claimant may submit written comments, documents, records, and other information in support of the second-level appeal. All such comments, documents, and information shall be considered by the Second-Level Appeal Committee, regardless of whether they were submitted in connection with the initial benefit determination or the first-level appeal.

Upon request, the Claimant shall be provided, free of charge, with reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits.

In deciding an appeal of a denial of benefits that is based, in whole or in part, on a medical judgment (for example, whether a particular treatment, drug, or item is experimental, investigational, or not Medically Necessary), the Second-Level Appeal Committee shall consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment and who is neither a person who was consulted in connection with the initial determination to deny benefits or the first-level appeal, nor a subordinate of such person. The Second-Level Appeal Committee shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of benefits and/or the appeal, regardless of whether the advice was relied upon in denying the benefits or deciding the appeal.

H-4. Decision on a Second-Level Appeal

A decision with regard to a second-level appeal of a denial of benefits shall be made within the time allowed (see **Claim Time Limits and Allowances**).

The Claimant shall be notified in writing or electronically of the decision with regard to the second-level appeal. If the decision on appeal upholds the denial of benefits, the notice shall be provided in a manner calculated to be understood by the Claimant and shall include the following:

1. The specific reason(s) for the decision on appeal;

2. Reference to the specific provision(s) of this Plan Document on which the decision on appeal is based;

3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;

4. Reference to any internal rule(s), guideline(s), protocol(s), or other similar criteria that were relied upon in deciding the appeal or a statement that a copy of such rule(s), guideline(s), protocol(s), or other criteria will be provided, free of charge, to the Claimant upon request;

5. If the decision on appeal is based on medical necessity, experimental treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of this Plan Document to the patient's medical circumstances, or a statement that such explanation shall be provided, free of charge, to the Claimant upon request;

6. The identity of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the second-level appeal, regardless of whether the advice was relied upon in deciding the appeal;

7. If the decision on appeal involves an urgent care claim, a statement that the Claimant is entitled to an expedited review pursuant to which the request for an expedited second-level appeal may be submitted orally or in writing by the Claimant and all necessary information, including the benefit decision on appeal, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available expeditious method;

8. A statement to the effect that the Claimant may have other voluntary alternative dispute resolution options, such as mediation, and that the Claimant may contact his or her local DOL Office to find out what options are available; and

9. A statement that the Claimant has the right to bring a civil action under § 502(a) of ERISA following an adverse benefit decision on appeal, once the Claimant has exhausted all administrative remedies.

10. A description of the Plan's external appeal procedures and the time limits applicable to such procedures.

H-5. Exhaustion of Administrative Remedies

All claim review procedures provided for in this Plan must be exhausted before any legal action is commenced.

I. External Review Process

I-1. Standard External Review

Standard external review is external review that is not considered expedited (as described in I-2 of this section).

1. Request for external review. The Plan will allow a claimant or authorized representative to file a request for an external review of an adverse benefit determination after all internal appeal procedures have been exhausted. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice,. For example if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. The Plan may charge a nominal fee for the filing of an external review.

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

   a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

   b. The adverse benefit determination or the final benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g. worker classification or similar determination);

   c. The claimant has exhausted the Plan's internal appeal processes.

   d. The claimant has provided all the information and forms required to process an external review.

   Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll free 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hours period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf, at least three (3) IRO's for assignments under the plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IRO's, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination,

the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

I-2. Expedited External Review

1. Request for expedited review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

   a. An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
   b. A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph I-1. 2. Above for standard external review to the claimant of its eligibility determination.

3. Referral to independent review organization. Upon a determination that a request if eligible for external review following the preliminary review, the Plan will assign and IRO pursuant to the requirements set forth in paragraph I-1. 3. above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

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

4. Notice of final external review decision. The Plan's (or Claims Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph I-1. 3. above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

NOTE: *A legal action for the recovery of any benefits pursuant to the Plan must be commenced no later than three years after the administrative appeal procedures have been exhausted.*

ARTICLE XIX – PLAN'S RIGHT TO AUDIT/BALANCE-BILLING BY PROVIDERS

A. Right to Review or Audit Claims

The Plan Administrator, in its sole discretion, may engage an independent medical billing reviewer and/or medical chart auditor to perform a comprehensive analysis of any network or non-network claim. The purpose of such an analysis is to identify charges billed in error and/or charges that are not Reasonable and Appropriate, if any. This analysis may involve the review of a patient's medical billing records, including but not limited to any statement of itemized charges and/or any description of the items, services, and supplies provided. If warranted, the analysis may also involve an audit of the patient's medical chart and records, in addition to the review of his or her medical billing records.

Not every claim will be subject to a bill review or medical chart audit. The Plan Administrator has the sole discretionary authority to select and submit claims for bill review and possible medical chart audit, but may, in its sole discretion, delegate the authority to the Claims Processor. The Plan Administrator may overrule any decision made by the Claims Processor to submit a claim or claims for bill review or audit and may decline to accept any proposal or recommendation to reprice a claim after a bill review or audit has been performed.

If, at the time that a claim is submitted, a Claimant fails to provide a statement of itemized charges or any other information necessary to decide the claim, such Claimant shall be provided in writing with a specific description of the information needed to decide the claim and shall be given 45 days to produce such information. The bill review or medical chart audit shall not go forward during that 45-day period unless the Claimant produces the information needed to decide the claim. If the Claimant does not produce the requested information within the 45-day period, no further request for such information shall be made of the Claimant, and the claim may be reviewed or audited based on the information initially submitted with the claim.

Upon completion of the bill review or medical chart audit, the reviewer or auditor shall prepare and submit a written report to the Plan Administrator or its agent which identifies those charges that are deemed to be in excess of Reasonable and Appropriate charges, as defined in this Plan Document. Regardless of any contractual arrangement to the contrary, the Plan Administrator has the sole discretionary authority to reduce any charge to a Reasonable and Appropriate charge in accordance with the terms of this Plan Document. No arrangement or contract of any kind shall override or preempt the Plan Document, and the Claims Processor has no discretionary authority to alter or override the authority of the Plan Administrator.

If the Claimant disputes the amount determined to be payable by the Plan Administrator, the Claimant may appeal the denial of any charge pursuant to the provisions of this Plan Document and ERISA appeal procedures.

B. Balance-Billing

In the event that a claim submitted by a provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance-billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance-billing is legal in many jurisdictions, and the Plan has no control over Non-PPO providers that engage in balance-billing practices.

In addition, with respect to services rendered by a PPO provider being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person should not be responsible for the difference between the amount charged by the PPO provider and the amount determined to be payable by the Plan Administrator, and should not be balance-billed for such difference. Again, the Plan has no control over any

PPO provider that engages in balance-billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the PPO provider.

The Covered Person is responsible for payment of Coinsurances, Deductibles, and Out-of-Pocket Maximums and may be billed for any or all of these.

ARTICLE XX – ADMINISTRATIVE MATTERS

A. Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;

2. To determine all questions of eligibility, status, and coverage under the Plan;

3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;

4. To make factual findings;

5. To decide disputes that may arise relative to a Covered Person's rights;

6. To prescribe procedures for filing a claim for benefits;

7. To keep and maintain the Plan Documents and all other records pertaining to the Plan;

8. To appoint and supervise a Claims Processor to pay claims;

9. To perform all necessary reporting as required by ERISA;

10. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate, and to allocate responsibility for the operation and administration of the Plan; and

11. To perform each and every function necessary for or related to the Plan's administration.

B. Type of Administration

Certain benefits of the Plan are administered by a Claims Processor under the terms and conditions of administration agreement(s) between the Plan Sponsor and the Claims Processor. The Claims Processor is not an insurance company or a Fiduciary of the Plan.

C. Alternative Care

In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan shall provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective. The total benefits paid for such services may not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor shall such election be construed as a waiver of the Plan Sponsor's right to administer the Plan thereafter in strict accordance with the provisions of the Plan Document.

D. Amendment or Termination of the Plan

Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the exclusive right to, without the consent of any Employee or Dependent:

1. Determine eligibility for benefits or to construe the terms of the Plan;

2. Alter or postpone the method of payment of any benefit;

3. Amend any provision regarding administrative matters;

4. Make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code; and

5. Terminate, suspend, withdraw, amend, or modify the Plan, in whole or in part, at any time and on a retroactive basis; provided, however, that no modification or Amendment shall divest an Employee of a right to those benefits to which he or she has become entitled under the Plan.

NOTE: Any modification, Amendment, or termination action shall be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment which is signed by at least one Fiduciary of the Plan. Employees shall be provided with notice of the change within the time allowed by federal law.

E. Anticipation, Alienation, Sale, or Transfer

Except for assignments to providers of service (see **ARTICLE XVIII – CLAIMS PROCEDURES**), no benefit payable under the provisions of the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge shall be void. Furthermore, no such benefit shall be in any manner subject to the debts, contracts, liabilities, engagements, or torts of or claims against any Employee or Covered Person, including the claim of a creditor, a claim for alimony or support, or any like or unlike claim.

F. Clerical Error

A clerical error by the Employer, the Claims Processor or Plan Sponsor shall not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

G. Creditable Coverage Certificates

Under HIPAA, a person has the right to receive a certificate of prior health coverage, called a "Certificate of Creditable Coverage" or a "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA Continuation Coverage terminates (including termination due to exhaustion of all Lifetime benefits under the Plan), the Plan Sponsor shall automatically provide a Certificate of Creditable Coverage to the person whose coverage has terminated, without charge. Such certificate shall be mailed to the person at the most current address on file for him or her. A Certificate of Creditable Coverage shall also be provided, on request, in accordance with the law (that is, at any time while coverage is in effect and/or within 24 months after termination of coverage). Written procedures for requesting and receiving Certificates of Creditable Coverage are available from the Plan Sponsor.

H. Discrepancies

In the event that there is a discrepancy between any separate booklet, including a Summary Plan Description, if any, provided to Employees and this Plan Document and Summary Plan Description, the Plan Document shall prevail.

I. Entire Contract

The Plan Document, any Amendments, and the individual applications, if any, of Covered Persons shall constitute the entire contract between the parties. The Plan does not constitute a contract of employment nor affect the rights of an Employer to discharge any Employee.

J. Facility of Payment

Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age. However, in the event that the Plan determines that a person is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event that such person has not provided the Plan with an address at which he or she may be located for payment, the Plan may, during the lifetime of such person, pay any amount otherwise payable to him or her to his or her husband, wife, or relative by blood, or to any other person or institution determined by the Plan to be equitably entitled thereto.

In the case of the death of any person receiving or claiming benefits under the Plan before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of such person: the lawful spouse, the child or children, the parent, or the sibling, or to the Covered Person's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Plan.

If a guardian, conservator, or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments shall be made to such guardian, conservator, or other person, *provided that* proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made shall be a complete discharge of any liability therefore under the Plan.

K. Fiduciary Responsibility, Authority, and Discretion

The Fiduciaries shall serve at the discretion of the Plan Sponsor and without compensation for such services, but they shall be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. The Fiduciaries shall discharge their duties under the Plan solely in the interest of the Employees and their Dependents and for the exclusive purpose of providing benefits to Employees and their Dependents and defraying the reasonable expenses of administering the Plan.

The Fiduciaries shall administer the Plan, shall have the authority to exercise the powers and discretion conferred on them by the Plan, and shall have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, the Fiduciaries shall have the sole discretionary authority to interpret the terms of the Plan and this Plan Document, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, even if the terms of the Plan and/or the Plan Document are found to be ambiguous, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Fiduciaries may employ such agents, attorneys, accountants, investment advisors, or other persons, who also may be employed by the Employer. The Fiduciaries may also engage third-parties, including but not limited to provider networks or utilization management organizations, that in their opinion may be desirable for the administration of the Plan. The Fiduciaries may pay any such person or third-party reasonable compensation, and may delegate to any agent, attorney, accountant, investment advisor, or other person or third-party selected by them any power or duty vested in, imposed upon, or granted to them by the Plan. However, the Fiduciaries shall not be liable for the acts or omissions of any agent, attorney, accountant, investment advisor, or other person or third-party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in establishing or implementing the Plan procedures for allocation or delegation, allocating or delegating the responsibility, or continuing the allocation or delegation.

L. Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, acts of terrorism, or any other cause beyond a party's control, the time for the performance of the act shall be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay shall be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations under the Plan.

M. Gender and Number

Except when otherwise indicated by the context, any masculine terminology shall include the feminine (and vice-versa) and any term in the singular shall include the plural (and vice-versa).

N. Illegality of Particular Provision

The illegality of any particular provision of this Plan Document shall not affect the other provisions and the Plan Document shall be construed in all respects as if such invalid provision were omitted.

O. Indemnification

To the extent permitted by law, Employees, Fiduciaries, and all agents and representatives of such Fiduciaries shall be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan, except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and the right to take the lead in any action in which it may be liable as an indemnitor.

P. Legal Actions

No Employee or Covered Person shall have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan shall be resolved by the Plan Sponsor under and pursuant to the Plan Document.

No legal action may be brought to recover on the Plan more than three years from the time written proof of loss is required to be given, or until the Plan's mandatory claim appeal(s) are exhausted. See **ARTICLE XVIII – CLAIMS PROCEDURES** for more information.

Q. Loss of Benefits

To the extent permitted by law, the following circumstances may result in disqualification or ineligibility for, or in the denial, loss, forfeiture, suspension, offset, reduction, or recovery of, any benefit that a Covered Person might otherwise reasonably expect the Plan to provide based on the description of benefits:

1. The cessation of an Employee's active service for the Employer;

2. An Employee's failure to pay his or her share of the cost of coverage, if any, in a timely manner;

3. A Dependent's failure to meet the Plan's eligibility requirements (for example, when a child reaches an age at which coverage is no longer available to him or her or when an Employee and his or her spouse divorce);

4. Injury to a Covered Person which results in payment of expenses for treatment by a third-party; or

5. The failure to file a claim for benefits within the time limits set forth in this Plan Document. Material Modification

R. Material Modification

The Affordable Care Act requires the Plan furnish Employees with notice of any material modifications to the Plan no later than 60 days prior to the effective date of the modification or changes made during the Plan Year. This does not apply to renewal of coverage or any modifications made as part of the renewal. "Material modifications" are those that would be construed by the average Employee as being "important" change, including changes that enhance or reduce benefits, increase premiums or cost-sharing, or impose new referral requirements. Such modifications are defined in ERISA Section 102.

S. Misstatements/Misrepresentations and Rescission

Employees are responsible for reviewing the Plan's eligibility terms before enrolling themselves and/or their Dependents in the Plan. When an Employee enrolls one or more Dependents in the Plan, the Employee is affirmatively representing that each such Dependent is eligible for coverage under the Plan. *Employees are prohibited from making fraudulent statements or from intentionally misrepresenting material facts (including but not limited to facts regarding the marital status, dependent status, or age of a Covered Person) in the enrollment process*. If an Employee and/or eligible Dependent makes a fraudulent statement or intentionally misrepresents material facts in the enrollment process, the Plan may rescind the Covered Person's coverage retroactively. Plan coverage may not be rescinded retroactively except in the case of fraud or intentional misrepresentation.

T. Non-Discrimination Due to Health Status

A person shall not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

1. A medical condition (whether physical or mental and including conditions arising out of acts of domestic violence);

2. Claims experience;

3. Receipt of health care;

4. Medical history;

5. Evidence of insurability;

6. Disability; or

7. Genetic information.

T-1. Nondiscrimination under GINA

To the extent that the Plan is subject to the Genetic Information Nondiscrimination Act of 2008 ("GINA"), it intends to comply with GINA. In accordance with GINA, the Plan shall not:

1. Adjust premiums or contribution amounts for the group covered under this Plan on the basis of genetic information;

2. Request or require a Covered Person or his or her family member to undergo any genetic test;

3. Request, require, or purchase genetic information for underwriting purposes; or

4. Request, require, or purchase genetic information with respect to any person prior to such person's enrollment in the Plan or coverage in connection with such enrollment.

If a Covered Person or his or her family member is Pregnant, reference to genetic information includes genetic information with respect to any fetus carried by such Pregnant individual. If a Covered Person or his or her family member is utilizing an assisted reproductive technology, reference to genetic information includes genetic information of any embryo legally held by such individual.

The Plan's compliance with GINA includes the definitions and exceptions stated in GINA. The Plan Sponsor is subject to penalties as stated in GINA for failure to meet the requirements of GINA.

U. Physical Examination

The Plan Sponsor, at Plan expense, shall have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

V. Plan Administrator's Discretion and Authority

The Plan Administrator has the exclusive authority and absolute discretion to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make determinations thereunder. Moreover, the Plan Administrator has the sole discretionary authority to construe and interpret the terms and provisions of the Plan Document, to make determinations that relate to a Covered Person's eligibility for benefits, and to decide disputes which may arise relative to a Covered Person's rights. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law.

The Plan Administrator has the sole discretionary authority to select vendors to provide services under the Plan. A list of those vendors is available from the Plan Administrator.

W. Privacy Rules and Intent to Comply

On and after April 14, 2003 (or effective April 14, 2004 if the Plan's premium equivalent is less than $5,000,000 annually), the Plan Sponsor certifies that the Plan is amended (by separate addendum) to comply with the Standards for Privacy of Individually Identifiable Health Information (that is, the "Privacy Rules") of HIPAA. See **ARTICLE XXII – PRIVACY REQUIREMENTS UNDER HIPAA** for more information.

The Plan and the Plan Sponsor shall not intimidate or retaliate against Employees who file complaints with regard to their privacy, and Employees shall not be required to give up their privacy rights in order to enroll in the Plan or to receive benefits thereunder.

X. Reimbursements

The following provisions apply to reimbursement issues.

X-1. Plan's Right to Reimburse Another Party

Whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan Sponsor and the Claims Processor shall be authorized to pay such benefits to the other party; provided, however, that the amounts so paid shall be deemed to be benefit payments under the Plan, and the Plan shall be fully discharged from liability for such payments to the full extent thereof.

X-2. Plan's Right to be Reimbursed for Payment in Error

When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan shall have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies, or other payees, and the Employee or Claimant shall make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a lump sum in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Claims Processor, upon authorization from the Plan Administrator, may deduct the amount of the overpayment from any future claims payable to the Employee, to any of his or her Dependents, or to the Claimant.

X-3. Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability

The Plan Administrator may, in its sole discretion, pay benefits for care or services pending a determination of whether such care or services are covered hereunder. Such payment shall not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan shall be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (or such person's parent, if the Covered Person is a minor) shall execute and deliver to the Plan Administrator or to the Claims Processor all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Claims Processor, upon authorization from the Plan Administrator, may deduct the amount of the overpayment from any future claims payable to the Employee, to any of his or her Dependents, or to the Claimant.

Y. Rights Against the Plan Sponsor or Employer

Neither the establishment of the Plan, nor any modification thereof or distributions hereunder, shall be construed as giving to any Employee or to any person any legal or equitable rights against the Plan Sponsor or its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Z. Termination for Cause

Coverage shall terminate for an entire family unit or for a COBRA Qualified Beneficiary in certain situations. Except as specified below, any termination shall be effective immediately upon receipt by the Employee or the COBRA Qualified Beneficiary of a written notice from the Plan Sponsor. Any such written notice shall specify the reason for termination/rescission, the facts supporting such action, the effective date of the

termination/rescission, and a notice that no expenses incurred after such date shall be covered by the Plan. Coverage shall end:

1. If a Covered Person makes a fraudulent statement or intentionally misrepresents material facts (including but not limited to facts regarding the marital status, dependent status, or age of a Covered Person) in an application for initial coverage or for a change in coverage, the Plan may rescind the covered person's coverage retroactively and no coverage shall be deemed to have been in effect beginning on the date that the fraudulent statement or intentional misrepresentation of material fact was made. A material misstatement shall be deemed valid after two years of continuous coverage after the making of the fraudulent statement or intentional misrepresentation;

2. If a Covered Person permits any other person the use of any evidence of coverage in their name (or in the Employee's name in the case of a Dependent). This provisions does not apply to an Employee with respect to his or her covered Dependents; and

3. If a Covered Person, singularly or in collusion with others, commits, attempt to commit, aids, or abets claim fraud.

AA. Titles or Headings

Where titles or headings precede explanatory text throughout the Plan Document, such titles or headings are intended for reference only. They are not intended and shall not be construed to be a substantive part of the Plan Document and shall not affect the validity, construction, or effect of the provisions of the Plan Document.

BB. Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

CC. Funding Sources and Employer and Employee Obligations

Plan benefits are paid from the general assets of the Plan Sponsor. The Plan Administrator shall, from time to time, evaluate and determine the amount to be contributed, if any, by each Employee.

COBRA costs are fully the responsibility of the Employee or Qualified Beneficiary and are generally 102% of the full cost of coverage for active (Non-COBRA) enrollees, except in special circumstances where a greater cost is allowed by law. See **ARTICLE VII – COBRA CONTINUATION COVERAGE** for more information.

For active Employees, the Employee's share of the cost(s) shall be deducted on a regular basis from his wages or salary. In other instances, the Employee shall be responsible for remitting payment to the Employer in a timely manner as prescribed by the Employer. If Plan benefits are part of an Employer-sponsored cafeteria plan under § 125 of the Internal Revenue Code, such coverage costs may be deducted on a pre-tax basis.

DD. Governing Law

THIS PLAN DOCUMENT SHALL BE ADMINISTERED IN ACCORDANCE WITH THE PROVISIONS OF ERISA AND THE OTHER FEDERAL STATUTES SPECIFICALLY REFERENCED HEREIN. TO THE EXTENT THAT STATE LAW APPLIES, AND IS NOT OTHERWISE PREEMPTED BY FEDERAL LAW, THIS PLAN DOCUMENT SHALL BE GOVERNED BY, AND CONSTRUED UNDER, THE LAWS OF THE STATE OF ALABAMA.

EE. Whom to Contact for Additional Information

An Employee or Covered Person may obtain additional information about Plan coverage of a specific drug, device, preventive service, procedure, or treatment from the office that handles claims on behalf of the Plan Administrator (that is, the Claims Processor). See **ARTICLE II – GENERAL PLAN INFORMATION** for the name, address, and telephone number of the Claims Processor.

ARTICLE XXI – ERISA STATEMENT OF RIGHTS

A. General Information

Employees and their eligible Dependents under the Plan are entitled to certain rights and protections under ERISA. The following is a summary of those rights.

A-1. Right to Receive Information About the Plan and Benefits

Employees have the right under ERISA to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, the Plan Document and other documents, if any, governing the Plan, including insurance contracts and collective bargaining agreements, if any, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the DOL and available at the Public Disclosure Room of the Employee Benefits Security Administration;

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, if any, and copies of the latest annual report (Form 5500 Series) and updated Plan Document. The Plan Administrator may charge a reasonable amount for such copies; and

3. 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 such summary.

A-2. Right to Continue Group Health Plan Coverage

Employees have the right under ERISA to:

1. Continue health care coverage for themselves and for their eligible Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees and their Dependents may have to pay for such coverage. See this Plan Document and other documents governing the Plan, if any, regarding the rules governing COBRA Continuation Coverage rights;

A-3. Right to Prudent Actions by Plan Fiduciaries

In addition to creating rights for Employees and Dependents, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan – that is, the Fiduciaries of the Plan – have a duty to do so prudently and in the interest of Employees and Dependents. No one, including the Employer, a union, or any other person, may fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA.

A-4. Right to Enforce Rights Under ERISA

If a claim for a welfare benefit, including medical benefits, is denied or ignored, in whole or in part, the Claimant has 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. If the Claimant does not appeal on time, then he or she may lose the right to file suit in court, because internal administrative appeal rights will not have been exhausted.

Under ERISA, there are steps a Claimant may take to enforce the above rights. For example:

1. If a Claimant requests a copy of the Plan Document or the latest annual report from the Plan and does not receive it within 30 days, the Claimant may file suit in a federal court. In such instance, the court may require the Plan Administrator to provide the materials requested and to pay the Claimant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator;

2. If a Claimant submits a claim for medical benefits that is denied or ignored, in whole or in part, he or she may file suit in a state or federal court;

3. If a Claimant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, he or she may file suit in a federal court; and

4. If a Plan Fiduciary misuses the Plan's money, or if a Claimant is discriminated against for asserting his or her rights, such Claimant may seek assistance from the DOL or may file suit in a federal court.

The court shall decide whether one of the parties to the lawsuit should pay court costs and attorneys' fees. If the Claimant is successful with respect to any of the examples set forth above, the court may order the person or entity that has been sued to pay such costs and fees. If the Claimant is not successful, the court may order him or her to pay such costs and fees.

A-5. Right to Assistance with ERISA Questions

If an Employee, a Dependent, or a Claimant has any questions about the Plan, he or she should contact the Plan Administrator. If an Employee, a Dependent, or a Claimant has any questions about his or her rights under ERISA, or if he or she needs assistance in obtaining documents from the Plan Administrator, he or she should call the nearest office of the Employee Benefits Security Administration for the DOL listed in the telephone directory or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue Northwest, Washington, DC 20210. Certain publications about an Employee's rights and responsibilities under ERISA may also be obtained by calling the toll-free hotline of the Employee Benefits Security Administration: (866) 444-3272.

ARTICLE XXII – PRIVACY REQUIREMENTS UNDER HIPAA

A. Purpose and Scope

The purpose of this Article is to cause the Plan to provide restrictions on uses and disclosures of protected health information ("PHI"), including that transmitted electronically ("ePHI"), by the Company, to provide for other rules and restrictions necessary for the Plan to comply with applicable laws regarding the privacy of PHI, and to establish disciplinary rules regarding violations of the privacy requirements regarding PHI or of the Plan's privacy policies and procedures. This Amendment is to be interpreted, construed, and limited in accordance with such intent, and, notwithstanding any provision herein to the contrary, shall be applied only as required by the HIPAA Regulations. To the extent that the Plan is or becomes a "hybrid entity" within the meaning of the HIPAA Regulations, this Article shall apply only to the Health Care Components of the Plan, and references in this section to the Plan shall be deemed to be a reference to the Health Care Components of the Plan. This Article shall govern and control over any and all provisions of the Plan that conflict with any provision of this Article.

B. Defined Terms

For the purposes of this Article, the following terms shall have the meanings set forth below, unless the context clearly indicates to the contrary; *provided that*, to the extent the following definitions are inconsistent or conflict with the applicable provisions of the HIPAA Regulations, the relevant terms and provisions of such regulations shall govern and control:

1. **Breach**: The acquisition, access, use, or disclosure of PHI in a manner not permitted under HIPAA or the HIPAA Regulations that compromises the security or privacy of the PHI;

2. **Business Associate**: An individual or entity, other than an Employee of the Company, that provides services to the Plan, such as a third-party administrator, COBRA vendor, or utilization review organization;

3. **Company:** Piggly Wiggly Alabama Distributing Company, Inc. and any related entity that has adopted the Plan as a Participating Employer;

4. **Covered Person**: An Employee or Dependent spouse or child enrolled in the Plan;

5. **Health Care Components**: The designated health care components of the Plan;

6. **HIPAA**: The Health Insurance Portability and Accountability Act of 1996, as amended from time to time;

7. **Non-Health Care Components**: The components of the Plan, if any, that are not Health Care Components and are not subject to the HIPAA privacy rules;

8. **Plan**: Health Benefits Plan for the Employees of Piggly Wiggly Alabama Distributing Company, Inc.

9. **Plan Contact Person**: The person or office designated to serve as contact person for the Plan;

10. **Plan Privacy Officer**: The person designated to serve as the privacy officer for the Plan;

11. **Plan Sponsor**: Piggly Wiggly Alabama Distributing Company, Inc.

12. **PHI**: Individually identifiable health information that is protected pursuant to HIPAA and the HIPAA Regulations;

13. **Policies**: The Plan's policies and procedures concerning PHI;

14. **HIPAA Regulations**: The regulations promulgated pursuant to the privacy provisions of HIPAA; and

15. **SHI**: Summary health information (that is, information that summarizes the claims history, claims expense, or type of claims experienced by Covered Persons under the Plan as such term is described in § 164.504 of the HIPAA Regulations).

C. Effective Date

The provisions of this Article shall be effective as of April 14, 2003, or such other date as may be appropriate under applicable law.

D. Provision of PHI to the Company Pursuant to an Authorization

The Plan may at any time disclose to and the Company may receive from the Plan PHI if such disclosure and use is pursuant to and in accordance with a valid authorization from the individual who is the subject of such information. Those with access to PHI are required to do the following:

1. Insure the confidentiality, integrity, and availability of PHI and ePHI that is created, received, maintained, or transmitted;

2. Protect against reasonably anticipated threats or hazards to the security of PHI or ePHI;

3. Protect against foreseeable misuse or abuse of and against improper disclosure of PHI and ePHI; and

4. Insure compliance of the above requirements by persons having access to PHI and/or ePHI.

E. Provision of SHI and Other Limited Information to the Company

The Company may receive and use health information from the Plan only if the information consists solely of SHI and only if the Company certifies to the Fiduciaries of the Plan that the information is being requested for one or more of the following purposes:

1. Enabling the Company to obtain premium bids from health insurers for providing health insurance coverage under the Plan;

2. Determining whether and, if so, how to modify or amend the Plan; or

3. Determining whether and, if so, how to terminate the Plan, in whole or in part.

In addition, as permitted under the HIPAA Regulations, the Plan may disclose to the Company information about whether a person is participating in the Plan, or is enrolled in or has disenrolled from a benefit option under the Plan.

F. General Provision of PHI to the Company

The Company may receive PHI from the Plan and use such PHI if the Company certifies in writing to the Plan's Fiduciaries that the Plan incorporates the restrictive provisions described below and the separation

requirements described in Adequate Separation below, and if the Company agrees to comply with the following restrictions and requirements regarding the PHI that is provided by the Plan to the Company:

1. The Company shall not use or further disclose the information other than as permitted or required by the applicable Plan documents or as required by law or the HIPAA Regulations;

2. The Company shall ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such information;

3. The Company shall not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Company;

4. The Company shall report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

5. The Company shall make available to Covered Persons PHI in accordance with the HIPAA Regulations;

6. The Company shall provide Covered Persons with the right to amend their PHI and shall incorporate any amendments to Covered Persons' PHI in accordance with the HIPAA Regulations;

7. The Company shall provide Covered Persons an accounting of disclosures of their PHI in accordance with the HIPAA Regulations. In the event that the Company discovers a Breach, it shall notify each individual whose unsecured PHI has been, or is reasonably believed by the Company to have been, accessed, acquired, used, or disclosed as a result of such breach, in accordance with HIPAA and the HIPAA regulations. The Company shall also notify the media of such breach (if required under HIPAA and the HIPAA Regulations) and the Secretary of the Department of Health and Human Services;

8. The Company shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Regulations;

9. If feasible, the Company shall return or destroy all PHI received from the Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, or, if such return or destruction is not feasible, the Company shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

10. The Company shall ensure the adequate separation required pursuant to Adequate Separation below.

G. Adequate Separation

At all times, there shall be adequate separation between the Plan and the Company and the Health Care Components and the Non-Health Care Components of the Plan, if any, in accordance with the requirements imposed under the HIPAA Regulations, including the requirements of § 164.504(f)(2)(iii) of the HIPAA Regulations. In order to comply with such adequate separation requirements:

1. The Employees, classes of Employees, or other persons under the control of the Company to be given access to PHI disclosed to the Company or who receive PHI relating to

treatment, payment under, health care operations of, or other matters pertaining to the Health Care Components of the Plan in the ordinary course of business include the Plan Privacy Officer;

2. The access to and use by the Company and the individuals described above is restricted to:

a. The Plan Sponsor functions with respect to which the Company is entitled to receive SHI pursuant to Provision of SHI and Other Limited Information to the Company above;

b. Uses and disclosures described in an authorization by the Covered Person;

c. Uses and disclosures that are described to Covered Persons in the "Notice of Privacy Practices" for the Plan; and

d. The Plan administration functions that the Company performs in connection with the operation and administration of the Plan, including but not limited to:

i. Any of the following activities:

(a) Conducting quality assessment and improvement activities (*provided that* the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities), population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives, and related functions that do not include medical treatment;

(b) Evaluating health plan performances;

(c) Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of § 164.514 of the HIPAA Regulations are met, if applicable;

(d) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(e) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including development or improvement of methods of payment or coverage policies; and

(f) Business management and general administrative activities of the Plan, including but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA and the HIPAA Regulations; Employee service activities, including the provision of data analyses, provided that PHI is not disclosed unless such disclosure is permissible under HIPAA and the HIPAA Regulations; resolution of internal grievances; and, consistent with the applicable requirements of the HIPAA Regulations, creation of de-identified health information or a limited data set.

ii. Activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care, and the following activities to the extent they relate to the individual(s) to whom health care is provided by the Plan:

(a) Determination of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

(b) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(c) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;

(d) Review of health care services with respect to medical necessity, coverage under the Plan, appropriateness of care, or justification of charges;

(e) Utilization review activities, including precertification and precertification of services, and concurrent and retrospective review of services; and

(f) Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums or reimbursement: name and address, date of birth, social security number, payment history, account number, and name and address of the health care provider and/or the Plan.

3. In the event that any person described above fails to comply with any of the requirements of this provision or with **General Provision of PHI to the Company** above, the noncompliance shall be reported to the Plan Privacy Officer in a report describing the name of the noncompliant person and a summary of the details regarding such person's noncompliance. Upon receipt of such report, the Plan Privacy Officer shall solicit a response from the person who has been reported as noncompliant, giving such person the opportunity to contest the charge of noncompliance or to offer justification or other reasons why sanctions should not be imposed with respect to the noncompliance. The Plan Privacy Officer, after considering all details, facts, and circumstances relating to an alleged act of noncompliance for which sanctions may be imposed pursuant hereto, shall determine if a sanction should be imposed (which sanction may range from a warning to recommended dismissal from employment). Upon determination of a sanction and if the sanction may be imposed under the authority of the Plan Privacy Officer, the sanction shall be imposed. If the sanction requires action of the Company, the Plan Privacy Officer shall confer with the appropriate managers of the Company. If the Company, following consideration of a proposed sanction from the Plan Privacy Officer for noncompliance with the requirements of **General Provision of PHI to the Company** and **Provision of SHI and Other Limited Information to the Company** by a person or entity, determines not to impose such sanction, the Company shall advise the Plan Privacy Officer. In such event, the Plan Privacy Officer must consider and propose an alternative sanction for the noncompliant person or entity.

H. Plan Privacy Officer

In accordance with the Regulations, a Plan Privacy Officer shall be appointed for the Plan. The then-existing Plan Privacy Officer may be removed at any time upon written notice provided that a successor Plan Privacy Officer has been appointed to serve.

I. Plan Contact Person

In accordance with the HIPAA Regulations, a Plan Contact Person shall be appointed (which may be the same person as is serving as the Plan Privacy Officer). The Plan's then-existing Plan Contact Person may be removed at any time upon written notice, provided that if a successor Plan Contact Person has not been appointed to serve, the Plan Privacy Officer shall serve as the Plan Contact Person.

J. Disciplinary Proceedings

The purpose of this provision is to establish appropriate disciplinary sanctions and proceedings as required by the HIPAA Regulations.

Any complaint brought pursuant to the Plan's complaint procedures that involves an alleged failure to comply with HIPAA, the HIPAA Regulations, the terms of this Article, or the Policies shall be referred to the Plan Privacy Officer for consideration as to disciplinary sanctions and proceedings under this provision.

Similarly, if the Plan Privacy Officer becomes aware of any other failure to comply with HIPAA, the HIPAA Regulations, the terms of this Article, or the Policies, the Plan Privacy Officer shall consider whether such matter is appropriate for the disciplinary sanctions and proceedings under this provision.

If the complaint or other failure involves the actions of a Business Associate, the appropriate disciplinary sanctions and proceedings shall be conducted under the terms of the Business Associate agreement. If the complaint or other failure involves the actions of the individuals responsible for the administration of the Plan identified in **Adequate Separation**, the appropriate disciplinary sanctions and proceedings shall be conducted under **Adequate Separation**. If the complaint or other failure involves the actions of any other Company employee or any agent of the Company, the appropriate disciplinary sanctions and proceedings shall be conducted under this provision.

In the case of either an unresolved complaint or other failure described above, the Plan Privacy Officer shall solicit a response from the person or agent who has been reported as noncompliant, giving the person or agent the opportunity to contest the charge of noncompliance or to offer justification or other reasons why disciplinary sanctions should not be imposed with respect to the noncompliance.

The Plan Privacy Officer, after considering all details, facts, and circumstances relating to such an alleged act of noncompliance, shall determine if a disciplinary sanction is warranted (which sanction may range from a warning to dismissal from employment, or in the case of an agent, termination of the agency agreement). Upon determination of a disciplinary sanction and if the sanction may be imposed under the authority of the Plan Privacy Officer, the disciplinary sanction shall be imposed.

If the disciplinary sanction requires approval of the Company, the Plan Privacy Officer shall confer with the appropriate managers of the Company. If the Company, following consideration of a recommended disciplinary sanction from the Plan Privacy Officer, determines not to impose such disciplinary sanction, the Company shall advise the Plan Privacy Officer. In such event, the Plan Privacy Officer must consider and propose an alternative disciplinary sanction for the noncompliant person or agent. The Plan Privacy Officer shall ensure that the imposed disciplinary sanction is adequately communicated to the violator and is enforced.

In the event that a disciplinary sanction triggers any rights of appeal (for instance, under a collective bargaining agreement), all such rights shall be available to the violator. In the case of any such appeal proceedings, the identity of the individual whose privacy rights were violated shall be removed to the extent feasible.

K. Implementation Authority

The Company shall have the authority to enter into and enforce on behalf of the Plan such contracts and agreements (including, specifically, Business Associate agreements) as may be appropriate or necessary to cause the Plan to satisfy its obligations under HIPAA and the HIPAA Regulations.

L. Indemnification

The Company shall indemnify and hold harmless each Employee of the Company who is identified in **Adequate Separation** as a person who is to be given access to or receive PHI against any and all expenses and liabilities arising out of such Employee's administrative functions or Fiduciary responsibilities in connection with violations of HIPAA and the HIPAA Regulations, including but not limited to any expenses and liabilities that are caused by or result from an act or omission constituting the negligence of such Employee in the performance of such functions or responsibilities, but excluding expenses and liabilities arising out of such Employee's own gross negligence or willful misconduct. Expenses against which such person shall be indemnified include but are not limited to the amounts of any settlement, judgment, costs, counsel fees, and related charges reasonably incurred in connection with a claim asserted or a proceeding brought. This provision shall not, however, apply to, and the Company shall not indemnify against, any expense that was incurred without the consent or approval of the Company, unless such consent or approval has been waived in writing by the Company.

ARTICLE XXIII – SECURITY RULES

A. General Information

On and after April 20, 2005 (or effective April 20, 2006 if the Plan's premium equivalent is less than $5,000,000 annually), the Plan shall comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160, 162, and 165 (the "Security Regulations").

B. Defined Terms

For the purposes of this Article, the following terms shall have the meanings set forth below.

1. **Electronic Protected Health Information ("ePHI")**: Has the meaning set forth in 45 CFR § 160.103, as amended from time to time, and generally means the PHI that is transmitted or maintained in any electronic media;

2. **Plan**: Health Benefits Plan for the Employees of Piggly Wiggly Alabama Distributing Company, Inc.

3. **Plan Documents**: The Plan's governing documents and instruments (that is, the documents under which the Plan was established and is maintained), including but not limited to the Health Benefit Plan for the Employees of Piggly Wiggly Alabama Distributing Company, Inc. Plan Document – High Deductible Option;

4. **Plan Sponsor**: Piggly Wiggly Alabama Distributing Company, Inc.

5. **Security Incidents**: Has the meaning set forth in 45 CFR § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

C. Plan Sponsor Obligations

Where ePHI shall be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the ePHI follows:

1. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

2. The Plan Sponsor shall ensure that the adequate separation that is required by 45 § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

3. The Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect such Information; and

4. The Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

a. The Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's ePHI; and

b. The Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

ARTICLE XXIV – NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how protected health information (or "PHI") may be used or disclosed by us [or your Group Health Plan] to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your PHI, and describes your rights to access, amend and manage your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to:
(i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact: Piggly Wiggly Alabama Distributing Company, Inc. 2400 J. Terrell Wooten Drive., Bessemer, AL 35020, (205) 481-2300

EFFECTIVE DATE

This Notice of Privacy Practices becomes effective on September 23, 2013.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your PHI. We are obligated to: provide you with a copy of this Notice of our legal duties and of our privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will make the revised Notice available by hand delivery.

Permissible Uses and Disclosures of PHI

The following is a description of how we are most likely to use and/or disclose your PHI.

- ***Payment and Health Care Operations*** We have the right to use and disclose your PHI for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

    - *Payment*

      We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits.

For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

- *Health Care Operations*

We will use or disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

Other Permissible Uses and Disclosures of PHI

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your PHI.

- ***Required by Law***
  We may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

- ***Public Health Activities***
  We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- ***Health Oversight Activities***
  We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

- ***Abuse or Neglect***
  We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence.

- ***Legal Proceedings***
  We may disclose your PHI: (i) in the course of any judicial or administrative proceeding; (ii) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

- ***Law Enforcement***
  Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some

of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.

- ***Coroners, Medical Examiners, Funeral Directors; Organ Donation Organizations***
  We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

- ***Research***
  We may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.

- ***To Prevent a Serious Threat to Health or Safety***
  Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- ***Military Activity and National Security, Protective Services***
  Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

- ***Inmates***
  If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.

- ***Workers' Compensation***
  We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- ***Emergency Situations***
  We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will disclose only the PHI that is directly relevant to the person's involvement in your care.

- ***Fundraising Activities***
  We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- ***Group Health Plan Disclosures***
  We may disclose your PHI to a sponsor of the group health plan – such as an employer or other entity –

that is providing a health care program to you. We can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.

- ***Underwriting Purposes***
  We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.

- ***Others Involved in Your Health Care***
  Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

  If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Uses and Disclosures of Your PHI that Require Your Authorization

Sale of PHI
We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing
We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes
We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

Required Disclosures of Your PHI

The following is a description of disclosures that we are required by law to make.

- ***Disclosures to the Secretary of the U.S. Department of Health and Human Services***
  We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

- ***Disclosures to You***
  We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.
  We will disclose your PHI to an individual who has been designated by you as your personal

representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that:
(i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or
(iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

- ***Business Associates***
  We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Third Party Administrator, Alternative Insurance Resources, Inc., which will be handling many of the functions in connection with the operation of our Group Health Plan; the retail pharmacy; and the mail order pharmacy. *[Insert Examples of Other Business Associates]*

- ***Other Covered Entities***
  We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

- ***Plan Sponsor***
  We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

YOUR RIGHTS

The following is a description of your rights with respect to your PHI.

- ***Right to Request a Restriction***

  You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. *We are not required to agree to any restriction that you may request.* If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for restriction to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

  We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

- ***Right to Request Confidential Communications*** If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

  You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for confidential communications to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

  We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

  We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

  Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.,* an Explanation of Benefits, or "EOB"). *Unless* you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan participant.

  Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within five business days.

  Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely important that you contact the designated contact listed on the first page of this Notice *as soon as* you determine that you need to restrict disclosures of your PHI.

  If you terminate your request for confidential communications, the restriction will be removed for *all* your PHI that we hold, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

- ***Right to Inspect and Copy***

You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your PHI that is contained in a designated record set, you must submit your request to the designated contact listed on the first page of this Notice. It is important that you contact the designated contact to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the designated contact might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the designated contact listed on the first page of this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

- ***Right to Amend***

If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by contacting the designated contact listed on the first page of this Notice. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to the designated contact so that we can begin to process your request. Requests sent to persons or offices, other than the designated contact might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

- ***Right of an Accounting***

You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to the designated contact listed on the first page of this Notice. It is important that you direct your request for an accounting to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

- ***Right to a Copy of This Notice***
  You have the right to request a copy of this Notice at any time by contacting the designated contact listed on the first page of this Notice. If you receive this Notice on our Website or by electronic mail, you also are entitled to request a paper copy of this Notice.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the number listed on the first page of this Notice. A copy of a complaint form is available from this contact office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and
(4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or any other way retaliate against you for filing a complaint with the Secretary or with us.

Group Health Plan Contact:	Stephanie Lawley Piggly Wiggly Alabama Distributing Company, Inc.
Telephone:	(205) 481-2300
Address:	2400 J. Terrell Wooten Drive Bessemer, AL 35020
AIR, Inc. Contact:	Suzanne Liles, Privacy Coordinator Alternative Insurance Resources, Inc.
Telephone:	(205) 871-3229
Address:	P.O. Box 660787 Birmingham, AL 35266-0787

ADOPTION OF THE PLAN DOCUMENT

Adoption

The Plan Sponsor hereby adopts this Plan Document on the date shown below. This Plan Document replaces any and all prior statements of the Plan benefits described herein.

Purpose of the Plan

The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and the eligible Dependents of such Employees. The benefits provided by the Plan are as listed herein.

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Participating Employers

Employers participating in this Plan are as stated in **ARTICLE II – GENERAL PLAN INFORMATION**. The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor shall be binding on all such Employers.

Acceptance of the Plan Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of date.

Piggly Wiggly Alabama Distributing Company, Inc.

By: _____

Title: _____

Date: _____