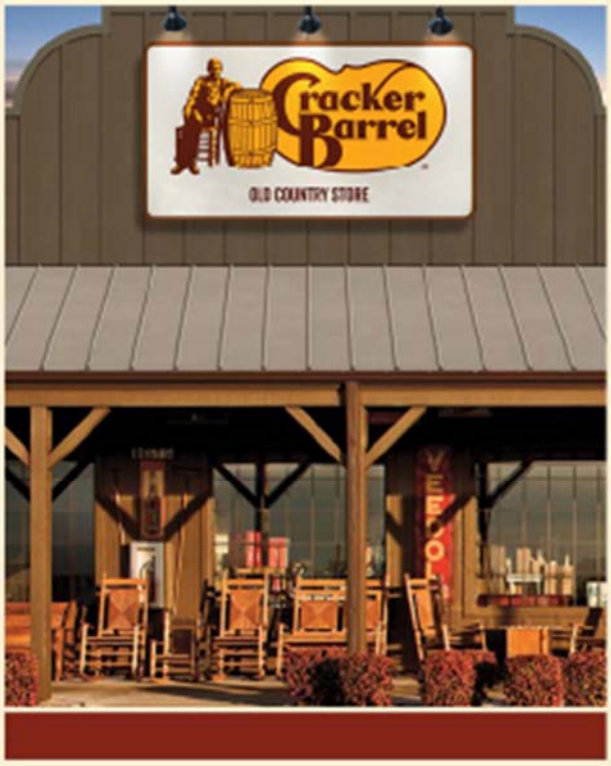


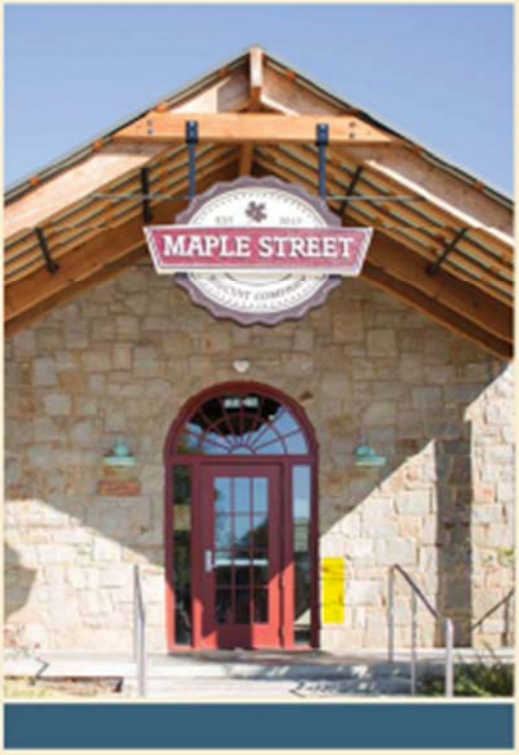


# WE CARE ABOUT YOUR HEALTH CARE

## SUMMARY PLAN DESCRIPTION

A summary of the health and welfare benefits available to eligible Cracker Barrel and Maple Street Biscuit employees.

Cracker Barrel OLD COUNTRY STORE

Home Office, Field Management and Employee Training Coordinators

MAPLE STREET BISCUIT CO.

Leadership & Family Support

# Introduction

*Effective January 1, 2024*

This booklet is the summary plan description (SPD) for The Health and Welfare Plan for Home Office and Field Management Employees of Cracker Barrel Old Country Store, Inc. (the "Plan"). Additionally, for purposes of convenience, this SPD also describes benefits provided under the Cracker Barrel Old Country Store, Inc. Section 125 Cafeteria Plan (the "Section 125 Cafeteria Plan").

This SPD applies to eligible employees designated by the Company (as defined below) as Cracker Barrel Home Office, Distribution Center, Field Management, Cedar Valley Inn, Employee Training Coordinator ("ETC"), and Maple Street Family Support Center employees. The Company may further designate employees by specific title or position for purposes of describing terms of coverage under certain benefits in this SPD. If you have any questions regarding your title or position, or whether you are an eligible employee under the Plan, please contact the Benefits Department at 1-888-596-7878 or benefits@crackerbarrel.com.

Take time to review the enclosed information and save it in a safe place for future reference.

If you have any questions about your benefits, please contact the appropriate administrator or insurer listed on the "Who to Contact" page.

**What is a summary plan description (SPD)?**

This SPD provides basic information about the Plan, including an explanation of eligibility, benefits coverage, your rights as a participant of the Plan and claim procedures. The information is not intended to be all-inclusive, but rather summarize the main features of the Plan.

This booklet and the information contained herein are not intended to and do not constitute either an employment agreement or contractual relationship. They also do not guarantee employment for a specified period of time.

**Other documents that govern**

The plan is in part self-insured and in part financed through group insurance contracts. The plan document, which incorporates insurance contracts, governs the plan and includes more detail on how it operates.

The plan is subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Most of the benefits described in this SPD including the health care FSA and limited health care FSA (which are covered under the Section 125 Cafeteria Plan) are subject to ERISA. Other benefits covered under the Section 125 Cafeteria Plan are not subject to ERISA. These include HSA contributions, dependent care FSA benefits and the portion of the Section 125 Cafeteria Plan that permits you to make tax-exempt contributions for benefits which are deducted from your paycheck. These benefits are described in this SPD for your convenience. Their inclusion is not intended to subject those benefits to the requirements of ERISA.

If there are any discrepancies or inconsistencies between this SPD and the governing Plan documents, the official Plan documents shall govern. However, for purpose of eligibility for benefits, this SPD shall govern. Participants and beneficiaries should not rely on any oral description of the Plan because the written terms of the Plan shall always govern.

**Modifications to this SPD**

This SPD and the plan documents may be amended, modified, suspended, or terminated from time to time and for any reason by a summary of material modifications (SMM) or revised SPD describing the change. Any SMM related to the plan is considered to be part of this SPD.

*Throughout this document, "Company" means Cracker Barrel Old Country Store, Inc. and Participating Employers. "You" or "your" refers to the employee eligible for coverage under the Plan and Section 125 Cafeteria Plan.*

# Table of Contents

# Benefits Overview

***Medical and Prescription Drug***

The Company offers four medical benefit options for medical and prescription drug coverage that provide for preventive care and health care when you're sick. The Plan also provides minimum essential coverage under the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 (the "Affordable Care Act").

***Dental***

The Company offers three benefit options for dental coverage that provide preventive, basic, and major dental services. There's an option with orthodontia coverage as well.

***Vision***

The vision plan provides coverage for vision exams, lenses, frames and contact lenses. You can also receive a discount for other vision services.

***Flexible Spending Accounts (FSAs)***

FSAs allow you to pay for certain unreimbursed expenses on a pre-tax basis. There are three types of accounts: health care FSA, limited health care FSA and dependent care FSA.

***Life Insurance and Accidental Death & Dismemberment***

The life insurance benefit options pay a benefit in the event of your death or an accident. The Company provides basic life and basic accidental death and dismemberment (AD&D) at no cost to you. (ETC employees promoted/hired after October 7, 2023 must meet full time eligibility to be eligible for basic life and basic accidental death and dismemberment.)

You may purchase optional life coverage for yourself, your spouse, and dependent children (up to age 26) on a post-tax basis.

**Identity Theft Protection**

Identity theft protection helps protect you or your family in the event you are a victim of identity theft. Coverage is available for yourself or you and your family.

**Critical Illness**

The critical illness coverage provides a lump sum payment if you are diagnosed with a critical illness. You may purchase coverage amounts of $10,000, $15,000, or $20,000.

***Long-Term Disability***

Long-term disability coverage provides a benefit in the event of a qualifying accident, injury, or sickness. If eligible, benefits begin after 90 days of total disability. (ETC employees are not eligible for long-term disability benefits.)

***Cracker Barrel Connect (Employee Assistance Program (EAP)***

A confidential EAP is available to all employees and their household family members through Cracker Barrel Connect. Cracker Barrel Connect assists with emotional, financial, and other personal problems. Short-term counseling is available for up to four visits. Additional online support services are available at **connect.crackerbarrel.com** and **guidanceresources.com**.

***Tobacco Cessation Program***

The Company offers a free tobacco cessation program through Cracker Barrel Connect to all employees and spouses. The program provides one-on-one telephone counseling as well as ideas and resources to help you break your tobacco habit.

# Eligibility

This SPD describes whether you and your dependents are eligible for all benefits under the Plan. The eligibility requirements listed below apply regardless of any conflicting provisions or terms in any other documents.

Notwithstanding anything in this section to the contrary, all active employees are eligible for and are automatically enrolled in the Cracker Barrel Connect EAP. Refer to the Cracker Barrel Connect EAP section later in this SPD for more information.

## Eligible Employees

### Full-Time Employee Eligibility

You are eligible for benefits under the Plan if you are employed by the Company or a participating employer and any of the following apply:

- You are hired as a full-time employee and based on the facts and circumstances on your start date, the Company reasonably expects you to complete an average of at least 30 hours of service per week (a “new full-time employee”).
- You are employed in a position that the Company reasonably expects to average at least 30 hours of service per week (an “ongoing full-time employee”). **NOTE: In the event you do not work at all during the ongoing Standard Measurement Period (described in the Variable Hour and Part-Time Employee Eligibility section below), you will not be eligible for benefits for the following calendar year.**

- You become an ongoing full-time employee because of a change in employment status from a variable hour employee or part-time employee, as determined by the Company (see "*Variable Hour and Part-Time Employee Eligibility*" below).

Please note: New full-time employees and ongoing full-time employees (collectively, "full-time employees") are not subject to an initial measurement period or standard measurement period, **except those that do not work at all during the measurement period as mentioned above**. Employees who have a change in employment status from an ongoing full-time employee to a variable hour or part-time employee must meet the criteria as a variable hour employee to be eligible for benefits. See "*Variable Hour and Part-Time Employee Eligibility*."

Additionally, eligibility for long-term disability benefits starts after eligible employees have completed one year of continuous active service with the Company.

If you're eligible for benefits, the Company automatically provides you coverage in the basic life, basic accidental death, and dismemberment (AD&D), and long-term disability benefits. (ETC employees are not eligible for long-term disability benefits.)

If you are a full-time employee, you have the option to enroll in the medical/prescription drug, dental, vision, Health Savings Account (HSA), flexible spending account (FSA), optional life insurance, critical illness, and identity theft protection plans. You have 30 days to enroll in coverage from the date you are first eligible, and thereafter, during Open Enrollment.

If you are hired by the Company as a leased employee or independent contractor, you are not eligible to participate in the Plan.

## Variable Hour and Part-time Employee Eligibility

You are eligible for benefits under the Plan if you are employed by the Company or a participating employer and the following applies: You are a new or an ongoing variable hour employee or part-time employee who has averaged at least 30 hours of service per week during your initial measurement period or a subsequent standard measurement period.

A variable hour employee is an individual who either:

- At the time of hire, the Company cannot determine is reasonably expected to complete an average of at least 30 hours of service per week during an initial measurement period, or
- Is hired into a position for which the customary annual employment is six months or less and begins around the same time each calendar year.

A part-time employee is an individual who, at the time of hire, the Company reasonably expects to complete an average of less than 30 hours of service per week during an initial measurement period. (ETC employees hired after October 7, 2023 are considered variable hour.)

**Initial Measurement Period**

For new variable hour or part-time employees, your hours of service will be measured for 11 months to determine if you meet the 30-hour average work week requirement for benefits.

- The initial measurement period will begin on your date of hire.
- You must average at least 30 hours or more of service per week during the initial measurement period to be eligible for benefits during the initial stability period (described below). If you are eligible for benefits, you'll have four weeks to enroll (known as your enrollment period). Your coverage will be effective the first day of the month following your enrollment period if you enroll in coverage.
- If you are not eligible for benefits based on the initial measurement period, you are not eligible for benefits during the initial stability period.

**Initial Stability Period**

The initial stability period is the 52-week coverage period beginning the day following the end of your enrollment period.

- If you are eligible for benefits based on your initial measurement period, you are eligible for benefits for the initial stability period. You must enroll in coverage during the initial enrollment period to be covered for the initial stability period.
- If you are not eligible for benefits based on your initial measurement period, you will not be eligible for benefits during the initial stability period. However, if you become eligible for benefits based on your hours of service during a standard measurement period (*see explanation that follows)*, you may enroll for coverage for the next standard stability period, even if next standard stability period overlaps with the initial stability period during which you were determined to not be eligible.

**For example**: You were hired on April 27, 2024. Your initial measurement period begins April 27, 2024, and ends 11 months later on March 24, 2025. If you worked an average of 30 hours of service per week during the initial measurement period and enrolled in coverage during the four weeks prior to your effective date, your coverage would be effective June 1, 2025. Your eligibility stability period for benefits runs through May 31, 2026. Your continued eligibility for coverage throughout the remainder of 2026 is re-evaluated in the standard measurement period that runs from October 2024 to October 2025. If you worked an average of at least 30 hours during that measurement period, your current eligibility remains in place for the remainder of the 2026 plan year. If you did not average at least 30 hours per week during the standard measurement period, your stability period ends May 31, 2026, and your coverage, if enrolled, cancels.

For up-to-date eligibility information and to enroll in benefit coverage, please visit the Benefit Administration website.

**Standard Measurement Period**

Beginning in October following your date of hire and each October thereafter, the Company will measure your average hours of service for a 52-week period, known as the standard measurement period. This measurement period may overlap with your initial measurement period or initial stability period, as described in the example above, and is used to determine if you meet the 30-hour average requirement for benefits eligibility for subsequent standard stability periods.

- If you are eligible for benefits, you'll have an opportunity to enroll for coverage during Open Enrollment held prior to the standard stability period (see explanation below). If you enroll for coverage, your coverage will be effective the first day of the next Plan year.

***Note: If you are not actively at work when your coverage is set to begin, your coverage under the life, disability, and critical illness plans will begin when you return for one full day.***

- If you are not eligible for benefits based on the standard measurement period because you did not average at least 30 hours of service per week, you are not eligible for benefits during the standard stability period.

**Standard Stability Period**

The standard stability period is the Plan year (January 1 – December 31) following the standard measurement period plus a 3-month standard administrative period.

If you average at least 30 hours of service or more per week during the standard measurement period, you'll be eligible for benefits during the next standard stability period (i.e., the subsequent Plan year). You must enroll for benefits during Open Enrollment prior to the beginning of the next standard stability period in order to be covered for the standard stability period.

**Note:** If you become ineligible for benefits for a standard stability period due to not working the required 30-hour average during the immediately preceding standard measurement period, you may again become eligible for coverage for a subsequent stability period if you average at least 30 hours of service or more per week in a subsequent standard measurement period.

Additionally, you are not eligible for long-term disability benefits until you have worked the required 30-hour average for one year of service (in your initial or subsequent standard measurement period).

If you're eligible for benefits, the Company automatically provides you coverage in the basic life, basic accidental death and dismemberment (AD&D), and long-term disability benefits. (ETC employees are not eligible for long-term disability benefits.)

You have the option to enroll in the medical/prescription drug, dental, vision, Health Savings Account (HSA), flexible spending account (FSA), optional life plans, critical illness, and identity theft protection plans.

If you are hired by the Company as a leased employee or independent contractor, you are not eligible to participate in the Plan.

## Eligible Dependents

Benefits under this Plan shall not be provided unless your spouse and dependent children meet the eligibility requirements specified below.

You may enroll your eligible dependents (where applicable) on the same date you enroll, as long as they meet the following criteria:

- Your legally married spouse (a common law husband or wife is ineligible). For California only: Domestic partners are eligible for coverage in the fully insured vision plan
- Your dependent children who include your:
  - Natural children
  - Adopted children and children placed with you for adoption
  - Foster children
  - Stepchildren
  - Children for whom you are required by a court order to provide coverage
  - Grandchildren for whom you have legal custody (parents of the grandchildren cannot live in the same household as the grandchildren)

**Please note**: Your dependent children must qualify as your dependent under the Internal Revenue Code for purposes of making tax exempt contributions, for purposes of receiving reimbursement for qualified medical expenses under the health care and limited health care FSAs or for purposes of receiving reimbursement for qualified dependent care expenses under the dependent care FSA.

**Dependent Children Age Limits**

- **For medical (including behavioral health), critical illness, ID Theft, Cracker Barrel Connect EAP, prescription drug, dental, vision and dependent life insurance:** You may cover your eligible children through the end of the month in which they turn age 26.
- **For the dependent care FSA:** You may be reimbursed for dependent care expenses for your children who are under the age of 13.

The 26-year age limit does not apply if the dependent child is mentally handicapped or physically disabled and wholly dependent on you for care and support. At reasonable intervals, but no more than annually, the Company may require a doctor's certificate as proof of the child's disability.

**Tobacco Cessation Program Eligibility**

All employees and their spouses are eligible for the Tobacco Cessation Program through Cracker Barrel Connect.

### Notification to Plan When Dependents Become Ineligible

You must notify the Benefits Call Center at 1-833-589-0714 immediately if an eligible dependent becomes ineligible for coverage. Coverage will end for that dependent on the date he or she becomes ineligible. If applicable, your employee contributions will be adjusted as soon as administratively possible after the change in coverage. Any claims paid for an ineligible person may be adjusted and may become your responsibility subject to applicable rules regarding rescission of coverage.

**If Both You and Your Spouse Work for Cracker Barrel or Maple Street Biscuit Company**

You and your spouse may not be covered as both an employee and a dependent at the same time under the benefit plans. You may each make a coverage election for yourself, or one of you may elect coverage for the other person in which case the other spouse should choose "no coverage."

Additionally, if your spouse works for Cracker Barrel or Maple Street Biscuit Company and is enrolled in basic life insurance as an employee, he or she cannot be enrolled as a spouse under the optional life benefit.

**Coverage for a Dependent Child of Two Employees (Cracker Barrel and/or Maple Street Biscuit)**

Only one parent may cover the dependent child(ren). Both parents cannot elect coverage under any plans for the same dependent.

**Note Regarding the Dependent Care FSA**

Highly compensated employees (generally, certain officers and highly paid employees) are not eligible for this benefit. For a definition of who is a highly compensated employee, as defined by the IRS, go to **irs.gov**.

Only dependent care expenses incurred for an eligible dependent may be reimbursed from a dependent care FSA. When your child reaches age 13, you can only use the dependent care FSA for expenses incurred before his or her 13th birthday.

## Verification of Dependent Eligibility

When enrolling a dependent, you will be asked to provide documentation that verifies your dependents' eligibility. This includes but is not limited to, correct social security numbers, birthdates, copies of birth certificates, marriage certificates or any other documents required by the plan to confirm eligibility. Periodically the Company will review enrolled dependents to ensure they continue to meet eligibility guidelines. You may be asked again at that time to provide documentation that verifies eligibility. The plan is relying on your representation of eligibility in accepting the enrollment of your dependents. **Your failure to provide required evidence of eligibility, including correct Social Security numbers, may result in disenrollment of the individual which may be retroactive to the date on which the individual became ineligible for coverage as described in the section "*Notification to Plan when Dependents become Ineligible.*"**

## Qualified Medical Child Support Orders (QMCSO)

The Company may be required to enroll your dependent children in medical and prescription drug, dental and vision coverage if a valid court ordered QMCSO is received. This coverage applies even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that might otherwise exist for dependent coverage. The Company may withhold from your paycheck any contributions required for such coverage. *For specifics, see "Qualified Medical Child Support Orders" in the Administrative section*.

## When Coverage Begins

**If you're a full-time employee, your effective date of coverage is as follows:**

- Coverage in basic life, basic AD&D, and the EAP begins on your date of hire.
- Coverage in the medical/prescription drug, dental, vision, Health Savings Account (HSA), flexible spending account (FSA), optional life insurance, critical illness and identity theft protection plans begins on your date of hire *as long as you enroll within 30 days of employment*.
- The long-term disability plan begins after one year of active employment. (ETC employees are not eligible for long-term disability benefits.)

***Note:***

- ***If you are not actively at work when your coverage is set to begin, your coverage under the life, disability, and critical illness plans will begin when you return to work for one full day.***

**If you're a variable hour or part-time employee:**

- Coverage in the EAP, including four free counseling sessions, begins on your date of hire.
- Coverage for all other benefits begins on the first day of the initial or standard stability period for which you qualified for benefits during the preceding measurement period and enrolled in coverage during your initial enrollment period or during Open Enrollment.

See the *"Variable Hour and Part-Time Employee Eligibility"* section for more specifics.

***Note:***

- ***If you are not actively at work when your coverage is set to begin, your coverage under the life, disability, and critical illness plans will begin when you return for one full day.***

If one of your covered dependents is in the hospital when your benefits begin and he or she was admitted prior to benefits beginning, that dependent's medical and critical illness coverage will begin once he or she is released from the hospital. Coverage for all other dependents will begin on the effective date.

If your enrollment is delayed, contributions must be paid in full back to your original effective date. To find out the total amount due and deadline for payment, call the Benefits Call Center at 1-833-589-0714. **Please note**: you may have to pay for your contributions on a post-tax basis. *For more about paying contributions when not in active employment, see the Contributions section.*

### Failure to Enroll On Time

**If you are a full-time employee and do not enroll within 30 days of your employment, or during any subsequent Open Enrollment period, you will have no coverage under the medical/prescription drug, dental, vision,, flexible spending account (FSA), Behavioral Health, optional life, critical illness and identity theft protection plans for the applicable Plan Year or portion thereof.** Your dependents will receive no coverage under the plans, as well.

Your next opportunity to enroll will be the next following Open Enrollment (typically held in the fall), unless you experience a special enrollment opportunity or other qualifying change in status ("life event") (such as marriage or birth of a child). *See the Life Events section*.

**If you are a variable hour or part-time employee and do not enroll during your enrollment period following your initial measurement period, or during a subsequent Open Enrollment following any standard measurement period during which you were determined to be eligible for benefits, you won't be covered under any benefits in the Plan, except for the Cracker Barrel Connect EAP. Your dependents will also receive no coverage under the Plan, except for the Cracker Barrel Connect EAP.**

Your next opportunity to enroll, provided you are eligible for such coverage based on the applicable measurement period, will be during the next Open Enrollment prior to the start of the next standard stability period. The only exception is if you experience a special enrollment event or other qualifying life event (such as marriage or birth of a child). *See the Life Events section*.

## When Coverage Ends

### *Full-time Employees*

Coverage under the Cracker Barrel Connect EAP ends 18 months following the date your employment ends or, if earlier, the date the Plan is terminated or discontinued. For all other benefits offered under the Plan, coverage in the Plan ends on the earliest of the following dates:

- The date you are no longer eligible, including due to a failure to work, on average, at least 30 hours of service per week during an applicable measurement period.
- The end of the calendar year in which you fail to re-enroll during Open Enrollment.
- The date on which you have been on a leave status for six months, unless state or federal law dictates otherwise.
- The date your employment ends (unless you qualify for and elect COBRA coverage).
- The last date coverage is paid for if you fail to make the required contributions by the due date *(see the Contributions section)*; or
- The date the Plan is terminated or discontinued.

**Variable Hour and Part-Time Employees:**

Coverage under the Cracker Barrel Connect EAP ends 18 months following the date your employment ends or, if earlier, the date the Plan is terminated or discontinued. For all other benefits offered under the Plan, coverage in the Plan ends on the earliest of the following dates:

- The date you are no longer eligible (the last day of the initial or standard stability period if you do not average at least 30 hours per week in the current measurement period).
- The end of the calendar year in which you fail to re-enroll during Open Enrollment.
- The date on which you have been on a leave status for six months, unless state or federal law dictates otherwise.
- The date your employment ends unless you meet the requirements for extending coverage (*see the provisions below on "Continuing Coverage After Termination*").

- The last date coverage is paid for if you fail to make the required contributions by the due date (*see the Contributions section*); or
- The date the Plan is terminated or discontinued.

**Special note about the FSAs:** Participation in the FSAs ends each Plan year unless you make an election during Open Enrollment to participate in the next Plan year. For the dependent care FSA, in addition to the above termination events, participation also ends on the date you or your spouse are no longer working or going to school and are home and able to care for your dependents.

### *Dependents*

Coverage in the Plan for your dependents ends on the earliest of the following dates:

- The date your coverage ends.
- The date your dependent is no longer eligible for benefits as described in this SPD.
- The end of the calendar year in which you fail to re-enroll during Open Enrollment.
- The last date coverage is paid for if you fail to make the required contributions by the due date *(see the Contributions section)*.
- The date the dependent becomes covered by the Plan as a Company employee; or
- The date the Plan eliminates dependent coverage.

**Make Note!** If you or any of your covered dependents no longer meet the eligibility requirements, you are responsible for notifying the Benefits Call Center at 1-833-589-0714.

**Family and Medical Leave Act of 1993 (FMLA)**

If you take an FMLA leave, you may continue benefit coverage under the same conditions as other active employees covered by the Plan for the duration of the FMLA leave. To continue coverage, you must continue paying your share of employee contributions. If you choose to terminate coverage during the leave, or if coverage terminates as a result of nonpayment of contributions, coverage in effect prior to your leave shall be reinstated automatically on the date you return from FMLA to active status.

For more about continuing benefits while on a leave, see "*Continuation of Coverage during a Leave of Absence" in the Administrative section.*

**Continuing Coverage after Termination**

For information regarding continuing coverage under COBRA or USERRA, *see the Administrative section of this book*.

Additionally, you may be able to continue your coverage under the life insurance plans' conversion or portability provisions. *See the Administrative section for important deadlines and more on "Continuing Life Insurance after Termination."*

**If You're Rehired within 30 days**

If your coverage ends because you ended your full-time employment with the Company and you are rehired as a full-time employee within 30 days, your coverage will be reinstated retroactive to your rehire date. You must keep your current elections in place for the remainder of the Plan year unless you incur a special enrollment event or certain life event after you are rehired.

On the date you return to work, coverage for you and your eligible dependents will be on the same basis as that provided for any other active employee and dependents on that date for the benefit and coverage elections you made prior to your break in service, subject to special enrollment event or certain life events.

If you did not have coverage at the time of your termination, you will not be able to enroll in coverage when you return. You will not have an opportunity to enroll until the next enrollment period (if you are a variable hour or part-time employee) or during Open Enrollment, or until you incur a special enrollment event or certain life event (provided that you are eligible for benefits based on the applicable measurement period).

**If You're Rehired After More Than 30 Days**

**Full-time employees:** If your coverage ends because you terminated your full-time employment and you're rehired as a full-time employee after a break in service that's longer than 30 days, you may be treated as a new eligible employee for purposes of making new elections for benefits. Your one year of service for LTD benefits will restart if you are rehired after 30 days as well.

**Variable hour and part-time employees:** Your continuation of eligibility depends on your status as an eligible employee, whether you had coverage when you terminated employment and the length of your break in service.

You will be treated as a new employee if you have a break-in-service of (either):

- At least 13 consecutive weeks without an hour of service
- Less than 13 consecutive weeks but at least four consecutive weeks without an hour of service and your break-in-service exceeds the number of weeks you were employed immediately preceding your break-in-service

If you are treated as a new employee and you return to work, you will be subject to a new initial measurement period.

If you are treated as a continuing employee (not a new employee) and you return to work during your initial or standard measurement period, your hours of service following the break-in-service and in such measurement period will be considered for your eligibility for benefits in the next stability period.

If you are treated as a continuing employee and you return to work during your initial or standard stability period, you retain your benefits eligibility status (as determined before the break-in-service) for the remainder of the initial or standard stability period. If you were previously enrolled in coverage before the break-in-service, you will be offered coverage as soon as administratively possible after your return, but not later than the first day of the calendar month following your resumption of employment.

If you declined coverage before your break-in-service, you will not be offered coverage until the subsequent stability period (provided that you are eligible for benefits based on the applicable measurement period), unless you have a subsequent special enrollment event or certain life event that would enable you to enroll in coverage after you return to work.

**When You Can Re-Enroll if You Become Ineligible for Coverage**

If you become ineligible for coverage due to non-payment of premium/contributions, you may re-enroll for coverage:

- During Open Enrollment of each year
- **Within 30 days** of a special enrollment event or life event, such as marriage, divorce, birth, etc.

You must meet the eligibility requirements at the time you re-enroll for coverage.

If you become ineligible for coverage due to being on leave status for six months, you may re-enroll within 30 days of the date you return from leave status for coverage effective on your return-to-work date.

**Other Events Ending Your Coverage**

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if you commit fraud, intentionally provide false information, or make a material misrepresentation including, but not limited to, submitting enrollment or eligibility information, filing claims or appeals, or responding to a request from the Plan Administrator or a claims administrator.

# Coverage Levels

You may choose from four levels of coverage for medical (including behavioral health), prescription drug, dental, vision and critical illness benefits:

- Employee only
- Employee + Child(ren)
- Employee + Spouse
- Family

You may choose employee only coverage for identify theft protection or family coverage.

# Contributions

***Medical and Prescription Drug, Dental, and Vision***
If elected, you and the Company share in the cost of medical (including behavioral health) and prescription drug coverage. You pay the full cost of dental and vision. Your contributions or premium payments will be deducted from your paycheck on a tax-exempt basis based on the coverage level that you choose.

The Company has established a Section 125 Cafeteria Plan which offers you a way to pay for medical (including behavioral health), prescription drug, dental and vision premiums with tax-exempt dollars. Although the portion of the Section 125 Cafeteria Plan permitting tax-exempt premiums is not part of the Plan, it affects how you pay for these benefits and how you can change your elections for benefits. *See "Enrolling in Benefits" and "Life Events."*

**Remember**: Your dependents must qualify as your dependent under the Internal Revenue Code for purposes of making tax-exempt contributions, for receiving reimbursement for qualified medical expenses under the health care and limited health care FSAs, and for receiving reimbursement for qualified dependent care expenses under the dependent care FSA.

**A note about the Health Savings Account (HSA):** The Company may make contributions to your health savings account (HSA) if you are enrolled in the Health Savings Advantage Plan. You may elect to make contributions to your HSA, as well, on a tax-exempt basis. Some limitations apply. See the *"Medical & Prescription Drug" section for more about contributing to an HSA.*

**Spousal Surcharge**

If you choose to cover your spouse under the Company medical plan and he or she works for an employer who offers medical coverage, you will pay an additional spousal surcharge for medical coverage. If your spouse does not have access to medical coverage through their employer, or they work for Cracker Barrel Old Country Store, Inc. or Maple Street Biscuits, the surcharge will not apply.

**Note**: If your spouse loses eligibility under their employer or becomes covered under another plan, it is your responsibility to notify the Benefits Call Center within 30 days of the event. Otherwise, you will not be able to make the change until the next Open Enrollment period and will continue to be responsible for this spousal surcharge.

**Tobacco Surcharge**

All members who enroll in the Company medical plan will have to identify whether or not they are a tobacco user (this includes vape and e-cigarettes). If you and/or your spouse (if enrolled) identify as a tobacco user, you will pay an additional percentage of the total plan cost for medical coverage, as well as additional amounts for optional life and critical illness coverage.

***FSA***

If elected, you contribute to the FSAs through tax-exempt payroll deductions. Some limitations apply. *See the FSA section for specifics.*

***Life Insurance and AD&D***

The Company pays the full cost of basic life and basic AD&D insurance coverage. If elected, you pay the full cost of optional life coverage for you, your spouse, and your children. Your contributions will be withheld from your paycheck on an after-tax basis.

Note: Due to IRS rules, the cost of coverage in excess of $50,000 of group life insurance is taxable income to you.

***Long-Term Disability***

The Company pays the full cost of long-term disability coverage for those employees eligible. Keep in mind that since the Company pays for coverage, the disability benefit is taxable to you when received. (ETC employees are not eligible for long-term disability benefits).

***Critical Illness and ID Theft Protection***

You pay the full cost of any Critical Illness and ID Theft Protection plans in which you enroll. Your contributions will be withheld from your paycheck on an after-tax basis.

***Cracker Barrel Connect EAP***

The Company pays the full cost for the Cracker Barrel Connect EAP for ***ALL*** employees and their dependents. Services include telephonic counseling, four free EAP sessions, and work life services.

***Tobacco Cessation Program***

The Company sponsors a Tobacco Cessation Program at no cost to employees and their spouses (if the spouse is enrolled in a Company medical plan).

The Company offers lower contribution rates for non-tobacco users for employees and their spouses who are enrolled in a Company medical plan, critical illness coverage, or in optional life insurance.

Below are the guidelines for receiving the non-tobacco user rates.

- Employees and enrolled spouses who are tobacco users and complete the Tobacco Cessation Program will be eligible for non-tobacco user rates. This change will be effective the first day of the next pay period following the date the Administrative vendor is notified of the completion of the program.
- Newly eligible employees and enrolled spouses who complete the Tobacco Cessation Program prior to their coverage effective date will be eligible for the non-tobacco user rates on their coverage effective date.
- To enroll in the tobacco cessation program, go online to guidanceresources.com and enter “Biscuit” as the Company ID, or call 1-800-688-6330.
- If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact ComPsych Guidance Resources at 1-800-688-6330 and they will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.
- Employees and enrolled spouses who stop using tobacco products without the assistance of the tobacco cessation program are also eligible for the non-tobacco user rates by logging on to www.mybenefitelections.com and completing a life event.

### Authorizing Paycheck Deductions and Paying for Arrears

When you enroll in benefits, you authorize deductions from your paycheck and acknowledge that deductions may change during the year due to certain special enrollment event or life event changes.

You are responsible for paying any arrears balance if contributions are not deducted by payroll. Arrears occur if:

- Your paycheck does not cover your contributions for benefits.
- You do not receive a paycheck while on vacation or on a leave.
- Your contribution amount increases for any reason.
- You enroll during your enrollment period and your coverage is retroactive.

Arrears balances are deducted from future paychecks if available. If you are on an approved leave of absence and are not receiving a paycheck, arrears notices are mailed monthly and your balance must be paid by the due date or your coverage will be cancelled, retroactive to your paid-through date. Fees may be applied for payments made by credit/debit card.

The administration of arrears is a payroll practice and is subject to change at any time. Arrears payments are made on a post-tax basis.

**Note**: You are responsible for keeping all benefit payments current. Failure to receive a notice does not excuse this responsibility. For questions or to make arrears payments, call 1-833-589-0714 or mail to: WEX, Inc, Account 179, PO Box 2798, Omaha, NE 68103.

# Enrolling in Benefits

If you're eligible for benefits as described in this SPD, the Company automatically provides you coverage in basic life, accidental death and dismemberment (AD&D), and long-term disability.

**Please note**: You are not eligible for long-term disability benefits until you have completed one year of continuous active service with the Company, during which you have worked the required 30-hour average of service per week.

You have the option to enroll in the medical (including behavioral health), prescription drug, dental, vision, health savings account (HSA), flexible spending accounts (FSA), optional employee and dependent life plans, critical illness and identity theft protection plans.

Please note: ETC employees are not eligible for long-term disability benefits and must meet the eligibility requirements. *See "Eligibility" section for more about determining your eligibility.*

***New Hire***

If you are a full-time employee, you have **30 days from your date of hire** to enroll yourself and any dependents in the optional benefit plans (medical (including behavioral health), prescription drug,

dental, vision, Health Savings Account (HSA), flexible spending accounts (FSA), optional employee and dependent life, critical illness and identity theft protection).

**If you're a variable hour or part-time employee:** Once you meet the hours requirement, you have **30 days prior to your effective date** to enroll. *See the "Eligibility" section for more about determining your eligibility.*

If you do not enroll within the 30 day window, you and your dependents will receive no coverage in benefit plans. Your next opportunity to enroll yourself or your dependents will be during the next Open Enrollment, unless you have a special enrollment event or other qualified life event.

***Open Enrollment***

If eligible, you'll have the opportunity to enroll or re-enroll yourself and your eligible dependents, add or remove your eligible dependents, or change benefit options each year during Open Enrollment (typically held in the fall). Your new coverage becomes effective January 1 of the next year, provided you are actively at work on that date.

The only other time you may enroll or make changes outside of Open Enrollment (provided that you are eligible for benefits) is if you experience a special enrollment event or other qualified life event (as outlined in the "Life Events" section) or if you have a Qualified Medical Child Support Order (QMCSO). For more about QMCSOs, *see the Administrative section of this book.*

**Please note:** You can reduce or cancel Optional life, Critical Illness, and Identity Theft Protection (all post-tax benefits) any month in the year. Health savings account (HSA) elections can be increased, decreased or canceled by you any month in the year.

**If you're a variable hour or part-time employee:** The Company will measure your average hours at the end of each 52-week ongoing standard measurement period to determine your continued eligibility for Open Enrollment.

# Life Events

If your family status changes or you experience a qualifying change in status "life event," you may be able to drop or add dependents or change your coverage during the Plan year. The change you make to your coverage must be consistent with your life event.

For example, if you adopt a child, you would be able to add the child to your coverage and change your contribution to an FSA plan, but you would not be permitted to remove your spouse from coverage or end your enrollment in the FSA plans.

If you have questions on the changes allowed, you may contact the Benefits Call Center at 1-833-589-0714.

**If you're a variable hour or part-time employee:** You must have met the 30-hour average during your most recent measurement period to be eligible for a life event change.

A life event includes:

- Birth or adoption of a child (or placement of a child in your home for adoption)
- Marriage, divorce, annulment, or legal separation
- Changes in residence of you, your spouse or dependent (provided the change impacts the benefits offered to you)
- Death of a dependent
- Court order, judgment or decree requiring coverage
- Other coverage ends (including exhaustion of continuation coverage) or becomes available (including through new employment of your spouse)
- Change in status of a dependent (becomes eligible or ceases to be eligible)
- Significant change in cost of benefits or coverage offerings (including the addition or improvement of a benefit)
    - **Please note:** If a cost of a benefit increases (or decreases) during the Plan year in an insignificant amount (as determined by the Company), the Plan may automatically make a prospective increase (or decrease) in your contributions. You will be notified if the cost of a benefit changes and this occurs.
- Change in employment status of you, your spouse or your dependent; or significant sustained reduction in hours worked
- Major changes in your spouse or dependent's insurance coverage
- FMLA or military leave of absence (cancel only)
    - **Please note:** If you do not cancel but continue your coverage during an FMLA or military leave of absence, you may change your election because of a life event so long as your change is consistent with the life event. For example, if you have a baby, you may change your coverage option to employee + children or family coverage, as applicable.
- Entitlement to Medicare or Medicaid
- Reduction in hours of service if you are reasonably expected to average less than 30 hours per week after a change in employment status (e.g., full-time to part-time) and you intend to enroll in another group health plan that provides minimum essential coverage in accordance with the Affordable Care Act (cancel only).
    - **Please note**: You must intend to enroll in another group health plan with an effective date no later than the first day of the second month following the month that coverage under the Plan is canceled, and you may be asked to make a representation that you have enrolled or intend to enroll in such coverage.
- Change in Marketplace eligibility if you are eligible for a special enrollment period to enroll in a qualified health plan through the Marketplace or you seek to enroll in a qualified health plan during the Marketplace's open enrollment period.
    - **Please note**: You must intend to enroll in the Marketplace for new coverage that is effective beginning no later than the day immediately following the last day that coverage under the Plan is canceled, and you may be asked to make a representation that you have enrolled or intend to enroll in such coverage.

If you experience any of these events, contact the Benefits Call Center at 1-833-589-0714 **within 30 days of your life event**. You will be requested to provide documentation of the life event **within 30 days of your status change**.

If you're adding a dependent because of a birth, an adoption, or placement for adoption, coverage will be effective the date of the birth or adoption or placement for adoption. If adding a dependent per a court order, the dependent will become effective the first day of the month following the date of the court order request. If adding a spouse, the coverage will be effective the date of the life event. If you do not enroll within 30 days, you'll have to wait until the next Open Enrollment period to make changes.

**Note:** In no instances will coverage become effective prior to the date of the life event. You will be required to provide documentation that verifies a dependent's eligibility.

### HIPAA Special Enrollment Rights:

The Special Enrollment Rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) apply due to a loss of other coverage, a need to enroll because of a new dependent's eligibility, or a gain of eligibility for certain subsidies.

- **After declining coverage:** If you are declining enrollment for yourself, your spouse or your dependents because of other health coverage, you may be able to enroll yourself or your dependents in the Plan in the future if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

**You must request enrollment within 30 days** after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

- **New dependents:** If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that **you request enrollment within 30 days** after the marriage, birth, adoption, or placement for adoption. If you're adding a dependent because of the birth, adoption, or placement for adoption, coverage will be effective the date of the birth or adoption or placement for adoption. If adding a spouse, the coverage will be effective the date of the qualifying event.
- **Loss of Medicaid or CHIP eligibility:** If you or your dependent's coverage under Medicaid or CHIP plan is terminated as a result of loss of eligibility, you may be able to enroll yourself or your dependents, provided that you request enrollment within 60 days after the coverage ends. If you enroll within the 60 day period, coverage takes effect on the date after your qualifying event occurred.
- **Premium assistance subsidy:** If you or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP with respect to this Plan, you may be able to enroll yourself or your dependent, provided that **you request enrollment within 60 days** after eligibility is determined. If you enroll within the 60 day period, coverage takes effect on the date after your qualifying event occurred.

**Please note:** Loss of eligibility does not include a loss of coverage due to failure to timely pay required contributions or premiums, or loss of coverage for cause (i.e., fraud or intentional misrepresentation). You will have to provide verification documentation for any dependents that you enroll.

# Who to Contact With Questions

| Coverage | Service Provider | Contact |
|---|---|---|
| Enrollment<br>Arrears<br>Life Event<br>Court Orders<br>Dependent Verification<br>Eligibility | Benefits Call Center (WEX) | www.mybenefitelections.com<br>1-833-589-0714<br><br>Arrears Payments: WEX, Inc. Acct 179; P.O. Box 2798, Omaha, NE 68103<br>Dependent Verification: WEX, Inc. 1700 E. Golf Road, Suite 1000 Schaumburg, IL 60173 |
| Life Insurance<br>Claims | Benefits Department | 1-888-596-7878<br>benefits@crackerbarrel.com |
| Medical (Health Savings Advantage Plan, Value Health Plan, Traditional Health Care Plan)<br><br><br><br>Telehealth | BlueCross BlueShield of Tennessee (BCBST)<br><br><br><br>Teladoc | bcbst.com/biscuit<br>1-844-383-2275 (CBRL)<br><br>Nurseline (24/7) (you must log into BlueAccess and then elect "Managing Your Health"<br>1-800-818-8581<br><br>1-888-283-6691 |
| Medical (Health Basics Plan)<br><br><br><br>Telehealth | Symetra<br><br><br><br>MeMD | Email: symsba@symetra.com<br>1-866-357-1778<br><br>Multiplan.com/symetra/cb-msb (medical network providers) 1-888-371-7427<br><br>Memd.me/group/cb-msb<br>1-844-800-7110 |
| Prescription Drug | Express Scripts (BCBST Plans)<br><br>OptumRx (Symetra Health Basics Plan) | express-scripts.com<br>1-800-978-6227<br><br>OptumRx.com<br>-<br>1-800-248-1062 |
| Health Savings Account (HSA) | Bank of America Health Benefit Solutions | myhealth.bankofamerica.com<br>1-866-791-0250 (Customer Care 24/7) |
| Behavioral Health | BlueCross BlueShield of Tennessee (BCBST) | 1-844-383-2275 |
| Cracker Barrel Connect EAP | ComPsych | Connect.crackerbarrel.com<br>Guidanceresources.com (use code: Biscuit)<br>1-800-688-6330 |
| Tobacco Cessation Program | ComPsych | Guidanceresources.com (use code: Biscuit)<br>1-800-688-6330 |
| Dental | Delta Dental of TN | Deltadentaltn.com<br>1-800-223-3104<br>Client code: 4210 |
| Vision | Davis Vision by MetLife | metlife.com/mybenefits<br>1-877-393-8885 |

| Coverage | Service Provider | Contact |
|---|---|---|
| Flexible Spending Account (FSA) | Chard Snyder | Chard-snyder.com<br>1-800-982-7715<br>1-888-245-8452 (fax)<br>Mailing address: P.O. Box 249, Fort Washington, PA 19034-9998 |
| Basic Life, Accidental Death and Dismemberment (AD&D) and Dependent Life | The Hartford | 1-888-563-1124 |
| Long-term Disability | The Hartford | 1-888-301-5615 |
| Critical Illness | The Hartford | 1-866-547-4205 |

# Medical & Prescription Drug

*See the end of this section for definitions of important terms used throughout.*

## Highlights

- The Company offers four medical options, the following three of which include prescription drug coverage:
  - Value Health Plan
  - Health Savings Advantage Plan (with HSA)
  - Traditional Health Care Plan
- All of the above cover in-network preventive care 100 percent in compliance with national guidelines and meet the minimum essential coverage requirements of the Affordable Care Act. However the Value Health Plan and the Traditional Health Care Plan do not meet the health plan requirements of Massachusetts.
- All of the above allow you to use any doctor, hospital or health care facility. But they cover more of the expenses when you stay in-network.
- The difference between the above options is how services are covered and that the Health Savings Advantage Plan includes a savings component called a health savings account (HSA).
- The medical claims administrator for the above is BlueCross BlueShield of Tennessee (BCBST).
- The prescription drug claims administrator for the above plans is Express Scripts.
- The behavioral health service claims administrator for the above plans is BlueCross BlueShield of Tennessee.
- HSA banking for the Health Savings Advantage Plan is provided by Bank of America Health Benefit Solutions.
- There is a fourth benefit option offered that is administered by Symetra Select Benefits. The Health Basics Plan is a fixed-payment indemnity plan with a preventive care benefit. This plan pays a fixed dollar amount up to the daily, annual or frequency maximums. **It is important to note that this plan is not a major medical health plan.** The pharmacy vendor for the Health Basics Plan is Optum Rx.

## Eligible Expenses

The Company has delegated to its claims administrator, the initial discretion to decide whether a treatment or supply is a covered health service (as defined in the *"Terms to Know"* section of this *Medical & Prescription Drug* section) and how the eligible expenses will be determined and otherwise covered under the Plan.

Eligible expenses are the amount that the Plan will pay for medical benefits.

- **In Network Benefits:**
    - For in-network medical benefits, you are not responsible for any difference between eligible expenses and the amount the doctor, hospital or health care facility bills.
    - If in-network medical benefits for covered health services are provided by a non-network doctor, hospital or health care facility (other than emergency health services or services otherwise arranged by the medical plan administrator) , you will be responsible to the non-network physician or provider for any amount billed that is greater than the amount the medical plan administrator, on behalf of the Plan, determines to be an eligible expense (as described in the Determining the Eligible Expenses section below).

- **Non-Network Benefits:**
    - For non-network medical benefits, you are responsible for paying, directly to the non-network doctor, hospital or health care facility, any difference between the amount the physician or provider bills you and the amount the medical plan administrator, on behalf of the Plan, will pay for eligible expenses. Eligible expenses are determined solely in accordance with reimbursement policy guidelines, as described in this SPD.

**Determining the Eligible Expenses**

***For Network Benefits***

When covered health services are received from a network physician or provider, eligible expenses will be at the contracted fee rates negotiated with the medical plan administrator, BCBST, and that physician or provider.

When covered health services are received from a non-network physician or provider, eligible expenses are at the non-network physician rate or provider's billed charges unless a lower amount is negotiated or authorized by law.

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is Cracker Barrel's health plan in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

***For Out-of-Area Services***

BCBST has a variety of relationships with other Blue Cross and/or Blue Shield Licenses. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area they serve, the claim for those services may be processed through one of these Inter-Arrangement. The Inter-Plan Arrangements are described below.

When you receive care outside of the BCBST service area, you will receive it from two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue.

**A. BlueCard Program**

When you receive covered services outside of the BCBST service area the claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to BCBST.

**B. Nonparticipating Providers Outside the BCBST service area**

When covered services are provided outside of the BCBST service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment BCBST will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

**C. Blue Cross Blue Shield Global Core**

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you received care from providers outside the BlueCard service area, you will typically have to pay the providers and

submit the claims yourself to obtain reimbursement for these services. You must contact BCBST to obtain precertification for non-emergency inpatient services.

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

***Don't Forget Your ID Card***

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

## How to Find Network Physicians, Hospitals and Facilities

Under the medical options, you have the flexibility to use any licensed health care physician or credentialed hospital/facility you choose. The level of coverage under the medical options, however, depends on whether you use a physician or hospital/facility within the BCBST network or not. BCBST's credentialing process confirms public information about the physicians or hospitals/facilities' licenses and other credentials but does not assure the quality of the services provided.

***Using In-network Services***

If you visit a physician or hospital/facility that is in the BCBST network for medical or behavioral health, you will receive the highest level of benefits offered under the medical option. These in-network providers have agreed to charge a discounted fee for their services. You will never pay for charges in excess of the discounted price, and in most cases, the physician or hospital/facility will file your claims for you.

***How to Find Network Providers***

- Online at bcbst.com/biscuit (search the P Network)
- Call 1-844-383-2275

It is always best to call your doctor's office or the hospital/facility prior to services being performed to verify network status.

***Blue Distinction Specialty Care***

Some doctors and hospitals may have more expertise in certain areas of specialty care than others, which can impact the quality and results of the care you receive. Blue Cross Blue Shield created a national recognition program called Blue Distinction Specialty Care, to make it easier for you to find quality care that is right for you.

There are two levels of designation that Providers can fall under in this program: Blue Distinction Centers or Blue Distinction Centers+.

**Blue Distinction Centers**
Blue Distinction Centers (BDCs) demonstrate quality care, treatment expertise and better overall patient results.

**Blue Distinction Centers+**
Blue Distinction Centers+ (BDCs+) demonstrate more affordable care in addition to quality care and treatment expertise.

To verify a Provider's status as a BDC or BDC+, call 1-844-383-2275 or use the Provider directory on bcbst.com or visit bcbs.com/blue-distinction-center/facility to use the Blue Distinction Center FinderSM.

Cracker Barrel, Blue Cross and Blue Shield Association, Blue Cross and other Blue Cross and/or Blue Shield licensees are not responsible for damages or non-covered charges resulting from Blue Distinction or other Provider directory information or care received from Blue Distinction or other Providers.

***Using Out-of-Network Services***

If you visit an out-of-network physician, hospital, or facility, you may have to pay the full price at the time of service, and then file a claim form for reimbursement. If you've met your deductible, you will be responsible for coinsurance, as well as the difference between what the medical option pays for services (usual and customary charge) and what the provider actually charges you for the service. We encourage you to always use a network provider when possible.

## Care Management through BCBST

A number of Care Management programs are available to you across the care spectrum, including those with low-risk health conditions and complicated medical needs.

Care Management personnel will work with you, your family, your doctors and other health care providers to coordinate care, provide education, support and to identify the most appropriate care setting. Depending on the level of Care Management needed, the BCBST Care Management will maintain regular contact with you throughout treatment, coordinate clinical and health plan coverage matters, and help you and your family utilize available community resources.

After evaluation of your condition, BCBST may at its discretion, determine that alternative treatment is medically necessary and medically appropriate.

## Prior Authorization

BCBST must authorize some covered services in advance in order for those covered services to be paid at the maximum allowable charge without penalty. Obtaining prior authorization is not a guarantee of coverage. Services that require a prior authorization include but are not limited to:

- Inpatient hospital (except initial maternity admission) and inpatient hospice stays
- Skilled nursing facility and rehabilitation facility admissions

- Certain outpatient surgeries and/or procedures
- Certain air ambulance services
- Certain specialty drugs
- Certain advanced radiological imaging
- Certain durable medical equipment
- Certain prosthetics
- Certain orthotics
- Certain genetic testing
- Out of the country non-emergency inpatient services

Authorization is required for all inpatient and higher levels of care, including Partial Hospitalization Program (PHP) and Intensive Outpatient Program. Other services requiring authorization include ECT, TMS, ABA and psychological testing.

If you are receiving services from a network provider in Tennessee, and those services require a prior authorization, the network provider is responsible for obtaining prior authorization. If the network provider fails to obtain prior authorization, you are not responsible for any penalty or reduction in benefits, unless you have signed a document agreeing to pay for the services regardless of coverage.

If you are receiving inpatient facility services from a network provider outside of Tennessee, and those services require a prior authorization, the network provider is responsible for obtaining prior authorization. If the network provider fails to obtain prior authorization, you are not responsible for any penalty or reduction in benefits, unless you have signed a document agreeing to pay for the service regardless of coverage.

If you are receiving any services, other than inpatient facility services, from a network provider outside of Tennessee, and those services require a prior authorization, you are responsible for obtaining prior authorization. If you fail to obtain prior authorization, your benefits may be reduced.

*See the Covered Services section for the timeframes required for prior authorization.*

## Coverage – Value Health Plan

### How the Plan Works

Office visits are covered in full by the Plan after a copay for primary care and/or specialist care. In-network preventive care services are covered in full by the Plan in accordance with the Affordable Health Care Act.

For most other covered services, you pay up to the annual deductible before the Plan pays. After you meet the deductible, services are covered at 50 percent.

To help you save money, BCBST has negotiated lower costs with network doctors, hospitals, and pharmacies. You receive those discounts when you use network providers. Unlike typical medical plans where there are two levels of coinsurance (one for in-network and one for out-of-network), the Value Health Plan has one level of coinsurance. You pay the same percentage for services regardless of which health care provider you see. Please note, however, the annual deductible and annual out-of-pocket

maximums are calculated separately for in-network and out-of-network services. Also, since network providers have agreed to special fees for services, your expenses will usually be lower if you use doctors, hospitals, and pharmacies in the network. You will also never pay for charges in excess of the discounted price.

Out-of-network providers have no contract with BCBST. They may bill you the difference between what the Plan pays for services (the eligible expense) and what the provider actually charges for the service. We encourage you to always use a network provider when possible.

**The Out-of-Pocket Maximum**

The Value Health Plan limits the amount you will have to pay out-of-pocket each year. If you reach the out-of-pocket maximum, the Plan will cover the eligible charges in full for the remainder of the year.

Both medical and prescription costs apply to your annual deductible and annual out-of-pocket maximum. The out-of-pocket maximums are calculated separately when you use an in-network or out-of-network provider.

# Summary of Benefits – Value Health Care Plan

*For specifics of the types of services covered, refer to the "Covered Services" section. For a detailed description of eligibility for these benefits, see the "Eligibility" section of this SPD. Call BCBST at 1-844-383-2275 for more information. The Value Health Plan does not meet the health plan requirements of Massachusetts.*

| **2024 Benefit Amounts** | **In-Network** | **Out-of-Network[1]** |
|---|---|---|
| Annual Deductible | $ 5,000 individual<br>$10,000 family | $10,000 individual<br>$20,000 family |
| Annual Out-of-pocket Maximum (deductible included) | $7,500 individual<br>$15,000 family | $20,000 individual<br>$40,000 family |
| Preventive Care[2] (based on national guidelines) | Plan pays 100% (no deductible) | No coverage |
| Hospitalization – inpatient, semi-private room and other hospital charges | Authorization is required for inpatient hospitalization. Call 1-844-383-2275 | |
| | Plan pays 50% after deductible | Plan pays 50% after deductible |
| Emergency Room Services | Plan pays 50% after deductible | Plan pays 50% after deductible |
| Emergency Room Services –nonemergency | No coverage | No coverage |
| Ambulance Services<br>Emergency<br>Non-Emergency, Medically Necessary<br>Non-Emergency, Non-Medically Necessary | <br>Plan pays 50% after deductible<br>Plan pays 50% after deductible<br>No Coverage | <br>Plan pays 50% after deductible<br>Plan pays 50% after deductible<br>No coverage |
| Urgent Care | Plan pays 50% after deductible | Plan pays 50% after deductible |
| Office Visit – primary care, specialist, lab services in an office, independent lab services, lab services outpatient facility | PCP - $45 copay<br>Specialist - $55 copay<br>Behavioral Health - $45 | Plan pays 50% after deductible |
| Teladoc | Plan pays 100% after $50 copay | Plan pays 50% after deductible |
| Outpatient Services – surgery, X-ray, diagnostic including CT, PET scan, MRI, MRA and nuclear | Plan pays 50% after deductible | Plan pays 50% after deductible |

| | | |
|---|---|---|
| medicine, therapeutic treatments, scopic procedures | | |
| Chiropractic Spinal Adjustment – (20 visit limit per calendar year) | Plan pays 50% after deductible | Plan pays 50% after deductible |
| Acupuncture (20 visit limit per calendar year) | Plan pays 50% after deductible | Plan pays 50% after deductible |
| Behavioral Health/Substance Abuse – inpatient or outpatient[3] | Authorization is required for inpatient services. Call 1-844-383-2275 | |
| | Plan pays 50% after deductible | Plan pays 50% after deductible |
| Transplant Services – Blue Distinction Centers for Transplants Only | Authorization is required for transplant services. Call 1-844-383-2275 | |
| | Plan pays 50% after deductible | No coverage |
| Other Covered Services<br>Limits apply for some services:<br>Speech therapy – 30 visits<br>Physical therapy – 30 visits<br>Skilled Nursing – 60 days per calendar year | Plan pays 50% after deductible | Plan pays 50% after deductible |
| Prescription Drugs[4] – generic, preferred brand, non-preferred brand | Plan pays 50% after deductible | Plan pays 50% after deductible |

[1] Out-of-network benefits are based on usual and customary charges. You are responsible for any charges in excess. Deductible and coinsurance for out-of-network services apply to the out-of-network maximum, not to the in-network maximum.
[2] Preventive care charges do not apply toward your out-of-pocket maximum. Preventive care is subject to guidelines described in regulations issued by the Department of Health and Human Services. Services that fall outside the preventive care benefit and other services performed during a preventive visit will be considered for coverage under the Plan.
[3] Although you are not required to first contact the Cracker Barrel Connect EAP before receiving Behavioral Health benefits, four counseling sessions per condition may be available for coverage in full if coordinated by the EAP. EAP visits are short-term counseling not medication management (no psychiatrist or nurse practitioner visits). To find a provider for behavioral health, call 1-844-383-2275.
[4] You are required to pay the difference between a brand and generic drug if you request a brand when a generic is available.

# Coverage – Health Savings Advantage Plan

Network Benefits apply to services received from network providers and non-contracted providers. Out of network benefit percentages apply to BCBST maximum allowable charge, not to the provider's billed charge. When using out of network providers, you must pay the difference between the provider's price and the maximum allowable charge.

## How the Plan Works

There are two components to this option:

- **HSA** – An account which may be funded by you and the Company and used to pay for qualified out-of-pocket health care expenses now or in the future.

**High Deductible Health Pla**n – Medical coverage that will cover eligible expenses at 75 percent in-network and 55 percent out-of-network after you meet your deductible (other than for preventive care).

**The HSA**

You and the Company may fund your HSA. If you do not complete the information required to establish a HSA, no contributions will be made.

- Your payroll contributions will be made with tax-exempt dollars. You may change your contribution amount at any time. Changes will be reflected as soon as administratively possible, usually by the next available payroll check.
- In 2024, the Company will match your HSA contribution dollar for dollar up to $700 for employee only or $1,400 for all other coverage levels.

**Annual HSA Contribution Maximum**
The maximum amount that can be contributed to your HSA each year is determined by the IRS. The HSA contribution maximum is the maximum you and the Company combined can contribute to your account.

The 2024 IRS maximums are $4,150 for individual and $8,300 for family. If you will be age 55 or older in 2024, you can contribute and additional $1,000. These maximums may be adjusted on an annual basis by the IRS.

**Please note**: Since you own the HSA, the responsibility to ensure you do not exceed the annual IRS contribution limit resides with you, the account owner. Your combined contributions to all HSAs you own are subject to the IRS maximums. Any contributions in excess of the IRS annual contribution maximum will be included in your gross income and be subject to any IRS penalties for excess contributions.

***Using Your HSA Funds***

You can use your HSA to pay for qualified out-of-pocket health care expenses (such as those expenses incurred before satisfying your annual deductible and coinsurance amounts after satisfying your deductible), up to the amount in your HSA. Qualified health care expenses are defined by the IRS.

For a complete list (IRS Publication 502), visit www.irs.gov and click on “Forms and Publications.” Or go to myhealth.bankofamerica.com.

**Please note:** You may use your HSA toward qualified health expenses that the Plan doesn’t cover. Any HSA amounts used to cover these expenses will not count toward your Plan’s annual out-of-pocket maximum.

**Portability**
The HSA is portable, meaning it is always yours to keep if you switch medical plans or leave the Company. You can maintain your HSA directly with Bank of America and make contributions directly to them. You can use the funds for current or future qualified health care expenses. You will be responsible for any account administrative fees upon leaving the Company.

**Taxes and Penalties**

Taxes and penalties apply if HSA funds are used for non-qualified health care expenses or if you contribute more than the annual IRS maximum to your HSA. It's your responsibility to manage your account and report HSA information (annual contributions, withdrawals, etc.) to the IRS as required on your individual tax return. Bank of America will provide you a Form 1099-SA and Form 5498.

When you turn age 65, you may use your HSA for non-eligible expenses without penalty. You'll only be subject to normal income taxes.

**Please note:** Your HSA account is not part of the Plan and is not subject to ERISA.

**Reimbursement for an HSA Expense**
For expenses where you can't use the supplied debit card (*see below*), you may need to pay expenses out of your own pocket and seek reimbursement or pay a bill directly from your HSA. Requests can be submitted online at myhealth.bankofamerica.com. Reimbursements can be made via check or direct deposit to a designated checking or savings account.

**Debit Card Processing**
You will receive an HSA Visa® debit card to use so you may pay physicians and providers directly from your HSA. Full instructions for use will be included with your card.

The HSA debit card can be used to pay for certain eligible expenses right at the point of service. In effect, the card allows you the convenience of immediate reimbursement. You are held responsible to ensure the expense is qualified. You are encouraged to keep accurate records of your expenses in the event the IRS questions your spending.

There is an expiration date on the card. If you re-elect the HSA each year, you can continue to use the same debit card until it expires at which time you will be issued a new card.

Additional debit cards for your spouse or dependents can be requested by going to myhealth.bankofamerica.com or by calling the Customer Care Center at 1-866-791-0250. They're available 24 hours a day, seven days a week.

***The High Deductible Health Plan***
Unlike a plan with copays, you're responsible for the full amount of covered services, such as doctor's office visits, prescriptions, etc., until you meet the annual deductible. Preventive care services are covered in full by the Plan as required by the Affordable Care Act.

To help you save money, the medical plan administrator and the prescription plan administrator have negotiated lower costs with network doctors, hospitals and pharmacies. You receive those discounts when you use network providers. You can also use money from your HSA to cover eligible expenses applied to your deductible.

Please note: Prices may differ between network physicians and providers. Click on BCBST's "Healthcare Cost Estimator" tool on bcbst.com/biscuit or call BCBST to find the highest quality medical care at the lowest cost. Express Scripts can help you reduce your prescription drug costs as well. You can access information about your prescription benefits at express-scripts.com including cost-saving tips like asking for generics and taking advantage of the convenient mail order service.

Once you meet the deductible, the plan begins to pay for covered services, and you pay your portion of coinsurance. The plan pays higher coinsurance for in-network services than for out-of-network services. You may use money in your HSA to help cover your coinsurance amount.

The Plan limits the amount you will have to pay out-of-pocket each year. In-network and out-of-network deductibles and out-of-pocket maximums are calculated separately. If you reach the out-of-pocket maximum, the Plan will cover the allowed in-network charges in full for the remainder of the year. If you have out-of-network services, the Plan will cover the usual and customary charges in full for the remainder of the Plan year. You are responsible for any charges over the usual and customary charge, if applicable.

Both medical (including behavioral health) and prescription costs apply to your annual deductible and annual out-of-pocket maximum.

*For more on prescription drugs, see the "Prescription Drugs" section.*

**A Note about Prescription Benefits**

Prescription drugs are subject to the medical deductible. This means, prescriptions will be treated like any other expense, and you'll be responsible for the full cost of your prescriptions until the deductible is met. After that, the Plan will begin to share in the costs. (Remember, Express Scripts has negotiated lower costs with network pharmacies to help you save money.)

Prescription drugs also apply to the Plan's out-of-pocket maximum. Once you reach the maximum, the Plan covers in full your eligible expense – medical or prescription.

# Summary of Benefits – Health Savings Advantage Plan

*For specifics of the types of services covered, refer to the "Covered Services" section. Call BCBST at 1-844-383-2275 for more information. For a detailed description of eligibility for these benefits, see the "Eligibility" section of this SPD.*

| **2024 Benefit Amounts** | **In-Network** | **Out- of-Network[1]** |
|---|---|---|
| Annual HSA Contribution Maximum<br>(per IRS) | $4,150 individual<br>$8,300 family<br>Additional $1,000 if 55 or older | $4,150 individual<br>$8,300 family<br>Additional $1,000 if 55 or older |
| Annual Deductible | $3,200 individual<br>$6,400 family | $5,400 individual<br>$13,200 family |
| Annual Out-of-pocket Maximum<br>(deductible included) | $6,000 individual<br>$12,000 family | $10,400 individual<br>$16,000 family |
| Preventive Care[2]<br>(based on national guidelines) | Plan pays 100% (no deductible) | No coverage |
| Hospitalization – inpatient, semi-private room and other hospital charges | Authorization is required for inpatient hospitalization. Call 1-844-383-2275 | |
| | Plan pays 75% after deductible | Plan pays 55% after deductible |

| | | |
|---|---|---|
| Emergency Room Services | Plan pays 75% after deductible | Plan pays 75% after deductible |
| Emergency Room Services –nonemergency | No coverage | No coverage |
| Ambulance Services<br>Emergency<br>Non-Emergency, Medically Necessary<br>Non-Emergency, Non-Medically Necessary | <br>Plan pays 75% after deductible<br>Plan pays 75% after deductible<br>No Coverage | <br>Plan pays 75% after deductible<br>Plan pays 55% after deductible<br>No coverage |
| Urgent Care | Plan pays 75% after deductible | Plan pays 55% after deductible |
| Office Visit – primary care, specialist, lab services in an office, independent lab services, lab services outpatient facility | Plan pays 75% after deductible | Plan pays 55% after deductible |
| Teladoc | Plan pays 75% after deductible | No coverage |
| Outpatient Services – surgery, X-ray, diagnostic including CT, PET scan, MRI, MRA and nuclear medicine, therapeutic treatments, scopic procedures | Plan pays 75% after deductible | Plan pays 55% deductible |
| Chiropractic Spinal Adjustment – (20 visit limit per calendar year) | Plan pays 75% after deductible | Plan pays 55% after deductible |
| Acupuncture (20 visit limit per calendar year) | Plan pays 75% after deductible | Plan pays 55% after deductible |
| Behavioral Health/Substance Abuse – inpatient or outpatient[3] | Authorization is required for inpatient services. Call 1-844-383-2275 | |
| | Plan pays 75% after deductible | Plan pays 55% after deductible |
| Transplant Services – Blue Distinction Centers for Transplants Only | Authorization is required for transplant services. Call 1-844-383-2275 | |
| | Plan pays 75% after deductible | No Coverage |
| Other Covered Services<br>Limits apply for some services:<br>Speech therapy – 30 visits<br>Physical therapy – 30 visits<br>Skilled Nursing – 60 days per calendar year | Plan pays 75% after deductible | Plan pays 55% after deductible |
| Prescription Drugs[4]– generic, preferred brand, non-preferred brand | Plan pays 75% after deductible | No coverage |

[1] Out-of-network benefits are based on usual and customary charges. You are responsible for any charges in excess. Deductible and coinsurance for out-of-network services apply to the out-of-network maximum, not to the in-network maximum.
[2] Preventive care charges do not apply toward your out-of-pocket maximum. Preventive care is subject to guidelines described in regulations issued by the Department of Health and Human Services. Services that fall outside the preventive care benefit and other services performed during a preventive visit will be considered for coverage under the Plan.
[3] Although you are not required to first contact the Cracker Barrel Connect EAP before receiving Behavioral Health benefits, four counseling sessions per condition may be available for coverage in full if coordinated by the EAP. EAP visits are short-term counseling not medication management (no psychiatrist or nurse practitioner visits). To find a provider for behavioral health, call 1-844-383-2275.
[4] You are required to pay the difference between a brand and generic drug if you request a brand when a generic is available.

# Coverage – Traditional Health Care Plan

### How the Plan Works

This is a traditional preferred provider organization (PPO) type plan with copays for office visits. Office visits are covered in full by the Plan after you pay a copay of $45 for primary care or $55 for specialist care. Preventive care services are covered in full by the Plan in accordance with the Affordable Care Act.

For most other covered services, you pay up to the annual deductible before the Plan pays. After you meet the deductible, services are generally covered at 75 percent in-network and 55 percent out-of-network.

The Plan limits the amount you have to pay out-of-pocket each year. **Please note: There are separate deductible and out-of-pocket maximums for in-network and out-of-network services.** If you reach the out-of-pocket maximum, the Plan will cover the allowed in-network charges in full for the remainder of the year. If you're using out-of-network services, the Plan will cover the usual and customary charges in full for the remainder of the Plan year. You are responsible for any charges over the usual and customary charge, if applicable.
Both medical (including behavioral health) and prescription costs apply to your annual out-of-pocket maximum.

## A Note about Prescription Benefits

There is a separate deductible per person for your prescription costs. Once you meet the prescription deductible, you will pay either a copay amount or a percentage of the cost, depending on the type of drug you purchase. Keep in mind that prescription drug costs apply to the medical out-of-pocket maximum. Once you reach the maximum, the Plan covers in full your eligible expenses — medical or prescription.

*For more on prescription drugs, see the Prescription Drug section.*

## Summary of Benefits – Traditional Health Care Plan

*For specifics of the types of services covered, refer to the "Covered Services" section. Call BCBST at 1-844-383-2275 for more information. For a detailed description of eligibility for these benefits, see the "Eligibility" section of this SPD.*

| 2024 Benefit Amounts | In-Network | Out-of-Network[1] |
|---|---|---|
| Annual Deductible | $2,800 individual<br>$5,750 family | $3,250 individual<br>$9,250 family |
| Annual Out-of-pocket Maximum (deductible included) | $6,000 individual<br>$12,000 family | $10,400 individual<br>$16,000 family |
| Preventive Care[2] (based on national guidelines) | Plan pays 100% | No coverage |
| Hospitalization – inpatient, semi-private room and other hospital charges | Authorization is required for inpatient hospitalization. Call 1-844-383-2275 | |
| | Plan pays 75% after deductible and the $200 per confinement copay | Plan pays 55% after deductible |
| Emergency Room Services – Emergency<br>Emergency Room Services – non-emergency | Plan pays 75% after $400 per visit copay (copay waived if admitted)<br><br>No coverage | Plan pays 75% after $400 per visit copay (copay waived if admitted)<br><br>No coverage |
| Ambulance Services<br>Emergency<br>Non-Emergency, Medically Necessary<br>Non-Emergency, Non-Medically Necessary | <br>Plan pays 75% after deductible<br>Plan pays 75% after deductible<br><br>No coverage | <br>Plan pays 55% after deductible<br>Plan pays 55% after deductible<br><br>No coverage |
| Urgent Care | Plan pays 100% after $60 copay | Plan pays 55% after deductible |

| | | |
|---|---|---|
| Office Visit<br>Primary Care<br>Specialist<br>Lab Services – office,<br>Independent lab services or<br>Outpatient facility | <br>Plan pays 100% after $45 copay<br>Plan pays 100% after $55 copay<br>Plan pays 75% after deductible | <br>Plan pays 55% after deductible<br>Plan pays 55% after deductible<br>Plan pays 55% after deductible |
| Teladoc | Plan pays 100% after $50 copay | No coverage |
| Outpatient Services – surgery, X-ray, diagnostics including CT, PET scan, MRI, MRA and nuclear medicine, therapeutic treatments, scopic procedures | Plan pays 75% after the deductible<br>Office visit copay may apply for services provided in an office setting | Plan pays 55% after the deductible |
| Chiropractic Spinal Adjustment<br>(20 visit limit per calendar year) | Plan pays 75% after deductible | Plan pays 55% after deductible |
| Behavioral Health/Substance Abuse | Notification is required for inpatient services. Call 1-844-383-2275 | |
| Inpatient | Plan pays 75% after deductible and $200 per confinement copay | Plan pays55% after deductible |
| Outpatient[3] | Plan pays 100% after $45 copay | Plan pays 55% after deductible |
| Transplant Services – Blue Distinction Centers for Transplants | Authorization is required for transplant services. Call 1-844-383-2275 | |
| | Plan pays 75% after deductible | No coverage |
| Other Covered Services<br>Limits apply for some services:<br>Speech therapy – 30 visits per year<br>Physical therapy – 30 visits per year<br>Skilled Nursing – 60 visits per year | Plan pays 75% after deductible | Plan pays 55% after deductible |
| **Prescription Drugs[4]** | | |
| Annual Deductible | $25 | |
| Retail 30-Day Supply –<br>Generic<br>Preferred Brand<br>Non-Preferred Brand | After the prescription deductible you pay:<br>$25 copay<br>35% ($45 min/$75 max)<br>65% ($100 min/$225 max) | |
| Mail Order 90-Day Supply – maintenance medications<br>Generic<br>Preferred Brand<br>Non-Preferred Brand | After the prescription deductible, you pay<br><br>$50<br>35% ($90 min/$250 max)<br>65% ($200 min/$750 max) | |
| Specialty Pharmacy (Accredo Pharmacy only) | After the prescription deductible you pay:<br>Tier 1 – you pay 25% ($800 max)<br>Tier 2 – you pay 35% ($1,050 max)<br>Tier 3 – you pay 45% ($1,300 max) | |

[1] Out-of-network benefits are based on usual and customary charges. You are responsible for any charges in excess. Deductible and coinsurance for out-of-network services apply to the out-of-network maximum, not to the in-network maximum.

[2] Preventive care charges do not apply toward your out-of-pocket maximum. Preventive care is subject to guidelines described in regulations issued by the Department of Health and Human Services. Services that fall outside the preventive care benefit and other services performed during a preventive visit will be considered for coverage under the Plan.

[3] Although you are not required to first contact the Cracker Barrel Connect EAP before receiving Behavioral Health benefits, four counseling sessions per condition may be available for coverage in full if coordinated by the EAP. EAP visits are short-term counseling not medication management (no psychiatrist or nurse practitioner visits). To find a provider for behavioral health, call 1-844-383-2275.

[4] You are required to pay the difference between a brand and generic drug if you request a brand when a generic is available.

# Covered Services

**(BlueCross BlueShield of TN Plans Only)**

While the "Summary of Benefits" tables on the preceding pages provide coinsurance and annual deductible information for covered health services, this section includes descriptions of the benefits. These descriptions include any limitations that may apply as well as covered health services for which you must obtain prior authorization from BCBST as required. Services that are not covered are described in the "Exclusions" section.

In general, only services, supplies, and treatments that are preventive or for the treatment of an injury or disease, medically necessary as determined by BCBST and rendered by a licensed health care provider are covered, according to Plan provisions. If you have questions about a specific service or your service is not listed below, contact BCBST at 1-844-383-2275 to see if it's a covered service.

**Please note:** A health care service, supply or pharmaceutical product is only a covered health service if it is medically necessary. The fact that a physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a sickness, injury, mental illness, disease or its symptoms does not mean that the procedure or treatment is a covered health service under the Plan.

**Ambulance Services**

The Plan covers emergency ambulance services and transportation provided by a licensed ambulance service to the nearest hospital that offers emergency health services.

Ambulance service by air is covered in an emergency if ground transportation is impossible, or ground transportation would put your life or health in serious jeopardy. If special circumstances exist, the Plan may pay benefits for emergency air transportation to a hospital that is not the closest facility to provide emergency health services. The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as the Plan determines appropriate) between facilities when the transport is:

- From non-network hospital to a network hospital
- To a hospital that provides a higher level of care that was not available at the original hospital
- To a more cost-effective acute care facility
- From an acute facility to a sub-acute setting

**Prior Authorization Requirement**: In most cases, BCBST will initiate and direct non-emergency ambulance transportation. If you are requesting non-emergency ambulance services, please remember that you must obtain prior authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, benefits will be lowered.

**Behavioral Health**

Arrangements have been made by the Company to have BCBST administer the behavioral health and substance abuse benefits under the Plan.

The behavioral health and substance abuse benefit provides coverage for behavioral health services, including treatment for alcoholism, drug addiction and other substance abuse. This benefit includes coverage for both inpatient and outpatient treatment. In order to receive the maximum plan benefit, you must use network providers. Contact BCBST at 1-844-383-2275 for assistance.

Authorization is required for all inpatient and higher levels of care, including Partial Hospitalization Program (PHP) and Intensive Outpatient Program. Other services requiring authorization include ECT, TMS, ABA and psychological testing.

Limitations: In addition to the general exclusions, the behavioral/substance abuse benefit will not cover services for any of the following:

- Court order treatment unless it is medically necessary
- Wilderness programs, boot camps and equine therapy

**Clinical Trials**

The Plan pays for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer
- Cardiovascular disease (cardiac/stroke)
- Surgical musculoskeletal disorders of the spine, hip and knees

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

Benefits are available only when the employee or dependent is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials included:

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

Routine costs for clinical trials do not include:

- The experimental or investigational service or item, except for:
  - Certain Category B devices
  - Certain interventions for patients with terminal illnesses

- Other items and services that meet specified criteria in accordance with BCBST's medical and drug policies
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the National Cancer Institute (NCI) as a clinical cancer center or comprehensive cancer center or be sponsored by any of the following:
  - National Institutes of Health (NIH), including the National Cancer Institute (NCI)
  - Centers for Disease Control and Prevention (CDC)
  - Agency for Healthcare Research and Quality (AHRQ)
  - Centers for Medicare and Medicaid Services (CMS)
  - Department of Defense (DOD)
  - Veterans Administration (VA)
  - U.S. Food and Drug Administration (FDA) in the form of an investigational new drug application
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBS) before participants are enrolled in the trial BCBST may, at any time, request documentation about the trial
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

**Prior Authorization Requirement:** You must notify BCBST as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Note:** Benefits are available when the covered services are provided by either network or non-network providers. For non-network providers, out-of-network benefits will be applied, and the member may be liable for anything over the maximum allowable charge.

**Congenital Heart Disease (CHD) Surgeries**

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a physician and received at a CHD Resource Services program facility. Benefits include the facility charge and the charge for supplies and equipment.

Benefits are available for the following CHD services:

- Outpatient diagnostic testing
- Evaluation
- Surgical interventions
- Interventional cardiac catheterizations (insert of a tubular device in the heart)

- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology)
- Approved fetal interventions

CHD services other than those listed above are excluded from coverage, unless determined by BCBST to be proven for the involved diagnoses. Contact BCBST at the toll-free number on your medical ID card for information about CHD services.

If you received CHD services from a facility that is not a designated facility, the Plan pays benefits as described under:

- Physician's office services – sickness and injury
- Physician fees for surgical and medical services
- Scopic procedures – outpatient diagnostic and therapeutic
- Therapeutic treatments – outpatient
- Hospital – inpatient stay
- Surgery – outpatient

**Prior Authorization Requirement:** You must obtain prior authorization from BCBST as soon as the possibility of a CHD surgery arises. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Dental Services – Accident Only**

Medically necessary and medically appropriate services performed by a doctor or dental surgery (DDS), a doctor of medical dentistry (DMD) or any practitioner licensed to perform dental-related oral surgery except as indicated below:

- **Covered Services**
    - Dental services and oral surgical care to treat intra oral cancer, or to treat accidental injury to the jaw, sound natural teeth, mouth, or face, due to external trauma. The surgery and services to treat accidental injury must be started within 3 months and completed within 12 months of the accident.
    - For dental services not listed in the subsection above, general anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient dental procedure are covered only when one of the conditions listed below is met.

      **Prior Authorization for inpatient services is required**

      1. Complex oral surgical procedures that have a high probability of complications due to the nature of the surgery.
      2. Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications.
      3. Mental health disorder or intellectual and developmental disability that precludes dental surgery in the office.
      4. Use of general anesthesia and the member's medical condition requires that such procedure be performed in a hospital; or

5. Dental treatment or surgery performed on a member 8 years of age or younger, where such procedure cannot be provided safely in a dental office setting
- Oral appliances to treat obstructive sleep apnea, if medically necessary.
- Extraction of impacted teeth, including wisdom teeth

- **Exclusions**

  - Routine dental care and related services
  - Treatment for correction of underbite, overbite, and misalignment of the teeth including braces for dental indications

**Temporomandibular Joint (TMJ) Services**

Covered services include diagnosis and treatment of TMJ or TMD, including, but not limited to, diagnostic study casts and oral application to stabilize the jaw point. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- There is clearly demonstrated radiographic evidence of significant joint abnormality
- Non-surgical treatment has failed to adequately resolve the symptoms
- Pain or dysfunction is moderate or severe
- Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

**Diabetic Services**

The Plan pays benefits for the following covered services:

- Diabetes self-management and training or diabetic eye examinations and foot care, which includes:
  - Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services, as long as the services are ordered by a physician and provided by appropriately licensed or registered health care professionals
  - Medical eye examinations (dilated retinal examinations) and preventive foot care for employee or dependents with diabetes
- Diabetic self-management equipment including insulin pumps and related supplies for the management and treatment of diabetes, subject to the conditions of coverage stated under "Durable Medical Equipment"

**Note:** Blood glucose monitors, syringes and test strips are provided under prescription drug coverage.

**Prior Authorization Requirement:** You must obtain prior authorization before obtaining any durable medical equipment for the management and treatment of diabetes that exceeds $1000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

***Diabetes Programs***

Under the Plan employees and eligible dependents who have type 2 diabetes have access to two separate diabetes programs at no cost. The Company pays the full cost for eligible members who are enrolled in one of the BCBST plans offered by the Company. You can only enroll in one of these programs, therefore you must select either Virta (Diabetes Reversal Program) or Livongo (Diabetes Management program) as your diabetes program.

- Virta is a research-backed treatment that is intended to reverse type 2 diabetes. Members enrolled in Virta lose weight, lower their blood sugar and reduce their medications through the help of health coaches and medical providers. The program includes testing supplies, a glucose monitor, health coaching, and access to an online community. Visit www.virtahealth.com/crackerbarrel-msbc, email support@virtahealth.com, or text "BARREL" to 57005 to learn more.
- Livongo is designed to help members manage their diabetes. Through the program members can get personalized help to understand, monitor and control their blood sugar. Members have access to supplies, a glucose monitor and health coaching. Visit Join.Livongo.com/BISCUIT, text "GO BISCUIT" to 85240 or call 800-945-4355 and use registration code: BISCUIT to receive more information.

**Durable Medical Equipment (DME)**
**Note:** DME is different from prosthetic devices. See "*Prosthetic Devices*" in the following for more on those covered services.

The Plan pays for rented or purchased durable medical equipment (DME) that is:

- Ordered or provided by a physician for outpatient use
- Used for medical purposes
- Approved by the FDA for the illness or injury for which it is prescribed
- Not consumable or disposable
- Not of use to a person in the absence of a sickness, injury, or disability
- Not solely for your convenience
- Durable enough to withstand repeated use
- Appropriate for use in the home
- Necessary for the effective functioning of the covered equipment

If more than one piece of DME can meet your functional needs, you will receive benefits only for the most cost-effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen
- Equipment to assist mobility, such as a standard wheelchair
- Hospital beds
- Delivery pumps for tube feedings
- Negative pressure wound therapy pumps (wound vacuums)
- Burn garments

- Insulin pumps and all related necessary supplies as described under “Diabetes Services”
- External cochlear devices and systems, including surgery to place a cochlear implant, which can either be an inpatient or outpatient procedure, see also “Hospital – Inpatient Stay, Rehabilitation Services – Outpatient Therapy and Surgery – Outpatient”
- Orthotic devices when prescribed by a physician and includes shoe inserts, arch supports, shoes (standard or custom), lifts and wedges and shoe orthotics
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces (cranial orthotics, dental braces and braces to treat curvature of the spine are excluded from coverage)
- Equipment for the treatment of chronic or acute respiratory failure or conditions

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and trachea-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to sickness or injury. Benefits for the purchase of speech aid devices and trachea-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

**Limits:**

- Benefits for speech aid devices and tracho-esophageal voice devices are limited to the purchase of one device during the entire period of time an employee or dependent is enrolled under the Plan
- Diabetic Shoes are limited to two pairs per calendar year
- Benefits are provided for the repair/replacement of a type of DME once every three calendar years.
- At the Plan’s discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the employee or dependent’s medical condition occurs sooner than the three-year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three-year timeline for replacement.
- The maximum allowable purchase or rental charge will not exceed the total maximum allowable charge for purchase. If you rent the same type of equipment from multiple DME providers, and the total rental charges from multiple providers exceed the purchase price of a single piece of equipment, you will be responsible for amounts in excess of the maximum allowable charge for purchase.
- Any other exclusions as outlined in the Evidence of Coverage (EOC) provided by BlueCross BlueShield of Tennessee.

**Prior Authorization Requirement:** You must obtain prior authorization before obtaining any durable medical equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Emergency Health Services – Outpatient**

The Plan's emergency services benefit pays for outpatient treatment at a hospital or alternate facility when required to stabilize a patient or initiate treatment.

**Note:** Network benefits will be paid for an emergency admission to a non-network hospital as long as BCBST is notified within one business day after the emergency admission or on the same day of emergency admission if reasonably possible. If you continue your stay in a non-network hospital after the date your physician determines that it is medically appropriate to transfer you to a network hospital, non-network benefits will apply.

**Family Planning and Infertility**

The Plan pays benefits for voluntary family planning services and supplies. Coverage includes elective sterilization procedures, contraceptive drugs administered by a provider (e.g., Depo-Provera, Norplant) and contraceptive devices, including fitting and removal.

The Plan also pays benefits for the diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a physician.

**Hearing Aids**

The Plan pays benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a covered service for which benefits are available under the applicable medical/surgical covered services categories in this section only for employee or dependents who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid

Limits: For adults, hearing aid benefit is limited to $1,500 (including repair/replacement) per hearing impaired ear every three years. The $1,500 limit does not apply to children.

**Home Health Care**

Covered services include those that a home health agency provides if you need medical care in your home due to the nature of your condition. Services must be:

- Ordered by a physician

- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse
- Not considered custodial care
- Provided on a part-time, intermittent care schedule when skilled care is required

Covered services include:

- Supplies and medications, by or under the supervision of a registered nurse
- Home infusion therapy
- Rehabilitative therapies such as physical therapy, occupational therapy, etc. (subject to the limitations of the Therapeutic/Rehabilitative Services benefit).
- Medical social services
- Dietary guidance
- Limited to 60 visits per calendar year

Home health visits may require Prior Authorization. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%. Physical, speech or occupational therapy provided in the home does not require Prior Authorization but does apply to the Therapy Services visit limits shown in "Benefits Summary."

**Hospice Care**

Hospice care is an integrated program recommended by a physician. It provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person. It also provides short-term grief counseling for immediate family members while the employee or dependent is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.

**Prior Authorization Requirement:** You must obtain prior authorization from BCBST before admission for an inpatient stay in a hospice facility. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Hospital – Inpatient Stay**

Hospital Benefits are available for:

- Non-physician services and supplies received during an inpatient stay
- Room and board in a semi-private room (a room with two or more beds)
- Physician services for radiologists, anesthesiologists, pathologists and emergency room physicians

The Plan will pay the difference in cost between a semi-private room and private room only if a private room is necessary according to generally accepted medical practice.

Benefit for an inpatient stay in a hospital are available only when the inpatient stay is necessary to prevent, diagnose or treat a sickness or injury.

*For benefits for other hospital-based physician services, see "Physician Fees for Surgical and Medical Services."*

*For benefits for emergency admissions and admissions of less than 24 hours, see "Emergency Health Services– Outpatient, Scopic Procedures – Diagnostic and Therapeutic and Therapeutic Treatments –."*

**Prior Authorization Requirement:** For a scheduled admission, you must obtain prior authorization before admission. For a non-scheduled admission (including emergency admissions), you must provide notification as soon as reasonably possible. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Lab, X-Ray, and Diagnostics - Outpatient**

Services for sickness and injury-related diagnostic purposes, received on an outpatient basis at a hospital or alternate facility or in a physician's office include:

- Lab and radiology/x-ray
- Mammography covered upon initial physician order, subject to the following:

| Mammogram | Traditional Health Care Plan | Value Health Plan | Health Savings Advantage Plan |
|---|---|---|---|
| Preventative | 1 Mammogram per year, covered at 100%, no deductible, any additional Mammograms are covered at Deductible/ Coinsurance | 1 Mammogram per year, covered at 100%, no deductible, any additional Mammograms are covered at Deductible/ Coinsurance | Covered at 100%, no deductible (1 preventative mammogram, either regular or 3D, per year) |
| Diagnostic | | | Deductible/Coinsurance |
| 3D (Preventative) | | | Covered at 100%, no deductible (1 preventative mammogram, either regular or 3D, per year) |
| 3D (Diagnostic) | | | Deductible/Coinsurance |

Benefits under this section include:

- The facility charge and the charge for supplies and equipment
- Physician services for radiologists, anesthesiologists, and pathologists

*For benefits related to other physician services, see "Physician Fees for Surgical and Medical Services."*

*For benefits related to lab, X-ray and diagnostic services for preventive care, see "Preventive Care Services."*

**Prior Authorization Requirement:** For sleep studies, you must obtain prior authorization from BCBST before scheduled services are received. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Lab, X-Ray, and Major Diagnostics (CT, PET Scans, MRI, MRA and Nuclear Medicine) – Outpatient**

Benefits include services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a hospital or alternate facility or in a physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment
- Physician services for radiologists, anesthesiologists and pathologists

*For benefits for other physician services, see "Physician Fees for Surgical and Medical Services."*

**Nutritional Counseling**

The Plan will pay for covered services for medical education services provided in a physician's office by an appropriately licensed or health care professional when:

- Education is required for a disease in which patient self-management is an important component of treatment
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional

Some examples of such medical conditions include:

- Coronary artery disease
- Congestive heart failure
- Severe obstructive airway disease
- Gout (a form of arthritis)
- Renal failure
- Phenylketonuria (a genetic disorder diagnosed at infancy)
- Hyperlipidemia (excess of fatty substances in the blood)

The Plan also covers nutritional counseling visits for obesity when the employee or dependent is referred by a physician.

**Obesity Surgery**

The Plan covers surgical treatment of obesity provided by or under the direction of a physician provided either of the following is true:

- You have a minimum body mass index (BMI) of 40.
- You have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to or exacerbated by obesity.

Benefits are available for obesity surgery services that meet the definition of a covered service, meet the pre-surgery requirements and are not experimental or investigational or unproven services.

**Prior Authorization Requirement:** You must obtain prior authorization from BCBST as soon as the possibility of obesity surgery arises. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Ostomy Supplies**

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts
- Irrigation sleeves, bags and ostomy irrigation catheters
- Skin barriers

**Pharmaceutical Products – Outpatient**

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

Benefits under this section are provided only for pharmaceutical products which, due to their characteristics (as determined by BCBST), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility.

**Physician Fees for Surgical and Medical Services**

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

**Physician's Office Services – Sickness and Injury**

Benefits are paid by the Plan for covered services received in a physician's office for the evaluation and treatment of a sickness or injury. Benefits are provided regardless of whether the physician's office is

free-standing, located in a clinic or located in a hospital. Benefits include allergy injections and hearing exams in case of injury or sickness.

Covered health services include genetic counseling. Benefits are available for genetic testing which is determined to be medically necessary following genetic counseling when ordered by the physician and authorized in advance by BCBST.

*For benefits for preventive services, see "Preventive Care Services."*

**Prior Authorization Requirement:** You must obtain prior authorization from BCBST for genetic testing, including BRCA genetic testing. If authorization is not obtained as required, benefits will be denied.

**Pregnancy – Maternity Services**

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

The Plan will pay benefits for an inpatient stay of at least:

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

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

Both before and during a pregnancy, benefits include the services of a genetic counselor when provided or referred by a physician. These benefits are available to all employee or dependents in the immediate family. Covered services include related tests and treatment.

Covered services also include the **Healthy Maternity Program**. Once an employee enrolls, the program provides:

- One-on-one support from a maternity nurse
- Weekly emails for each stage of pregnancy and online pregnancy resources
- Immunization help
- Emotional support, during and after your pregnancy
- Help from high-risk maternity nurses or a certified lactation counselor*

To enroll in the Health Maternity Program, log in or register at www.bcbst.com/myhealthymaternity or call 1-800-818-8581.
*If you talk to a nurse before 21 weeks, you may be eligible for an electric breast pump.

**Don't forget to add your baby to your health coverage within 30 days from the birth date or the child will not be covered. Log on to mybenefitelections.com to process a Life Event change.**

**Prior Authorization Requirement:** You must obtain prior authorization from BCBST as soon as reasonably possible if the inpatient stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

Home births – Must be performed by an appropriately licensed provider.

**Preventive Care Services**

Preventing disease and detecting health issues at an early stage are important to living a healthy life. Following the recommended preventive health guidelines, based on your age and gender, along with the advice of your doctor, may help you stay healthy. We encourage you and your family members to receive age and gender appropriate preventive health care services.

The Company pays 100 percent coverage for in-network eligible preventive benefits as specified in the Affordable Care Act. Blue Cross Blue Shield and Health Basics Plan enrolled members do not pay anything for these services.

- Eligible preventive services are based on guidelines described in regulations issued by the U.S. Department of Health and Human Services.
- Preventive care benefits do not apply toward your deductible or out-of-pocket maximum.

If you receive other preventive care benefits beyond the U.S. Department of Health and Human Service's guidelines, certain services will be covered as any other eligible expense. Services that fall outside the preventive care benefit, such as for diagnostic rather than routine care, and other services performed during a preventive care visit will be subject to the deductible and coinsurance provisions of the Plan. For more about preventive care services, go to: https://www.healthcare.gov/coverage/preventive-care-benefits.

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

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

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration

Preventive care benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits are available only if breast pumps are obtained from a DME provider, hospital, or physician. The Plan will cover one breast pump at 100% per pregnancy.

BCBST will determine the following:

- Which pump is the most cost effective
- Whether the pump should be purchased or rented
- Duration of a rental
- Timing of an acquisition

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

- Routine lab tests
- Diagnostic consults to prevent disease and detect abnormalities
- Diagnostic radiology and nuclear imaging procedures to screen for abnormalities
- Breast cancer screening and, subject to the following:
    - One baseline breast cancer screening for women between ages 35-39, then once every 12 months for women age 40 and older.
- Colorectal screenings, subject to the following:
    - Once every 24 months for high-risk individuals.
    - Once every 120 months for not at high-risk individuals, or 48 months after a previous flexible sigmoidoscopy.
    - No minimum age requirement.
- Tests to support cardiovascular health

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services. *For questions about your preventive care benefits under this Plan, call the number on the back of your ID card.*

**Private Duty Nursing - Outpatient**

The Plan covers private duty nursing care given on an outpatient basis by a licensed nurse such as a registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.).

**Prosthetic Devices**

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part or help an impaired limb or body part work. Examples include, but are not limited to:

- Artificial arms, legs, feet, and hands

- Artificial face, eyes, ears, and nose
- Breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device. The device must be ordered or provided either by a physician or under a physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

**Limits:** Benefits for the replacement of a type or prosthetic device are provided once every three calendar years.

At BCBST's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are more than the cost of replacement or when a change in the employee or dependent's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

**Note:** Prosthetic devices are different from durable medical equipment or DME. *See also "Durable Medical Equipment."*

**Prior Authorization Requirement:** You must obtain prior authorization from BCBST before obtaining prosthetic devices that exceeds $1,000 in cost per device. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Reconstructive Procedures**

Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an injury, sickness, or congenital anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant followed by mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other covered service. You can contact BCBST at the number on your medical ID card for more information about benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. A good example is upper eyelid surgery or browplasty. At times, the procedure will be done to improve vision which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a cosmetic procedure. This plan does not provide benefits for cosmetic procedures.

The fact that an employee or dependent may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

**Prior Authorization Requirement:** For a scheduled reconstructive procedure, you must obtain prior authorization from BCBST before a scheduled reconstructive procedure is performed. For a non-scheduled reconstructive procedure, you must provide notification within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Rehabilitation Services – Outpatient Therapy and Manipulative Treatment**

The plan provides short-term outpatient rehabilitation services for the following types of therapy:

- Physical therapy
- Occupational therapy
- Manipulative treatment
- Speech therapy
- Post-cochlear implant aural therapy
- Vision therapy
- Cognitive rehabilitation therapy following a post-traumatic brain injury or cerebral vascular accident
- Pulmonary rehabilitation
- Cardiac rehabilitation

For all rehabilitation services, a licensed therapy provider, under the direction of a physician (when required by state law), must perform the services. Benefits include rehabilitation services provided in a physician's office or on an outpatient basis at a hospital or alternate facility.

The plan will pay benefits for speech therapy only when the speech impediment or dysfunction results from injury, sickness, stroke, cancer, autism spectrum disorders or a congenital anomaly, or is needed following the placement of a cochlear implant.

Benefits can be denied or shortened for employee or dependents who are not progressing in a goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive manipulative treatment.

**Habilitative Services**

Benefits are provided for habilitative services provided on an outpatient basis if you have a congenital, genetic, or early acquired disorder. Both of the following conditions must be met.

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

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial care, respite care, day care, therapeutic recreation, vocational training, and residential treatment are not habilitative services. A service that does not help you meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When you reach your maximum level of improvement or do not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

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

For purposes of this benefit, the following definitions apply:

- Habilitative services means occupational therapy, physical therapy and speech therapy prescribed by your treating physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic or early acquired disorder.
- A congenital or genetic disorder includes, but is not limited to, hereditary disorders.
- An early acquired disorder refers to a disorder resulting from sickness, injury, trauma or some other event or condition suffered by you prior to your developing functional life skills such as, but not limited to, walking, talking or self-help skills.

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

**Limits: (in-network and out-of-network combined for all)**

- For cardiac rehabilitation: 36 visits per calendar year
- For physical therapy: 30 visits per calendar year

- For pulmonary rehabilitation: 36 visits per calendar year
- For occupational therapy: 30 visits per calendar year
- For speech therapy: 30 visits per calendar year (not applicable for autism diagnosis)
- For post cochlear implant aural therapy: 20 visits per calendar year

These visit limits apply to network benefits and non-network benefits combined.

**Prior Authorization Requirement:** You must obtain prior authorization from BCBST five business days before receiving physical therapy, occupational therapy, and speech therapy or as soon as is reasonably possible. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Scopic Procedures – Outpatient Diagnostic and Therapeutic**

The plan pays for diagnostic and therapeutic scopic procedures, and related services received on an outpatient basis at a hospital, alternate facility, or physician's office.

Diagnostic scopic procedures are those for visualization, biopsy, and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment
- Physician services for anesthesiologists, pathologists, and radiologists
- Colonoscopy covered upon initial physician order, subject to the following:

| Colonoscopy | Traditional Health Care Plan | Value Health Plan | Health Savings Advantage Plan |
|---|---|---|---|
| Preventative | 1 Colonoscopy covered per year, covered at 100%, no deductible, any additional Colonoscopies are covered at Deductible/ Coinsurance | 1 Colonoscopy covered per year, covered at 100%, no deductible, any additional Colonoscopies are covered at Deductible/ Coinsurance | Covered at 100%, no deductible |
| Diagnostic | | | Deductible/Coinsurance |

*For other physician services, see "Physician Fees for Surgical and Medical Services."*

**Note:** Benefits for surgical scopic procedures, which are for the purpose of performing surgery, are not covered under this benefit. Examples of surgical scopic procedures included arthroscopy, laparoscopy, bronchoscopy, hysteroscopy. For benefits for surgical scopic procedures, see *"Surgery – Outpatient."*

**Skilled Nursing Facility and Inpatient Rehabilitation Facility Services**

Facility services for an inpatient stay in a skilled nursing facility or inpatient rehabilitation facility are covered by the Plan. Benefits include:

- Non-physician services and supplies received during the inpatient stay
- Room and board in a semi-private room (a room with two or more beds)
- Physician services for radiologists, anesthesiologists, and pathologists

Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a skilled nursing facility or inpatient rehabilitation facility for treatment of a sickness or injury that would have otherwise required an inpatient stay in a hospital. *For benefits for other physician services, see "Physician Fees for Surgical and Medical Services."*

The plan will determine if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- The initial confinement in a skilled nursing facility or inpatient rehabilitation facility was or will be a cost effective alternative to an inpatient stay in a hospital.
- You receive skilled care services that are not primarily custodial care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

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

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for employee or dependents who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

**Note:** The plan does not pay benefits for custodial care or domiciliary care, even if ordered by a physician.

**Prior Authorization Requirement:** For a scheduled admission, you must obtain prior authorization before admission. For a non-scheduled admission (or admissions resulting from an emergency) you must provide notification as soon as is reasonably possible. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Limits:** This benefit is limited to 60 days per calendar year, combined in-network and out-of-network.

**Substance Abuse**

BCBST provides the behavioral health and substance abuse benefit administration under the Plan.

The behavioral health and substance abuse benefit provides coverage for behavioral health services, including treatment for alcoholism, drug addiction and other substance abuse. This benefit includes coverage for both inpatient and outpatient treatment. In order to receive the maximum plan benefit, you must use network providers. Contact BCBST at 1-844-383-2275 for assistance.

**Limitations:**
In addition to the general exclusions, the behavioral/substance abuse benefit will not cover services for any of the following:

- Court ordered treatment unless it is medically necessary
- Wilderness programs, boot camps and equine therapy

**Prior Authorization Requirement:** For a scheduled inpatient admission, you must provide notification. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Surgery - Outpatient**

The Plan pays for surgery and related services received on an outpatient basis at a hospital or alternate facility or in a physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment
- Certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy)
- Physician services for radiologists, anesthesiologists, and pathologists

Examples of surgical procedures performed in a physician's office are mole removal and ear wax removal.

**Prior Authorization Requirement:** For sleep apnea surgeries, you must obtain prior authorization from BCBST before scheduled services are received or, for non-scheduled services, within 24 hours or as soon as is reasonably possible. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Therapeutic Treatments – Outpatien*t***

The plan pays benefits for therapeutic treatments received on an outpatient basis at a hospital or alternate facility or in a physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology. Dialysis coverage is limited to in-network providers only.

Covered services include medical education services that are provided on an outpatient basis at a hospital or alternate facility by appropriately licensed or registered health care professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists, and radiologists.

**Prior Authorization Requirement:** For all outpatient therapeutics you must obtain prior authorization from BCBST before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, benefits payable by the plan will be reduced by 45%.

**Transplantation Services**

Organ transplant benefits are complex. In order to maximize your benefits, you are strongly encouraged to contact BCBST's Transplant Case Management department by calling the number on the back of your ID card as soon as your Provider tells you that you might need a transplant.

Transplant benefits are different than benefits for other services. If a facility in the Blue Distinction Centers for Transplants Network is not used, benefits may be subject to reduced levels. All transplant services must meet medical criteria for the medical condition for which the transplant is recommended.

You have access to three levels of benefits:

- **Blue Distinction Centers for Transplants (BDCT) Network**: If you have a transplant performed at a facility in the BDCT Network, you will receive the highest level of benefits for covered services. BCBST will pay at the benefit level listed in the *"Summary of Benefits"* for BDCT Network. A facility in the BDCT Network cannot bill you for any amount over your Out-of-Pocket maximum, which limits your liability. Not all network providers are in the BDCT Network. Please check with the Transplant Case Management department to determine which facilities are in the BDCT Network for your specific transplant type.

- **Transplant Network:** If you have a transplant performed at a facility in the Transplant Network (non-BDCT), BCBST will pay at the benefit level listed in the *"Summary of Benefits"* for the Transplant Network. Benefits will be limited to the applicable Transplant Maximum Allowable Charge (TMAC). When you use a facility in the Transplant Network, network providers have the right to bill you for any unpaid amount up to the contracted rate; this amount may be substantial. Not all network providers are in the Transplant Network. Please check with the Transplant Case Management department to determine if the Transplant Network is the best network available for your specific transplant type.

- When the BDCT Network does not include a facility that performs your specific transplant type, the Plan will pay at the benefit level listed in the "Benefit Summary" for either the Transplant Network or an Out-of-Network provider, based on the facility that is used. Benefits will not be limited to a Transplant Maximum Allowable Charge (TMAC). If you use a facility in the Transplant Network, network providers have the right to bill you any unpaid amount up to the contracted rate. If you use an out-of-network facility, out-of-network providers have the right to bill you for any unpaid billed charges. These amounts may be substantial. Please check with the Transplant Case Management department to determine if there are facilities available in the BDCT Network for your specific transplant type.

Covered Services:

- Pancreas
- Pancreas/kidney
- Kidney
- Liver
- Heart
- Heart/lung
- Lung
- Bone marrow or stem cell transplant (allogeneic and autologous) for certain conditions
- Small bowel
- Multi-organ transplants as deemed medically necessary

Benefits may be available for other organ transplant procedures that are not investigational and that are medically necessary and medically appropriate.

**Organ and Tissue Procurement:**

Organ and tissue acquisition/procurement are covered services, subject to the benefit level listed in the *"Summary of Benefits"* and limited to the services directly related to the transplant itself:

- Donor search
- Testing for donor's compatibility
- Removal of the organ/tissue from the donor's body
- Preservation of the organ/tissue
- Transportation of the tissue/organ to the site of transplant
- Donor follow-up care directly related to the organ donation, except as otherwise indicated under exclusions.

**Note:** Covered services for the donor are covered only to the extent not covered by other health coverage.

**Travel Expenses for Transplant Recipients:**

Travel expenses for transplant services are covered only if you go to a facility in the BDCT Network. Covered travel expenses must be approved by the Transplant Case Management department and include:

- Travel to and from the facility in the BDCT Network for a covered transplant procedure and required pre-testing and post-transplant follow-up. Any travel expenses for follow-up visits occurring more than 12 months from the date of the transplant are not covered. Covered travel expenses will not apply to the deductible or out-of-pocket maximum.
- Meals and lodging expenses are covered up to $150 per day, subject to the following:
  - Lodging expenses are limited to $50 per person per day.
  - Meals are only covered when provided at the facility where you are receiving inpatient medical care.
  - The aggregate limit for travel expenses, including meals and lodging, is $5,000 per covered transplant.

For full details on available travel expenses, visit bcbst.com to review our administrative services policy. Enter "travel, meals and lodging" in the *Search* field.

Not all bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy, meet the definition of a covered health service.

Benefits are also available for corneal transplants that are provided by a physician at a hospital.

**Exclusions**
The following services, supplies, and charges are not covered under this section:

- Transplant and related services, including donor services, that did not receive Prior Authorization.
- Non-covered services.
- Services that would be covered by any private or public research fund, regardless of whether you applied for or received amounts from such fund.
- Any non-human, artificial or mechanical organ not determined to be medically necessary.
- Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ.
- Removal of an organ from a member for purposes of transplantation into another person, except as covered by the Donor Organ Procurement provision as described above.
- Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled or anticipated to be scheduled within an appropriate time frame for the patient's covered stem cell transplant diagnosis.
- Other non-organ transplants (e.g., cornea) are not covered under this section but may be covered as an inpatient hospital service or outpatient facility service, if medically necessary.
- Complications, side effects or injuries as a result of organ donation.

**Important!** There are specific guidelines regarding benefits for transplant services. Contact BCBST at the telephone number on your ID card for information about these guidelines.

**Prior Authorization Requirement:** Transplant services require prior authorization. Transplant services that have not received prior authorization will be reduced or denied.

**Urgent Care Center Services**

The Plan provides benefits for services, including professional services, received at an urgent care center. Telehealth is also a covered service at urgent care center services. *For urgent care services provided in a physician's office, see "Physician's Office Services – Sickness and Injury."*

**Wigs**

The plan pays benefits for wigs and other scalp hair prostheses regardless of the medical reason of hair loss.

**Limits:** Any combination of network benefits and non-network benefits is limited to one wig every six months based on medical necessity. Plan covers up to $250 per wig.

# Exclusions and Limitations

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

Although certain services and supplies are not eligible for benefits under the Plan, you may be able to use your HSA, if applicable, to cover some of these costs. **Note:** Any services not covered by the Plan and paid from your HSA will not apply toward your out-of-pocket responsibility.

When benefits are limited, those limits have been described in the "Covered Services" section. Please review all limits carefully, as the Plan will not pay benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

No amount will be payable for:

- Health services and supplies that do not meet the definition of a covered health service (*see the "Terms to Know" section of this Medical & Prescription Drug section*)
- An accidental injury that occurs while working for pay or profit
- A sickness for which you are entitled to benefits under any Worker's Compensation or similar law whether or not you have declined participation under the law
- Services or supplies provided by any government health plan or for which there would be no cost to you if you did not have coverage
- Expenses that are incurred for treatment provided by your spouse, children, brothers, sisters, parents, or grandparents or treatment provided by your spouse's children, brothers, sisters, parents, or grandparents
- Cosmetic procedures which are procedures or services that change or improve appearance without significantly improving physiological function, as determined by BCBST
  **Exceptions to this exclusion are:**
  - Services required by the Women's Health and Cancer Rights Act of 1998

  - Deformities that result from sickness
  - Deformities that result from accidental injury that occurred while covered under the Plan and when services are rendered within one year of the accident
  - Congenital defects that interfere with bodily but not psychological function
  - Any congenital defect of a newborn child
  - Replacement of diseases tissue surgically removed while covered under the Plan
- Elective and non-emergent/non-urgent services received outside of the United States exclusively for the purpose of receiving health care.
- Infertility testing or any family planning procedure that requires outside intervention, such as, but not limited to, artificial insemination, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT)
- Experimental or investigational and unproven services and all services related to experimental or investigational and unproven services are excluded – the fact that an experimental or investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental or investigational or unproven in the treatment of that particular condition (denial of benefits will not be based solely on the fact that you are or were a participant in a clinical trial)
    - This exclusion does not apply to covered health services provided during a clinical trial for which benefits are provided as described in clinical trials for cancer under covered health services
- Custodial care – services that are any of the following:
  - Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring, and ambulating)
  - Health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing
  - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively
- Surgery that is intended to allow you to see better without glasses or other vision correction (for example: radial keratotomy, laser, and other refractive eye surgery)
- The reversal of any sterilization procedure
- Eyeglasses, contact lenses, eye exams to assess visual acuity or the fitting of glasses and lenses
- Dental services other than:
  - Hospitalization and anesthesia for children for which benefits are described above under covered health services
  - Dental anesthesia and hospital services for children
  - Charges for the removal of completely bony impacted teeth
  - Treatment of accidental injuries to natural teeth within three months after the accident
  - Malignant tumors
- Services and supplies received for a sickness or injury that is a result of war, declared or undeclared, or participation in a riot, civil disturbance or criminal act
- Prescription or non-prescription drugs, medicines or insulin which are received as an outpatient – these are covered under the prescription benefit
- Non-prescription drugs or medicines, or drugs or medicines that are not approved under the United States Food and Drug Act or its successor(s)
- Treatment of weight loss and anti-obesity drugs and formulas except surgical treatment for morbid obesity when BMI is 40 or greater, or 35 or over with co-morbidity

- Special nursing services if those same services are provided by the regular nursing staff of any hospital in which the patient is confined
- Charges by a doctor for any phone call or interview during which the patient is not examined
- Smoking cessation programs including behavior modification or other support programs unless associated with existing chronic lung disease (except as covered under ComPsych – ComPsych performs EAP functions and administration and provides coverage for smoking cessation programs. Contact ComPsych for more information.)
- Elective abortions unless (1) the abortion is permissive under applicable law and the health care Practitioner submits an attestation regarding the same; AND (2) one or more of the following circumstances exists and the health care Practitioner so attests: (i) the abortion is necessary to prevent the death of the mother or to prevent serious risk of substantial harm to the mother; (ii) the fetus is not viable; (iii) the pregnancy is the result of rape or incest; or (iv) the fetus has been diagnosed with a lethal or otherwise significant. abnormality
- Treatment or surgery to change gender or restore sexual function
- Medical and surgical treatment of excessive sweating (hyperhidrosis)
- Alternative treatments – acupressure, aromatherapy, hypnotism, massage therapy, rolfing, art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- A service, treatment or procedure that is illegal in the state in which it is performed.
- Virtual reality therapy services, devices, and software.

**High Cost Drug Exclusion Program** –Notwithstanding anything herein to the contrary, the Cracker Barrel Rx Exclusion Program (the "Rx Exclusion Program") excludes drugs with an expected annual cost of $500,000 or greater, or other drugs as recommended by the Plan's third-party prescription consultants, from coverage under the Company's medical and pharmacy plans. The list of medications that will be excluded under the Rx Exclusion Program is available on **www.bcbst.com/atdlist** and **www.express-scripts.com**, and will be updated semi-annually.

# Prescription Drug

Prescription drug coverage is provided for medically necessary outpatient prescription drugs and supplies. You or your dependent must be covered at the time the prescription or refill is filled.

## Pharmacy Benefits

Express Scripts contracts with a number of retail pharmacies nationwide that provide a discount on prescription drugs. For a list of participating pharmacies, go to **express-scripts.com** or call 1-800-978-6227.

## Using Out-of-Network Pharmacies

When you purchase drugs at a non-network pharmacy, you must pay the full price of the prescription and file a claim to be reimbursed. To access a drug claim form, go to **express-scripts.com** or call 1-800-978-6227. Express Scripts will send the reimbursement directly to you. You have one year from the date of fill to submit direct claims to Express Scripts.

### Using the Home Delivery Service

You can order your 90-day maintenance medications through the Express Scripts home delivery service. Prescriptions are shipped in confidential, tamper-evident packaging.

To get started with home delivery, go to **express-scripts.com** or call 1-800-978-6227.

### Specialty Pharmacy Medications

Certain medications used for treating complex health conditions must be obtained through Express-Script's Specialty Pharmacy, Accredo.

Accredo Specialty Pharmacy is specialized in handling these types of medications. Plus, they are staffed with clinicians to help you get the best results from your medication therapy through one-on-one consultations and provide proactive therapy management through Therapeutic Resource Centers. You can call Accredo directly for assistance. If you fill a prescription for a specialty medication at a retail pharmacy, it may not be covered.

The following conditions may require medications that fall under specialty pharmacy, which include, but are not limited to:

- Ankylosing Spondylitis
- Crohn's Disease
- Growth Hormone Deficiency
- Multiple Sclerosis
- Oral Oncology
- Osteoporosis
- Primary Immunodeficiency Disease
- Psoriasis/Psoriatic Arthritis
- Rheumatoid Arthritis
- Respiratory Syncytial Virus (RSV)
- Viral Hepatitis
- Transplantation

For additional details, call 1-800-978-6227

## Other Express Scripts Programs:

**SaveOnSP Program**

The SaveOnSpecialty program is included in the pharmacy benefit for Traditional Health Care Plan enrollees. Certain specialty medications are eligible for the SaveOnSP program that can help lower your out-of-pocket costs to $0. You'll pay $0 for your medication when you participate in SaveOnSP. If you choose not to participate, you'll pay a higher cost share when you fill your medication.

Conditions covered by SaveOnSP include, but are not limited to the following, and are subject to change:

- Hepatitis C
- Multiple sclerosis
- Psoriasis
- Inflammatory conditions
- Rheumatoid arthritis
- Oncology
- Hereditary angioedema
- Cystic fibrosis
- Hemophilia
- Asthma and allergy

If you fill an eligible medication, a representative from SaveOnSP will contact you to discuss the program.

**Hepatitis Cure Value® program (HCV)**
With this program, members obtain their medication exclusively from Accredo, the Express Scripts specialty pharmacy. Key benefits of the program include cost savings due to market-leading product discounts, increased access to therapies that treat hepatitis C, and high-touch support from Hepatitis C Therapeutic Resource Center℠ (TRC) clinicians. The Express Scripts clinicians receive disease specific training and help patients complete therapy and realize a cure.

**HIV Care Value℠ program (HIVCV)**
Through the HIV Care Value℠ program, the Express Scripts clinicians support members by adhering to the pre-exposure prophylaxis (PrEP) therapy developed for the treatment of HIV to prevent it by taking a single pill once a day.

**Multiple Sclerosis Care Value℠ program (MSCV)**
Through the MSCV program, members fill multiple sclerosis products exclusively at Accredo, where MS patients receive first-in-class care. Proprietary depression screening, specialized clinicians, social support tools, and digital resources help patients stay on their therapy through Accredo

**Oncology Care Value® program (OCV)**
This program aligns the cost of a drug to its efficacy for specific types of cancer and helps ensure members get the medications they need at the right price. It includes a rigorous clinical review process by a dedicated clinical team at Express Scripts and specialist pharmacist support through the Oncology Therapeutic Resource Center. The program focuses on medications including those for prostate cancer, lung cancer and renal cell carcinoma, among others.

## Covered Drugs

The prescription benefit uses the Express Scripts National Preferred Formulary List. The National Preferred Formulary List is a list of medications preferred by the Plan that can help you maximize your pharmacy benefit by minimizing your prescription costs.

For compounded medications where active pharmaceutical ingredients are used, access may be limited to a subset of pharmacy network providers that meet higher credentialing standards.

For an up-to-date listing, go to **express-scripts.com** or call 1-800-978-6227.

Covered expenses include charges for:

- Drugs and medicines that require the written prescription of a doctor, are purchased from a licensed pharmacist or from a doctor who is licensed to dispense drugs and are required in the treatment of illness.
- Insulin
- Allergy serums
- Pre-natal vitamins for pregnancy as prescribed by your doctor
- Prescription and over-the-counter smoking cessation products (with a prescription) for adults in accordance with the Affordable Care Act guidelines
- Oral contraceptives

Covered expenses will be limited to the cost of a generic drug if a generic drug is available. A brand name drug will be considered a covered expense if a generic drug is not available, or if the doctor writes DAW (dispense as written) on your prescription.

If you request a brand name drug when a generic drug is available, you must pay the difference between the cost of the generic drug and the brand name drug, in addition to the brand name drug copay, even if your doctor writes DAW (dispense as written) on your prescription.

**Contraceptive Coverage**

We cover contraceptive that require a prescription, fall under the preventive care benefit and are filled at an in-network pharmacy.

## Exclusions and Limitations

The following limitations apply to all prescription drugs you receive.

Benefits will be payable only if the covered prescription drugs are received while you or your dependent are covered for these prescription drug benefits and recommended and prescribed by a doctor.

Certain drugs may require prior authorization or have limitations such as quantity limits or step therapy programs. For further details or to find out if a specific drug has limitations, go to **express-scripts.com** or call 1-800-978-6227.

***No amount will be payable for:***

- The part of a single purchase at a pharmacy of any drug or medicine that exceeds a 30-day supply with the exception of certain drugs packaged as three months' supply (up to a 90-day supply may be purchased through mail order.)
- More than one purchase of a drug, medicine, insulin or allergy serum during the dosage period recommended by the prescribing doctor
- Bulk chemicals
- Drugs, medicines, or insulin that:
  - Are not approved under the United States Food and Drug Act
  - Are dispensed in a quantity or an amount in excess of that specified by the prescribing doctor
  - Are dispensed more than one year after the date on which the drug, medicine or insulin was ordered by the prescribing doctor
  - Are consumed or used or administered while the employee or dependent is confined to a hospital or similar institution that has on its own premises a facility or dispensing pharmaceuticals
- Therapeutic/medical devices, appliances and non-covered supplies, immunization agents, biological serums, blood or blood plasma
- The administration of drugs, medicines, or insulin
- Over-the-counter drugs and supplies with the exception of insulin and covered diabetic supplies
- Anti-obesity drugs and formulas except for morbid obesity when complicated by other serious medical conditions
- Needles and syringes, except for the administration of insulin
- Vitamins, except pre-natal vitamins or hematopoietic vitamins as prescribed by your doctor
- Fertility drugs
- Anabolic steroids
- Drugs used for cosmetic purposes
- Nutritional supplements
- Progesterone suppositories
- Dental fluorides
- Drugs used for sexual dysfunction
- Homeopathic products
- Antitoxins/Antivenins
- Anti-viral antibodies
- Pregnancy termination drugs
- Diagnostics
- Investigational drugs
- Replacement of medications that have been lost, spilled, broken, dropped, stolen or otherwise compromised
- Drugs excluded under the Rx Exclusion Program described above in the Medical Plan Exclusions and Limitations section

Specialty oral oncology prescriptions will be filled twice a month for the first three months of treatment. Half of the 30-day dosage will be delivered each time.

New prescription drugs are becoming available on the market every day. Some of these new drugs may not be covered under the Plan. To confirm whether or not a specific prescription drug is covered under the Plan, go to **express-scripts.com** or call 1-800-978-6227.

**Note: Cost-sharing for any prescription drugs obtained through the use of a discount card or coupon provided by a prescription drug manufacturer or any other form of prescription drug third-party Cost-sharing assistance *will not* apply toward any deductible or the out-of-pocket limit.**

## Filing a Claim

Once you are enrolled in the Plan, you will receive your medical ID card. You will receive a separate prescription card. The prescription ID card will be sent electronically if you have an email address on file. You can request a printed card by reaching out to Express Scripts. It is important to show your new ID cards to your health care providers and pharmacy to ensure that claims are submitted correctly, and you receive maximum benefits.

**In-Network Claims**

If you use an in-network physician, hospital, facility or pharmacy, there are no claim forms to file. The provider will file the claim with BCBST or Express Scripts, the third-party claims administrators. You are responsible only for any applicable out-of-pocket costs.

**Out-of-Network Claims**

If you use an out-of-network health care provider or pharmacy, you may need to file the claim yourself. Be sure to do so as soon as possible. You must submit your claim within 12 months of the date of service or date of fill. Obtain a claim form online by calling the appropriate number on the back of your ID card.

You may not assign your benefits under the Plan to any provider except as required under a State Medicaid Plan pursuant to §1912(a)(1)(A) of the Social Security Act. Any document you sign stating that an assignment of rights to benefits is occurring is not binding to the Plan. As a result, the Plan will not honor the purported assignment. The Plan will pay benefits to you unless you make a written request for the non-network provider to be paid directly at the time you submit your claim.

The Plan will only pay benefits to you or, with written authorization by you, your provider and not to a third party, even if your purports to have assigned benefits to that third party.

**Overpayment and Underpayment of Benefits**

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

If the Plan pays you more than it owes under the Coordination of Benefits provisions in this Plan, you should pay the excess back promptly. The Company reserves the right to recover any overpayment by legal action or offset payments on future eligible expenses.

If the Plan overpays a health care provider, BCBST reserves the right to recover the excess amount from the provider on behalf of the Plan pursuant to “Refund of Overpayments,” as follows.

**Refund of Overpayments**

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

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

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

If the employee or dependent, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part:

- Future benefits for the employee or dependent that are payable under the Plan, or
- Future benefits that are payable to other employees or dependents under the Plan.

The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

**Explanation of Benefits**

In each month that BCBST processes at least one claim for you or your dependent, you will receive an Explanation of Benefits (EOB). An EOB makes it easy for you to manage your family's medical costs by providing claims' information in easy-to understand terms.

If you would rather track medical and behavioral claims for yourself and your covered dependents online, you may do so at **bcbst.com** for medical claims and behavioral claims. You may also elect to discontinue receipt of EOBs by making the appropriate selection on the site.

An EOB provides a summary of your claim, including:

- Description of service provided
- The amount charged (the amount billed by your provider)
- The eligible expense (the amount approved for payment)
- The amount paid by your Plan
- The amount(s) for which you are responsible:

- Deductible
- Coinsurance
- Other amounts not covered by the Plan

To request a paper EOB, call the toll-free number on your ID card. You can also view and print all your EOBs online at **bcbst.com** for medical claims and behavioral claims.

An EOB is not a bill. If you owe any portion of the claim, you will be billed by the doctor, hospital, or health care facility.

## Terms to Know

**Usual and Customary Charge –** this is the charge for a particular service or procedure that is customarily charged by doctors in the community in which the service or procedure is performed. The usual and customary charge is determined by the claims administrator, BCBST, in accordance with generally accepted principles and applied on a uniform and consistent basis.

**Deductible** – The amount of money you must pay for medical expenses for each family member each year before medical benefits are payable, in most cases. (Eligible preventive care benefits are not subject to the deductible.) After you have paid your deductible, future expenses are covered at the coinsurance amount. Ineligible expenses do not get applied to your deductible. In-network and out-of-network deductibles are calculated separately.

**Coinsurance** – Once you have satisfied your deductible, the Plan pays a percentage of the charges, and you pay a percentage of the charges, for covered medical expenses (including behavioral health and prescription drugs). The amount you are required to pay is called your coinsurance. Coinsurance amounts apply toward your annual out-of-pocket maximum.

**Covered Health Services** – those health services, including services, supplies or pharmaceutical products, which the Plan through its claims administrators determines to be:

- Medically necessary and medically appropriate
- Described as a covered health service in this SPD
- Provided to an employee or dependent who meets the Plan's eligibility requirements
- Not otherwise excluded in this SPD

Covered Health Services shall not include items or services that are illegal or unlawful when furnished by the Provider.

**Eligible Expenses** – For covered health services, incurred while the Plan is in effect, eligible expenses are determined by the Plan as stated below and as detailed in the "How the Plan Works" section.

Eligible medical expenses are determined in accordance with the claims administrator, BCBST's reimbursement policy guidelines. BCBST develops the reimbursement policy guidelines, in its own discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

**Experimental or Investigational Services** – Medical, surgical, diagnostic or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time BCBST or Express Scripts makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use
- Subject to review and approval by any institutional review board for the proposed use (devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be experimental or investigational)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight

  **Exceptions**:
  ◊ Clinical trials for which benefits are available as described under "Clinical Trials."

  If you are not a participant in a qualifying clinical trial, and have a sickness or condition that is likely to cause death within one year of the request for treatment, the Plan, through its claims administrator, BCBST, at its discretion, may consider an otherwise experimental or investigational service to be a covered health service for that sickness or condition. Prior to such consideration the Plan, through its claims administrator, must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

**Medically Necessary** – Health care services provided for the purpose of preventing, evaluating, diagnosing, or treating a sickness injury, mental illness, condition, disease or its symptoms, that are all of the following as determined by the Plan. The services must be:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, disease or its symptoms
- Not mainly for your convenience or that of your doctor or other health care provider
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease or symptoms

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. The Plan reserves the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Plan's sole discretion.

The Plan's medical claims administrator, BCBST, develops and maintains clinical policies that describe the generally accepted standards of medical practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by BCBST and revised from time to time), are available to employee or dependents on **www.bcbst.com** or by calling the number on your ID card, and to physicians and other health care professionals on **www.bcbst.com**.

**Out-of-pocket maximum** – The out-of-pocket maximum is the most you will pay in deductible and coinsurance toward covered health expenses in a Plan year. Prescription drug costs do apply toward your out-of-pocket maximum. In-network and out-of-network out-of-pocket maximums are calculated separately.

Once you reach the out-of-pocket maximum, the Plan pays 100 percent of covered services for in-network providers and 100 percent of the eligible expenses for out-of-network providers.

Amounts you pay toward the cost of certain medical services will not count toward your annual out-of-pocket maximum. These include costs for:

- Any service that is not a covered service under the health coverage
- Expenses in excess of the eligible expense
- Expenses in excess of annual maximums

## Medicare Part D Eligibility

If you are eligible for Medicare, you will receive an annual notice from the Company each October indicating whether the prescription drug coverage offered under each of the medical benefit options is creditable (i.e., on average, as good as Medicare Part D) or non-creditable coverage for the Plan year. For Plan year 2024, the Health Basics Plan is non-creditable coverage. The Value Health Plan, Health Savings Advantage Plan and the Traditional Health Care Plan are creditable coverage.

The annual notice will also describe your Medicare Part D enrollment options. It's very important that you read that notice because you may be subject to a late enrollment penalty if you have non-creditable coverage and you do not timely enroll in Medicare Part D. You may join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. In certain cases, you may be eligible for a two-month special enrollment period.

If you would like another copy of the Medicare Part D notice, contact the Benefits Call Center at 1-833-589-0714. You can also find more information on Medicare Prescription Drug Plans (including Medicare enrollment periods) at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

## Coverage – Health Basics Plan

*Some covered services may be affected by state-specific riders. A rider is a document that contains provisions that may add to or change Plan provisions. You are affected by a rider if you live in one of the following states: Arkansas, Florida, Idaho, Indiana, Louisiana, Maryland, Maine, Missouri, Mississippi, Montana, Ohio, Oklahoma, South Carolina, South Dakota, Washington, and West Virginia. If you don't already have a copy of your state-specific rider, contact Symetra Life Insurance Company. For purposes of eligibility for these covered services, see the "Eligibility" section of this SPD.*

### How the Plan Works

The plan includes two levels of coverage:

- Eligible preventive services covered at 100 percent under the minimum essential coverage (MEC) – you must use a MultiPlan network physician or facility for preventive services
- Sick care services are covered at a fixed-dollar amount under the fixed-payment medical coverage – you can use any doctor, hospital or facility you choose, but your costs will be lower if you use a MultiPlan network provider. For prescription drug coverage, you need to use an Optum Rx pharmacy. For all services, you pay no deductibles, no coinsurance and no copays.

For sick care, the plan will pay the fixed dollar amount up to the daily, annual or frequency maximums. You will be responsible for paying the balance, if any. If the fixed-dollar amount is more than the cost of service, you keep the remaining balance. *See the Summary of Benefits chart or your Certificate of Coverage for specifics of the fixed payments.*

### How to Find Network Physicians, Hospitals and Pharmacies

- For medical providers: go online to **multiplan.com/symetra/cb-msb** or call 1-888-371-7427
- For pharmacies: go online to **OptumRx.com** or call 1-800-248-1062

It's always best to call your doctor's office and pharmacy to verify they belong to the network.

### Need a doctor? Call MeMD!

MeMD offers phone, online, or app access to a nationwide network of U.S. licensed physicians. There are no copays, and you can make unlimited calls. You can contact MeMD to discuss symptoms with a physician who will recommend treatment options, diagnose common conditions, and may prescribe medication, when appropriate. (Not all states allow medication prescriptions via telehealth services.)

Once your medical coverage begins, log on to **MeMD.me/group/cb-msb** to register so you can use the service whenever you need it. Download the app from the App Store for easy access from your smartphone. MeMD is available 24/7 at 1-844-800-7110.

## Preventive Services under the Minimum Essential Coverage (MEC) Benefit

You are entitled to the covered expenses listed below. For coverage under this Plan, covered expenses must be ordered or written as a prescription by a physician or provider. Services that are not listed herein are not covered expenses under the MEC benefit.

Preventive and wellness services for eligible adults and children and women's preventive services are in compliance with the Affordable Care Act. In addition to those listed here, a description of covered preventive services can be found at **healthcare.gov/what-are-my-preventive-care-benefits**. Recommended ages, frequency and populations are for example only. Coverage will be in accordance with current recommendations under the Affordable Care Act or, if none, with reasonable medical judgment. Unless otherwise noted, frequency will be presumed to be annual.

Subject to the Plan's provisions, limitations and exclusions, the following are covered benefits when received in-network with no cost-sharing for you. If it's verified that the eligible service is not available in-network, benefits may be paid at the in-network benefit level (i.e. no cost-sharing) so long as there is no in-network provider for the eligible service within 25 miles from your residence.

## Preventive Care Services for Adults

Wellness or office exams billed by physicians with the below services or with a covered preventive diagnosis and billed with a preventive code or defined for preventive under the pharmacy benefit are covered under the Plan

Charges for covered Preventive Services:

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Type 2 diabetes screening for adults 35 to 70 years who are overweight or obese
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk

- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza (Flu Shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
- Obesity screening and counseling for all adults
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Syphilis screening for all adults at higher risk
- Hepatitis B screening for people at high risk.
- Hepatitis C screening for adults at increased risk, and one time for everyone born 1945-1965.
- Lung cancer screening for adults 55-80 at high risk because they're heavy smokers or have quit in past 15 years.
- Falls Prevention for adults 65 years and over, living in a community setting.
- Statin preventive medication for adults 40 to 75 at high risk; and
- Tuberculosis screening for certain adults without symptoms at high risk.

## Preventive Services for Children

Wellness or office exams billed by physicians with the below services or with a covered preventive diagnosis and billed with a preventive code or defined as preventive under the pharmacy benefit are covered under the Plan.

Recommended Well Baby/Child Visit Schedule:

- Ages: 0 to 11 months – 6 visits
- Ages: 1 to 4 years – 7 visits
- Ages: 5 to 10 years annual visits
- Ages: 11 to 14 years annual visits
- Ages: 15 to 17 years annual visits

Charges for covered Preventive Services:

- Alcohol and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)

- Blood pressure screening for children (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)
- Cervical dysplasia screening for sexually active females
- Congenital hypothyroidism screening for newborns
- Depression screening for adolescents
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders (ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)
- Fluoride chemoprevention supplements for children without fluoride in their water source, ages 6 months – 5 years
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, weight and body mass index measurements for children (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)
- Hematocrit or hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth through age 18 – doses, recommended ages, and recommended populations vary (Learn more about immunizations and see the latest vaccine schedules):
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Inactivated Poliovirus
  - Influenza (Flu Shot)
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical history for all children throughout development (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)
- Obesity screening and counseling
- Oral health risk assessment for young children (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years)
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)
- Vision screening for all children
- Hepatitis B for adolescents at high risk;
- Bilirubin concentration screening for newborns;

- Blood screening for newborns;
- Fluoride varnish for all infants and children as soon as teeth are present; and
- Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits.

## Preventive Care Services for Women (Including Pregnant Women)

Wellness or office exams billed by physicians with the below services or with a covered preventive diagnosis and billed with a preventive code or defined as preventive under the pharmacy benefit are covered under the Plan annually or as needed to include pre-natal visits.
Charges for covered preventive services as listed below:

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women, at 12-16 weeks or 1st pre-natal visit
- BRCA counseling about genetic testing for women at higher risk
- Breast cancer mammography screenings every 1 to 2 years for women over 40
- Breast cancer chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- Domestic and interpersonal violence screening and counseling for all women
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human immunodeficiency virus (HIV) screening and counseling for sexually active women
- Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Sexually transmitted infections (STI) counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Well-woman visits to obtain recommended preventive services for women under 65
- Preeclampsia prevention and screening for pregnant women with high blood pressure;
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before; and
- Urinary incontinence screening for women yearly.

## Summary of Benefits – Fixed-Payment Indemnity Coverage

*These benefits are insured by Symetra Life Insurance Company. For a detailed description of these benefits, see your Certificate of Coverage. For a detailed description of eligibility for these benefits, see the "Eligibility" section of this SPD.*

*For information about the employee life and AD&D and dependent life benefits insured by Symetra Life Insurance, see the "Life Insurance & AD&D" section.*

| Service | What the Plan Pays in 2024 |
|---|---|
| Doctor's Office Visit, Urgent Care and Outpatient Hospital Benefit | $80 per day – $640 per person/per calendar year maximum |
| Outpatient Diagnostic X-ray and Lab Benefit | $125 per day – $625 per person/per calendar year maximum |
| Outpatient Major Diagnostic Testing Benefit | $375 per day – 2 days per person/per calendar year maximum |
| Emergency Room Benefit | $200 per day – $600 per person/per calendar year maximum |
| Inpatient Hospital Benefits – 500 days per lifetime unless noted | |
| Hospital Stay | $800 per day – 10 days per person /per calendar year and 500 days per lifetime |
| Intensive Care Unit | $1,600 per day – 10 days per person /per calendar year and 500 days per lifetime |
| Substance Abuse Facility | $800 per day – 10 days per person /per calendar year and 500 days per lifetime |
| Mental Health Facility | $400 per day – 10 days per person /per calendar year and 180 days per lifetime |
| Nursing Facility<br>60 consecutive days per stay maximum | $400 per day<br>This benefit is paid only if following a covered hospital stay of at least three consecutive days and the insured is under age 65. Max of 60 consecutive days per person per stay and 500 days per lifetime. |
| Surgical Benefit – Maximum of one surgical benefit per day; $5,000 combined calendar year maximum per person | |
| In a Doctor's Office | $90 per day |
| In an Ambulatory Facility/Outpatient Surgical Facility | $600 per day |
| In a Hospital (Inpatient) | $2,000 per day |
| Surgical Anesthesia Benefit – Maximum of one anesthesia benefit per surgical procedure per day; $1,250 combined calendar year maximum per person | |
| In a Doctor's Office | $22.50 per day |
| In an Ambulatory Facility/Outpatient Surgical Facility | $150 per day |
| In a Hospital (Inpatient) | $500 per day |
| Ambulance Transportation Benefit | |
| Ground Transport | $500 per day |
| Air Transport | $1,000 per day |
| Trips Combined (Ground & Air) | 5 per person /per calendar year maximum |
| Prescription Drug | |
| Generic | $5 per day – 24 days per person/per calendar year maximum |
| Brand Name | $35 per day – 24 days per person/per calendar year maximum |

| | |
|---|---|
| Group Accident Benefit | |
| Coverage per occurrence | Up to $500 |
| Occurrences | 3 per person /per calendar year maximum |
| Critical Illness Benefit – Per first diagnosis of covered critical illness condition | |
| Employee | $5,000 |
| Spouse | $5,000 |
| Child | $1,250 |

*The plan does not meet the health plan requirements of Massachusetts or California and is not available in New Hampshire. Critical Illness coverage differs in Montana and Washington. Benefits for residents in Idaho and Maryland differ slightly. For more information, see the Certificate of Coverage.*

## Covered Services

*See the Summary of Benefits table for the covered services under this Plan. For additional specifics, refer to your Certificate of Coverage provided by Select Benefit Administrators, a division of Symetra Life Insurance Company (SBA).*

Claims should be filed in accordance with the claims procedure provided in the *Certificates of Coverage* for your fixed-payment indemnity and outpatient prescription drug indemnity benefits.

## Exclusions and Limitations

*See the Summary of Benefits table for the exclusions and limitations under this Plan. For additional specifics, refer to your Certificate of Coverage provided by Select Benefit Administrators, a division of Symetra Life Insurance Company (SBA).*

## Prescription Drug

For questions about outpatient prescription drug indemnity benefits, contact OptumRx by phone at 1-800-248-1062 or online at **optumrx.com**

## Survivor Benefit

Upon your death, coverage may be continued for insured **Dependents**, with no **Premium** due, for all benefits, excluding the Dependent Life Insurance Benefit, covered under the **Policy**. All **Dependent** coverage will cease on the earliest date below:
a. The date the **Insured** no longer qualifies as a **Dependent** as defined in the **Policy**.
b. The date your spouse remarries.
c. The date the **Dependent** becomes eligible for any other plan that includes inpatient hospital benefits.
d. The date your spouse qualifies for **Medicare**.
e. The termination date of the **Policy**.
f. Two years from the date of your death.

### Critical Illness Benefits

### Highlights

- Generally pays a $5,000 for first diagnosis per covered condition per person benefit amount for specific covered critical illness conditions
- Child benefit is 25 percent of per occurrence amount

### How the Plan Works

*For a detailed description of these benefits, see your Certificate of Coverage. Critical Illness coverage differs in Montana and Washington.*

### Filing A Claim

To file a claim for Critical Illness benefits, you should submit the appropriate form to Symetra Life Insurance Company as soon as possible. Contact Symetra Life Insurance Company to get a claim form. Claims should be filed in accordance with the claims procedure provided in the *Certificate of Coverage* for your Critical Illness benefits.

### Group Accident Benefits

### Highlights

Pays up to $500 of eligible expenses for an accident up to three occurrences per person per calendar year

### How the Plan Works

*For a detailed description of these benefits, see your Certificate of Coverage.*

### Filing A Claim

To file a claim for group accident benefits, you should submit the appropriate form to Symetra Life Insurance Company as soon as possible. Contact Symetra Life Insurance Company to get a claim form. Claims should be filed in accordance with the claims procedure provided in the Certificate of Coverage for your Group Accident benefits.

## Filing a Claim for Fixed Payment Indemnity Benefits

Once you are enrolled in the Health Basics Plan, you will receive your medical ID card. It is important to show your new ID card to your health care providers and pharmacy to ensure that claims are submitted correctly, and you receive maximum benefits. You must provide Symetra Life Insurance Company with written notice of claim within 20 days or as soon as reasonably possible.

Claims should be filed in accordance with the claims procedure provided in the *Certificates of Coverage* for your fixed-payment indemnity and outpatient prescription drug indemnity benefits.

# Dental

*See the end of this section for definitions of important terms used throughout.*

## Highlights

- The Company provides three dental options:
  - Value Dental
  - Basic Dental
  - Basic Dental with Orthodontia
- All options cover diagnostic/preventive, basic and major services.
- The Basic Dental with Orthodontia covers orthodontia.
- All plans provide in-network and out-of-network coverage. All out-of-network charges are based on the usual and customary charges as determined by Delta Dental of Tennessee.
- The dental plans are insured by Delta Dental of Tennessee.

## Coverage – Basic & Basic with Orthodontia Dental PPO and Premier Plans & Value Plan

### How the Plans Work

The Basic, Basic with Orthodontia, and Value Health dental plans are passive PPO plans. Unlike typical medical plans where there are two levels of benefits (one for in-network and one for out-of-network), the dental plans have one level.

You pay the same percentage for services regardless of which dentist or dental provider you see. However, since network providers have agreed to special fees for services, your expenses will usually be lower if you use dentists in the network.

If you use a non-network dental provider, the amount the Plan will pay is based on the maximum reasonable charge. You are responsible for any non-covered expenses over that amount.

Example: How services are covered:
(Assumes deductible is met. Dollar amounts are not actual amounts and are shown for illustration only.)

| Service | In-Network | Out-of-Network |
|---|---|---|
| | Special and Negotiated Fee | Reasonable and Customary |
| Root Canal | $450 | $750 |
| Play Pays 80% | $360 | $600 |
| You Pay | $90 | $150 |

## How to Find Network Dentists

- Online at deltadentaltn.com (click on “members”, then “find a dentist”)
- Call 1-800-223-3104

It’s always best to call your dentist’s office prior to services being performed to verify the dentist belongs to the Delta Dental network, as your expense will usually be lower.

## Summary of Benefits

For specifics of the types of services covered under these benefits, refer to the “Covered Services” section. What the Plan covers is based on the negotiated fee or maximum reasonable charge. For a detailed description of eligibility for these benefits, see the “Eligibility” section of this SPD.

| Covered Services for Basic Dental and Basic Dental with Orthodontia | Basic Dental | Basic Dental with Orthodontia | Covered Services for Value Dental | Value Dental |
|---|---|---|---|---|
| Annual Deductible | For Basic and Major Services:<br>$50 per Individual<br>$150 per Family (max) | For Basic and Major Services:<br>$50 per Individual<br>$150 per Family (max) | Annual Deductible | For Basic and Major Services:<br>$50 per Individual<br>$150 per Family (max) |
| Maximum Annual Coverage (for all services combined, except orthodontia) | $1500 | $1500 | Maximum Annual Coverage (for all services combined) | $1000 |
| Preventive & Diagnostic<br>Oral exams and X-rays (two per year)<br>Cleanings (three per year)<br>Fluoride treatment for children under age 19 (one per year) | Covered at 100%<br>(not subject to deductible) | Covered at 100%<br>(not subject to deductible) | Preventive & Diagnostic<br>Oral exams and X-rays (two per year)<br>Cleanings (three per year)<br>Fluoride treatment for children under age 19 (one per year) | Covered at 100%<br>(not subject to deductible) |
| Basic Services<br>Fillings<br>Extractions<br>Root canal therapy<br>Periodontal treatment<br>Gingivectomy | Covered at 80% after $50 deductible | Covered at 80% after $50 deductible | Basic Services<br>Fillings<br>Simple Extractions<br>Gingivectomy | Covered at 80% after $50 deductible |

| | | | | |
|---|---|---|---|---|
| Major Services<br>Crowns<br>Bridges<br>Dentures | Covered at 50% after $50 deductible | Covered at 50% after $50 deductible | Major Services<br>Root canal therapy<br>Periodontal treatment<br>Other Oral Surgery<br>Crowns<br>Bridges<br>Dentures | Covered at 40% after $50 deductible |
| Orthodontia Benefits | | | | |
| Lifetime Deductible for Orthodontia | n/a | $50 per Individual | | n/a |
| Maximum Lifetime Limit for Orthodontia | n/a | $1,500 per Individual | | n/a |
| Orthodontia Services | n/a | Covered 50% after the deductible | | n/a |
| Implants | | | | |
| | 50% | 50% | | n/a |

## Covered Services

Preventive and Diagnostic Services

- Clinical oral examination – only two per person per calendar year
- X-rays – complete series or panoramic (Panorex) – only one per person, including panoramic film, in any 36 consecutive months
- Bitewing X-rays – only two charges per person per calendar year
- Prophylaxis (cleaning and scaling), including periodontal maintenance or perioprophy procedures (following active therapy) – only three per person per calendar year
- Topical application of fluoride (excluding prophylaxis) for employee or dependents under age 19 – only one per person per calendar year
- Space maintainers for missing primary teeth for employee or dependents age 14 and under
- Occlusal, periapical, extra-oral X-rays

***Basic Services***

- Fillings – amalgam and composite fillings
  **Note**: Silicate, acrylic and composite fillings are covered only for teeth in front of the first bicuspid. Replacement fillings are limited to once in a 24-month period.
- Root canal therapy – any X-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service (For the Value Plan, this service is covered as a Major Service.)
- Osseous Surgery – flap entry and closure is part of the allowance for osseous surgery and not a separate dental service (For the Value Plan, this service is covered as a Major Service.)
- Periodontal scaling and root planing – entire mouth (For the Value Plan, this service is covered as a Major Service.)
- Adjustments – complete denture (any adjustment of or repair to a denture within six months of its installation is not a separate dental service)

- Recement bridge
- Simple extractions
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth (For the Value Plan, this service is covered as a Major Service.)
  - ◊ Removal of impacted tooth, soft tissue
  - ◊ Removal of impacted tooth, partially bony
  - ◊ Removal of impacted tooth, completely bony
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure
- General anesthesia – paid as a separate benefit only when medically or dentally necessary, as determined by Delta Dental of Tennessee, and when administered in conjunction with complex oral surgical procedures which are covered under this Plan
- Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive dental services are performed (any X-ray taken in connection with such treatment is a separate dental service)
- Topical application of sealant, per anterior or posterior tooth for a person less than 14 years old, limited to once per tooth per 3-year period.
- Gingivectomy – limited to once per quadrant every 3 years.
- Provisional splints – limited to once every 24 months

***Major Services***

- Crowns – covered only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration
  - o Porcelain fused to high noble metal
  - o Full cast, high noble metal
  - o Three-fourths cast, metallic
- Removable Appliances
- Fixed Appliances
  - o Bridge pontics – cast high noble metal
  - o Bridge pontics – porcelain fused to high noble metal
  - o Bridge pontics – resin with high noble metal
  - o Retainer crowns – resin with high noble metal
  - o Retainer crowns – porcelain fused to high noble metal
  - o Retainer crowns – full cast high noble metal
- Prosthesis over implant – a prosthetic device, supported by an implant or implant abutment is a covered expense

  **Note:** Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired).
- Implants – covered only under the Basic and Basic with Orthodontia Plans. Covered up to annual maximum of $1500.
- For the Value Plan, the following services are covered as Major Services:
  - Root canal therapy – any X-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service

- Osseous Surgery – flap entry and closure is part of the allowance for osseous surgery and not a separate dental service
- Periodontal scaling and root planing – entire mouth
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
    - ◊ Removal of impacted tooth, soft tissue
    - ◊ Removal of impacted tooth, partially bony
    - ◊ Removal of impacted tooth, completely bony

***Orthodontia Services (Basic with Orthodontia PPO Plan only)***

**Note:** Each month of active treatment is a separate dental service.

Covered expenses include:

- Orthodontic work-up including X-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances
- Cephalometric X-Rays
- Continued active treatment after the first month
- Fixed or removable appliances – only one appliance per person for tooth guidance or to control harmful habits

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the *Summary of Benefits*.

Payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made monthly. The first payment is due when the appliance is installed. Subsequent payments will be issued on a regular basis for continuing active orthodontic treatment. The first installment is 33 percent of the total fee for the entire course of treatment subject to your copayment percentage and lifetime maximum. The remainder of the total fee is prorated over the estimated duration of treatment. Payments will begin in the month following the appliance placement date and are subject to your copayment percentage and lifetime maximum. Payments are only made for services provided while a person is insured.

## Expenses Not Covered

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

- Services performed solely for cosmetic reasons (including teeth whitening)
- Replacement of a lost or stolen appliance
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless:
    - o The replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth

- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards
- Procedures, appliances or restorations (except full dentures) whose main purpose is to:
  - Change vertical dimension
  - Diagnose or treat conditions or dysfunction of the temporomandibular joint
  - Stabilize periodontally involved teeth
  - Restore occlusion
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars
- Bite registrations, precision, or semiprecision attachments
- Instruction for plaque control, oral hygiene and diet
- Dental services that do not meet common dental standards
- Services that are deemed to be medical services
- Services and supplies received from a hospital
- **For Value Plan only**: The surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant

**General Limitations**

No payment will be made for expenses incurred for you or any one of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- For or in connection with a sickness which is covered under any workers' compensation or similar law
- For changes made by a hospital owned or operated by or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected condition
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared
- To the extent that payment is unlawful where the person resides when the expenses are incurred
- For charges which the person is not legally required to pay
- For charges which would not have been made if the person had no insurance
- To the extent that billed charges exceed the rate of reimbursement as described in the *Summary of Benefits*
- For charges for unnecessary care, treatment, or surgery
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society

## Filing a Claim

All bills for a covered expense must be sent directly to Delta Dental of TN. You will receive an explanation of benefits from Delta Dental of TN, identifying the covered expense, the amount of benefit paid, and the amount that is owed by you, if any.

To file a claim for dental benefits, you should submit the appropriate form to Delta Dental of TN as soon as possible. Contact Delta Dental of TN directly to get a claim form. Claims should be filed in accordance with the claims procedure provided in the *Certificate of Coverage* for your dental benefits.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, Delta Dental of TN will pay for the least costly service – as long as it's a professionally accepted, necessary and appropriate treatment.

If you request or accept a more costly covered service, you are responsible for any expenses exceeding the least costly service.

**Delta Dental of TN recommends you request a predetermination of benefits before major treatment begins.**

***Predetermination of Benefits***

Predetermination of benefits is a voluntary review of a dentist's proposed treatment plan and expected charges. It's not preauthorization of service and not required. But it's recommended if expenses can reasonably be expected to be $200 or more.

The treatment plan submitted for review should include supporting pre-operative X-rays and other diagnostic materials as requested by Delta Dental of TN's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Delta Dental of TN will determine covered dental expenses for the proposed treatment plan. If there is no predetermination of benefits, Delta Dental of TN will determine covered dental expenses when it receives a claim.

Predetermination of benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

## Terms to Know

**Deductible** – The amount of money you must pay for dental expenses for each family member each year before basic, major and orthodontia services are payable. (Eligible preventive and diagnostic services are not subject to the deductible.) After you have paid your deductible, future expenses are covered at the coinsurance amount. Deductible cannot be met with ineligible expenses.

When three family members have met the individual deductible, the deductible has been satisfied for all covered family members. No more than the individual deductible of each person's covered expenses can be applied to the family deductible.

Once the deductible has been satisfied, the Plan will pay its percentage of covered services.

**Annual maximum** – Applies toward preventive/diagnostic, basic and major dental services only. Once the Plan has paid the annual maximum benefit for an individual, you are responsible for all dental costs for that individual for the remainder of the calendar year.

**Orthodontia lifetime maximum** – The maximum amount the Plan will pay toward orthodontia expenses for the lifetime of an employee or dependent.

Once the employee or dependent has met the lifetime maximum, no further orthodontia benefits are payable for that individual.

**Maximum Reimbursable Charge** – The maximum reimbursable charge for covered services is determined based on the lesser of:

- The dentist's normal charge for a similar service or supply; or
- The policyholder-selected percentile of charges made by dentists of such service or supply in the geographic area where it is received as compiled in a database selected by Delta Dental of TN.

The maximum reimbursable charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Delta Dental of TN. Additional information about how Delta Dental of TN determines the maximum reimbursable charge is available upon request.

# Vision

## Highlights

- The Company provides one vision option
- The plan covers annual eye exams with a network doctor after a small copay
- Non-network coverage is available up to a specified dollar amount
- You can receive new frames every other calendar year or, instead of glasses, new contact lenses every calendar year
- Discounts are available for laser vision correction
- Coverage also includes free membership into the Davis Vision by MetLife mail order contact lens service
- Vision benefits are administered through Davis Vision by MetLife and insured by Metropolitan Life Insurance Company

# Coverage

## How the Plan Works

Vision benefits are designed to protect your visual wellness by offering eye exams and prescription eyewear through a network of Davis Vision by MetLife eye doctors.

- If you use a Davis Vision by MetLife eye doctor for your vision services, you will pay a small copay for your eye exam and lenses and certain frames or contact lenses. You receive an allowance or special discounts for the purchase of eyewear outside the copay coverage.
- If you use a non-Davis Vision by MetLife eye doctor, you will pay the full cost of the services, and then apply for reimbursement. Reimbursements are fixed amounts for services, regardless of what the eye doctor charges.

***Davis Vision by MetLife Mail Order Contacts***

Mail order contact lenses replacement contacts (after initial benefit) through **davisvisioncontacts.com** mail order service ensures easy, convenient, purchasing online and quick, direct shipping to your door.

### How to Find Network Eye Doctors

- Online at metlife.com/mybenefits
- Call 1-877-393-8885

It's always best to call the eye doctor's office prior to services being performed to verify the doctor belongs to the Davis Vision by MetLife Network.

## Summary of Benefits

*For a detailed description of these benefits, see your Certificate of Coverage. For a detailed description of eligibility for these benefits, see the "Eligibility" section of this SPD***.**

| Covered Services | In-Network | Out-of-Network |
|---|---|---|
| Eye Exam (one per year) | $15 copay | Plan reimburses up to $30 |
| Lenses (one per year):<br>Single Vision<br>Bifocal<br>Trifocal<br>Lenticular (post-cataract) | $15 copay | Plan reimburses:<br>Up to $25<br>Up to $35<br>Up to $45<br>Up to $80 |
| Frames (every other year):<br>Davis Vision Collection – Designer, Fashion<br>Davis Vision Collection – Premier Frames<br>Other Frames | <br>$0 copay<br>$25 copay<br>$125 allowance, plus 20% discount* on any amount over $125<br>At Visionworks locations - $175 allowance, plus 20% discount on any amount over $175 | <br>Plan reimburses up to $35<br>Plan reimburses up to $35<br>Plan reimburses up to $35 |

| | | |
|---|---|---|
| Contact Lens (one per year, instead of eyeglasses):<br>Davis Vision Premium Collection (2 or 4 boxes; replacement/disposable)<br><br><br>Other Contacts<br><br><br><br>Medically Necessary (subject to prior approval) | <br>$15 copay for 2 or 4 boxes of contacts<br>$0 copay for contact lens exam and fitting<br><br>$120 allowance, plus 15% discount* on any overage, towards contact lenses and contact lens exam and fitting fees<br><br>Plan pays 100% | <br><br>Plan reimburses up to $90<br><br><br>Plan reimburses up to $90<br><br><br><br>Plan reimburses up to $250 |
| **Covered Services** | | |
| Other Lens Options<br>Polycarbonate Lenses<br>Scratch Protection Plan**- single<br>Scratch Protection Plan**- multifocal<br>Glass Photochromic Lenses<br>Blended Segment Lenses<br>Ultraviolet (UV) coating<br>Digital SV - Intermediate Vision Lenses<br>Anti-reflective Coating - Standard<br>Anti- reflective Coating – Premium<br>Anti-reflective Coating – Ultra<br>Anti-reflective Coating - Ultimate<br>Polarized Lenses<br>Plastic Photosensitive Lenses<br>Hi-index 1.67 (thinner and lighter) Lenses<br>Hi-index 1.74 (thinner and lighter) Lenses<br>Progressive Addition Lenses – Standard<br>Progressive Addition Lenses – Premium<br>Progressive Addition Lenses – Ultra<br>Progressive Addition Lenses – Ultimate<br>Premium Scratch Resistant Coating<br>Blue Light Filtering | In addition to the costs above:<br>$30<br>$20<br>$40<br>$20<br>$20<br>$12<br>$30<br>$35<br>$48<br>$60<br>$85<br>$75<br>$65<br>$55<br>$120<br>$50<br>$90<br>$140<br>$175<br>$30<br>$15 | No Coverage |
| Laser Vision Correction Services (subject to prior approval) | special discounts at network locations | No Discounts |
| Low Vision Coverage (subject to prior approval)<br>Comprehensive Evaluation (one every 60 months)<br>Follow-up visits (four every 60 months)<br>Optical devices (per aid)<br>Lifetime maximum for all aids | <br>$300 allowance<br><br>$100 allowance<br>$600 allowance<br>$1,200 allowance | <br>Plan reimburses up to $300<br><br>Plan reimburses up to $100<br>Plan reimburses up to $600<br>Plan reimburses up to $1,200 |

Discounts not applicable in California or at any Walmart, Sam's Club or Costco locations.
**Scratch protection plan is a one-year warranty.

## Covered Services

See the Summary of Benefits table.

### Expenses Not Covered

The following items are not covered by the Plan:

- Any expense not shown in the Summary of Benefits
- Medical treatment of eye disease or injury
- Vision therapy
- Special lens designs or coatings, other than those previously described
- Non-prescription (plano) lenses
- Contact lenses and eyeglasses in the same benefit cycle
- Services not performed by licensed personnel
- Two pairs of eyeglasses in lieu of a bifocal
- Eye exams required as a condition of employment except, as otherwise provided under the Occupational and Safety Program
- Services or materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment (including laser vision correction), other than previously described
- Charges for the replacement of lost or stolen lenses or frames
- Services or supplies provided before your effective date of coverage or after our coverage ends
- Expenses covered by any other group insurance
- Expenses covered by a health maintenance organization or hospital, or medical services prepayment plan available through an employer, union, or association
- Any expenses covered by any union welfare plan or government program, or a plan required by law
- Medically necessary contact lenses prescribed for you for which prior approval was not obtained from Davis Vision or its authorized representative.

## Filing a Claim

If you use a Davis Vision by MetLife eye doctor, there is no claim form to file. You simply pay your copay or discounted amount.

If you use a non-Davis Vision by MetLife eye doctor, you must pay the doctor directly and then submit a claim to Davis Vison by MetLife for reimbursement. You can obtain a claim form at **metlife.com/mybenefits** or by calling 1-877-393-8885. Send your claim to:

Davis Vision by MetLife
Attn: Claims Processing
881 Elkridge Landing Rd
Linthicum Heights, MD 21090

Claim forms must be submitted within 20 days of the date of service or as soon as reasonably possible. Claims submitted after that timeframe may not be honored. Claims should be filed in accordance with the claims procedure provided in the *Certificate of Coverage* for your vision benefits.

# Flexible Spending Accounts (FSAs)

*For a detailed description of eligibility for these benefits, see the "Eligibility" section of this SPD.*

## Highlights

- Three types of FSAs:
  - Health care FSA
  - Limited purpose health care FSA
  - Dependent care FSA
- Allow you to set aside contributions to pay for unreimbursed health care or dependent care expenses.
- Your contributions are on a tax-exempt basis.
- You pay no federal, Social Security, and possibly no state or local income taxes on your contributions.
- There are limitations on the amount you may set aside.
- The dependent care FSA is not available to highly compensated employees (e.g., highly paid employees). *For a definition of who is a highly compensated employee, as defined by the IRS, go to **irs.gov**.*
- The FSAs are administered by Chard Snyder.

## Coverage

### How the FSAs Work

FSAs are a way for you to pay for certain health care or dependent care expenses with tax-exempt dollars. You pay no federal, Social Security and, depending on where you work and live, no state or local income taxes on the money you use to pay these expenses. For this reason, the services and supplies you pay for actually cost you less. The IRS determines which expenses are eligible for FSAs.

You may enroll in both the health care and dependent care FSAs, or just one. The limited purpose health care FSA is only available to those employees who enroll in the Health Savings Advantage Plan with a health savings account (HSA). The limited health care FSA is a special health care FSA which can **only** be used for eligible dental and vision expenses.

You cannot enroll in both the health care FSA and the limited purpose health care FSA.

**Note:** The health care, limited purpose health care and dependent care FSAs are separate accounts. **You cannot use the money from one FSA to pay for expenses in another.**

## Health Care FSA

A health care FSA can be used to pay for eligible health care expenses for yourself or an eligible tax dependent regardless of whether your dependent is enrolled in your medical, dental or vision plans.

Examples of eligible health care expenses are charges applied to your deductible or coinsurance amounts, dental, vision or hearing expenses, over-the-counter medications, menstrual care products and other out-of-pocket costs. The health care FSA cannot be used to pay premiums.

The maximum contribution you may make to a health care FSA account for 2024 is $3,200. The minimum contribution amount is $100.

You will receive a debit card from Chard Snyder to pay for eligible health care expenses.

**Reimbursement of Health Care Expenses**
The entire annual amount you elect to put into your health care FSA is available on the first day of coverage. Your eligible expenses must be for services incurred in the applicable calendar year, regardless of when you paid for them. You have until March 31 of the next year to submit your previous year's expenses for reimbursement. You must submit claims no later than that date to receive reimbursements. If your coverage cancels prior to the end of the Plan year, you have 90 days to submit claims for reimbursement.

**Example**: For a 2024 FSA, you will have until March 31, 2025, to submit any 2024 claims for reimbursement.

By IRS rules, you cannot participate in a full-purpose health care FSA and be eligible to make or receive contributions to a Health Savings Account (HSA) at the same time. If you enroll in the Health Savings Advantage Plan, you will only be eligible for the Limited Purpose Health Care FSA unless you certify that you are not eligible for a Health Savings Account (HSA).

## Limited Purpose Health Care FSA

If you enroll in the Health Savings Advantage Plan, and you certify that you are eligible for a Health Savings Account (HSA) you may only enroll in a limited purpose health care FSA.

The limited purpose health care FSA works similar to the health care FSA, except that you can only be reimbursed for eligible dental and vision expenses. You cannot be reimbursed for other types of medical expenses under the limited purpose health care FSA. The Health Savings Account is a good place to save for other medical expenses.

The maximum contribution you may make to a Limited Purpose Health Care FSA account in 2024 is $3,200. The minimum contribution amount is $100.

You will receive a debit card from Chard Snyder to pay for eligible limited purpose health care expenses.

## Dependent Care FSA

A dependent care FSA account can be used to pay eligible, non-medical dependent care expenses incurred for the care of eligible dependents while you and your spouse work or attend school. Eligible dependents include children under age 13 or handicapped family members of any age who are unable to care for themselves. You must be able to declare them as dependents on your tax return. The Internal Revenue Code governs the maximum contribution amount allowed to a dependent care account. Your contribution amount cannot be more than the smallest of:

- Your income or your spouse's income, whichever is smaller; if your spouse is a student or incapable of self-care, your spouse is considered to earn:
  - $3,000 per year with one dependent
  - $6,000 per year with two or more dependents
- $5,000 per year if your tax filing status is "married filing jointly" or "single head of household"
- $2,500 per year if your tax filing status is "married filing separately"

The minimum contribution amount is $100.

**Note:** Highly compensated employees are not eligible to participate in the dependent care FSA. The dependent care FSA is not part of the Plan and is not subject to ERISA.

### Reimbursement of Dependent Care Expenses

Your eligible expenses must be for care incurred after your effective date in the applicable calendar year, regardless of when you paid for them. Just like the health care FSA, you have until March 31 of the following year to submit claims for reimbursement from the prior year. If coverage cancels prior to the end of the Plan year, you have 90 days to submit claims for reimbursement.

Different from health care FSA is the timing of your reimbursement, which will depend on whether there is enough money in your dependent care FSA to cover the full amount of your claim.

Dependent care FSA contributions are added to your account as the contributions are deducted from your paychecks.

- If there is enough money in your account, you will receive a check reimbursing you for the full amount of your claim.
- If you do not have enough money in your dependent care FSA to be reimbursed the full amount requested, you will receive a partial payment, and the balance will be paid as new contributions are posted to your account from your tax-exempt payroll deductions.

**Example**: If you elect payroll deductions of $100 per month ($1,200 per year) into your dependent care FSA at the beginning of the year and you have an eligible expense of $85 on February 1, your reimbursement amount will be $85, leaving an available account balance of $15. Then on March 1, if you have an eligible expense of $150, your reimbursement amount would be $115 ($100 from your tax-exempt contribution in February, plus the $15 available balance from January). The remaining $35 of the claim would be paid after enough money has accumulated in your account from your tax-exempt payroll deductions.

### Eligible Expenses

- The health care FSA can be used to pay for health care expenses such as deductibles, coinsurance amounts, prescription drug costs, dental, vision, hearing, over-the-counter medications, menstrual care products and other out-of-pocket expenses that are FSA eligible, but not otherwise covered by your insurance.
- If you enroll in the Health Savings Advantage Plan medical option and certify you are eligible for a Health Savings Account (HSA), you may only elect a limited purpose health care FSA to cover only eligible dental and vision expenses.
- The dependent care FSA can only be used to pay for eligible, non-medical dependent care (day care) expenses incurred while you and your spouse work or attend school.

For a full listing of FSA-eligible expenses, go to **chard-snyder.com** or the IRS website at **irs.gov**.

Keep in mind that the FSA plans are IRS regulated plans, so it is recommended to keep copies of all documentation to support your claim(s) in the event of an IRS audit.

## Filing a Claim

For health care expenses where you can't use the supplied debit card (see below), you will need to pay expenses out of your own pocket and then submit your receipt (or copy of your paid bill) and a claim form to Chard Snyder. You can find claim forms at **chard-snyder.com**.

You can fax, upload, or mail your claim to Chard Snyder.

- Fax to 1-888-245-8452
- Upload on the Chard Snyder mobile app or online at chard-snyder.com
- Mail to Chard Snyder
  P.O. Box 249
  Fort Washington, PA 19034-9998

Reimbursements will be made as soon as possible.

Due to the nature of health care FSA and limited purpose health care FSA benefits, claims will be considered post-service claims. *For purposes of claim denials and appeals, see the "Claims and Appeals Procedures" section of this SPD as it relates to post-service claims.*

### Debit Card Processing

**Please note:** The FSA debit card is to be used with the health care FSA and limited purpose health care FSA, but not for the dependent care FSA claims.

You will receive a FSA debit card to use so you may pay providers directly from your FSA. The card is pre-loaded with your calendar year FSA amounts. Full instructions for use will be included with your card.

The FSA debit card can be used to pay for certain eligible expenses right at the point of service. In effect, the card allows you the convenience of immediate reimbursement. However, if requested, you may be required to submit documentation to Chard Snyder confirming the date of the expense, specific service or medication, and the name of the doctor's office or retail store. If you fail to submit the required documentation, your card may be suspended if you use it for ineligible expenses. You may be required to repay the Plan for any purchases that you are not able to substantiate.

There is an expiration date on all cards. If you re-elect the FSA each year, you can continue to use the same debit card until it expires, at which time you will be issued a new card.

**Use It or Lose It**

Federal regulations require that if you have not spent all the money in your FSA account for eligible expenses incurred by the end of the Plan year and submitted claims by March 31 of the following year for the prior Plan year's expenses, you must forfeit your remaining balance.

Remember, the money left in one account cannot be used to cover expenses in the other account.

# Life Insurance & Accidental Death and Dismemberment (AD&D)

*For a detailed description of these benefits, including definitions and exclusions, see your Certificate of Coverage. For a detailed description of eligibility for these benefits, see the "Eligibility" section of this SPD.*

## Highlights

- The Company provides basic life and basic accidental death and dismemberment (AD&D) at no cost to you.
- You may purchase additional life insurance for yourself, your spouse, and your dependent children (up to age 26).
- All life insurance benefits are underwritten and insured by The Hartford.

## Beneficiary

When you enroll in your benefits, you must name a beneficiary who will receive life insurance proceeds in the event of your death. You may name any one person, or you may have more than one beneficiary.

Note:  You are the beneficiary for accidental dismemberment benefits and spouse/child life benefits.

If you have not named a beneficiary, or if your beneficiary is not living at the time of your death, the death benefit will be paid to the first survivor(s), who is living on the date of your death, in the following order:

1. Your estate
2. Your spouse.
3. Your natural and adopted children.
4. Your parents.
5. Your siblings.

You may change your beneficiary at any time on www.mybenefitelections.com

## Accelerated Death Benefit

This benefit allows you to receive a portion of your death benefit while you're still living. Qualifying events to receive this benefit include:

- Terminal illness, with a diagnosed life expectancy of less than 12 months

The accelerated death benefit pays up to 80 percent of the amount of Basic and Optional Life Insurance in force, up to $500,000. You must have at least $10,000 of life insurance coverage in force and under age 60.

## Coverage Reductions Starting at Age 65

If you continue to work past age 65, your applicable life and AD&D coverage amount will be reduced. Reductions to Dependent Life applies to your spouse as well. See below age reductions.

- For ages 65 through 69, you'll receive 65 percent of the coverage amount.
- For ages 70 and older, you'll receive 50 percent of the coverage amount.

Age reduction occurs on the January 1 following attainment of a limiting age.

## Coverage – Basic Life

### How the Plan Works

In the event of your death, basic life provides a benefit to your designated beneficiary.

### Coverage Levels

Basic Life insurance is one and a half (1.5) times your annual base salary (up to 1 million). If you are an officer of the Company, different coverage levels apply. See your Certificate of Coverage for more details.

### Repatriation Benefit

If you die outside the territorial limits of the state or country of your place of permanent residence, the Plan will pay a benefit to transport your body to a mortuary near your primary place of residence. The maximum benefit payable is $5,000 or 2 percent of the basic life benefit, whichever is less.

### Suicide Exclusion

If you die due to suicide within two years of your coverage effective date, whether you are sane or insane, the amount payable will exclude any amount of optional life coverage which has not been in effect for at least two years.

## Coverage – Basic AD&D

### How the Plan Works

If your death is the result of an accident, AD&D provides an additional benefit. If you have an accidental loss of sight, speech, hearing or limb within 365 days of an accident, AD&D pays a percentage of the benefit amount to you or your beneficiary depending on the type of loss.

Death benefits are paid to your designated beneficiary. Loss of limb, sight, speech and hearing benefits are paid to you.

### Coverage Levels

AD&D coverage is one and a half (1.5) times your annual base salary (up to1 million). If you are an officer of the Company, different coverage levels apply. *See your Certificate of Coverage for more details.*

### AD&D Table of Losses

The following table outlines the benefits payable under basic AD&D. The maximum benefit payable for all losses for any one accident is the full benefit amount. Additional losses are detailed in the *Certificate of Coverage.*

| For Loss of: | The Benefit is: |
|---|---|
| Life | 100% benefit amount |
| Two or more of the following losses: foot, eye, speech or hearing | 100% benefit amount |
| Quadriplegia | 100% benefit amount |
| Paralysis of three limbs | 75% benefit amount |
| Paralysis of lower limbs | 75% benefit amount |
| Paralysis of one limb | 25% benefit amount |

| | |
|---|---|
| Sight in one eye, speech or hearing in both ears | 50% benefit amount |
| Loss of a hand or foot | 50% benefit amount |

### Additional Accident Benefits

When a benefit is payable under accidental death and dismemberment, an additional accident benefit may be payable under the categories below. The additional benefit provisions and amounts are detailed in your *Certificate of Coverage*.

- Common carrier
- Safety Belt use
- Airbag use
- Transportation/Repatriation

## Coverage – Optional Employee Life

### How the Plan Works

In the event of your death, optional life provides a benefit based on the amount of coverage you've elected. Optional life benefits for you are paid to your designated beneficiary.

If you elect optional life, you are required to pay the premiums for such coverage on a post-tax basis.

**Please note**: You cannot be insured as both an employee and a dependent. If you and your spouse both work for the Company, you cannot insure each other under the spouse optional life benefit.

### Coverage Levels

| | |
|---|---|
| Optional Life for You | 1x, 2x, 3x or 4x your base annual earnings (up to $1 million) |

**Note:** During each Open Enrollment, you may increase your level of coverage by one level.

**Note**: Basic and Optional coverages are being offered under a single ERISA plan. The Company pays the premium for the Basic life coverage on behalf of employees. Employees who elect Optional coverage will be required to contribute the premiums specified to the Plan. Any amount paid by employees may be used to reduce what the Employer pays for Basic coverage.

## Coverage – Optional Dependent Life

### How the Plan Works

In the event a covered spouse or dependent child dies, optional dependent life insurance pays a benefit to you, as the beneficiary.

If you elect optional dependent life, you are required to pay the premiums for such coverage on a post-tax basis.

**Please note**: You cannot be insured as both an employee and a dependent. Also, if you and your spouse (or child's other parent) both work for the Company, you cannot both insure your children. Only one of you should cover your children.

### Coverage Levels

- Optional Spouse life available for purchase: $10,000, $20,000, or $30,000. The cost for optional spouse life is based on the spouse's age and spouse's tobacco user status.
- Optional Child life (up to age 26) available for purchase: $10,000

## Filing a Claim

To file a claim for life insurance benefits, you or your beneficiary should submit the appropriate form as soon as possible. Call The Hartford at 1-888-563-1124 or send an email to benefits@crackerbarrel.com to get a claim form.

All decisions concerning the payment of claims under the Plan are at the sole discretion of The Hartford.

Claims should be filed in accordance with the claims procedure provided in the *Certificates of Coverage* for your life and AD&D benefits.

# Long-Term Disability

*For a detailed description of these benefits, including definitions and exclusions, see your Certificate of Coverage. For a detailed description of eligibility for these benefits, see the "Eligibility" section of the SPD.*

## Highlights

- Company-provided long-term disability benefits provide income in the event of an extended illness or injury.
- You are eligible for long-term disability benefits after you complete one year of active service or for a variable hour employee after you have worked the required 30-hour average in your initial or subsequent standard measurement period. **(NOTE: ETC employees are not eligible for long-term disability benefits**).
- There is a maximum benefit that will be paid per month.
- There is a pre-existing condition limitation clause.
- Long-term disability benefits are insured by The Hartford.

# Coverage

## How the Plan Works

In the event you suffer an extended illness or injury that persists beyond 90 days, you may be eligible for a benefit equal to a percentage of your income. Approved long-term disability benefits will begin at the end of a 90 day elimination period.

During an elimination period, if you return to work in between multiple absences for the same disability, the elimination period is combined depending on the length of the break. After the elimination period if you return to work and become disabled due to the same or a related disability within 6 months of returning to work the recurrent disability will be considered one Period of Disability, provided The Policy remains in force. If you return to work for 6 months or more, any recurrent disability will be treated as a new disability. The new disability is subject to a new elimination period.

### Definition of Disability

The definition of disability varies under the terms of the *Certificate of Coverage* based on your title or position.

## Coverage Levels

Benefits are paid based on your pay on your last day of active employment with the Company. If long-term disability is approved, you will receive 50 percent of your current monthly earnings.

The maximum benefit amount depends on your employee classification. See your *Certificate of Coverage* for details.

**Note:** Company-provided long-term disability benefits are taxable income to you; therefore, the actual benefit amount you receive may be less than 50 percent of your pre-disability earnings.

### Deductible Sources of Income

Your benefit may be reduced by any deductible sources of income (as listed in your *Certificate of Coverage*) which you receive or are eligible to receive while you are disabled. This income will be subtracted from your gross monthly payment.

## Maximum Benefit Period

The maximum period of payment is 60 months.

If you are an executive employee, the maximum benefit period differs. *See your Certificates of Coverage for more details.*

### Pre-existing Condition Limitation

Benefits will not be paid if your disability begins in the first 12 months following the effective date of coverage and your disability is caused by, contributed to by, or the result of a pre-existing condition.

### Limited Benefits

Limited benefits apply for specific conditions, as outlined here.

The lifetime cumulative maximum period of payment for all disabilities due to mental illness is 24 months. Only 24 months of benefits will be paid even if the disabilities are not continuous and/or are not related.

The lifetime cumulative maximum period of payment for all disabilities due to alcoholism or drug abuse is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities are not continuous and/or are not related.

Other limitations or exclusions to your coverage may apply. See your *Certificate of Coverage* for further details.

## Filing a Claim

You should notify The Hartford of your disability claim as soon as possible, so that a claim decision can be made in a timely manner.

You can initiate the claim process by going to TheHartford.com/mybenefits and create an account or log in to manage your claim.

All decisions concerning the payment of claims under the Plan are at the sole discretion of The Hartford.

You must notify The Hartford immediately when you return to work in any capacity.

Claims should be filed in accordance with the claims procedure provided in the *Certificates of Coverage* for long-term disability benefits.

# Critical Illness – Voluntary Plan insured by The Hartford

Critical Illness can provide a lump-sum benefit upon diagnosis of a covered illness that can be used however you choose—from expenses related to treatment, to deductible or day-to-day costs of living such as your mortgage or bills.

You may elect a lump sum amount of $10,000, $15,000, or $20,000. If you cover your spouse or child(ren), it is 100% of your coverage amount. You spouse's premium will be based on your age and

tobacco status. Covered illnesses include cancer conditions, vascular conditions, organ failure or transplant, neurological conditions, congenital heart disease, and muscular dystrophy, among others.

If you enroll in Critical Illness, you are eligible for Ability Assist® EAP which provides 24/7/365 access to help for financial, legal, or emotional issues. You are also eligible for HealthChampionSM, an administrative and clinical support program following serious illness or injury. Coverage may also be continued for you and your dependent(s) under a group portability policy.

**Please note**: If you and your spouse (or child's other parent) both work for the Company, you cannot both insure you child(ren). Only one of you should cover your child(ren) under the Critical Illness plan.

*For a detailed description of these benefits, including definitions and exclusions, see your Certificate of Coverage.*

# Cracker Barrel Connect Employee Assistance Program (EAP)

For a detailed description of eligibility for these benefits, see the "Eligibility" section of this SPD.

## Highlights

- Company provided benefit.
- Confidential counseling and referral service.
- Also includes access to work/life resources.
- The Cracker Barrel Connect EAP is insured by ComPsych.

## How the Program Works

The Cracker Barrel Connect program offers complete confidentiality to employees and their families. The decision to use the Cracker Barrel Connect EAP is completely up to you, and your contact with Cracker Barrel Connect EAP is strictly confidential, unless life or safety is threatened, or disclosure is required by law.

You initiate the call by contacting Cracker Barrel Connect EAP at 1-800-688-6330. Trained counselors are available to take your call. You will receive personalized counseling to help you clarify the problem, identify options and develop a plan of action.

You can reach the Cracker Barrel Connect EAP online at **connect.crackerbarrel.com** for quick access to resources such as videos, interactive guides, and materials for mental health, wellness, financial, legal, and more. Additional resources require your login to **guidanceresources.com**. Enter "Biscuit" for the company name ID.

On **guidanceresources.com** you have access to self-directed help through KOA and the KOA Foundations app. The KOA Foundations app can help you tackle concerns like stress, depression, low self-esteem, sleep issues, etc. You choose your own path. Go to **guidanceresources.com** and click on Digital Self-Care Tools to register. Then download the KOA foundation app on your phone.

### Counseling Sessions

Short-term counseling is provided free of charge through the Cracker Barrel Connect EAP by experienced counselors in your local community. Short-term counseling consists of up to four free visits to help you deal with issues such as stress, family problems, alcohol or drug dependencies, financial worries and depression.

If it is determined that after your short-term counseling sessions with a Cracker Barrel Connect EAP counselor that you need specialized treatment or hospitalization, your counselor will refer you to an appropriate resource in the community.

### Work/Life Resources

As part of your Cracker Barrel Connect EAP benefit, you have access to many work/life resources where you'll find assistance with a range of personal and professional topics, such as financial assistance, help finding balance in your life and more. Cracker Barrel Connect EAP can also take the work out of managing life's details. They provide assistance in searching for everything from older adult care, volunteer services, pet care, education, financial programs and other daily issues.

You can access many of the work/life resources online at **guidanceresources.com**. Enter "Biscuit" for the company name ID.

### Program Costs

Short-term care through the Cracker Barrel Connect EAP program is paid for by the Company. Short-term care refers to any counseling with an EAP professional, whether by phone or in person.

If you are referred to a professional outside the Cracker Barrel Connect EAP for long-term care, the treatment is provided under your medical plan (if enrolled) and any deductibles, coinsurance or other limitations and/or exclusions would apply. *See the EAP Program in the Medical and Prescription Drug section for details.*

## Filing A Claim

You generally do not need to file claims for Cracker Barrel Connect EAP benefits. However, if you believe you or your family member was improperly denied access to an EAP benefit, you should contact ComPsych at 1-800-688-6330 to initiate the appeals process. For purposes of claim denials and appeals, see the "Claims and Appeals Procedures" section of this SPD as it relates to post-service claims.

# Tobacco Cessation Program

## How the Program Works

The Company offers a free tobacco cessation program to all employees and their spouses.

The Healthy Guidance program provides one-on-one telephone counseling, a customized plan, helpful ideas and resources, behavior modification techniques and strategies to help you break your tobacco habit. Once you complete the program, your paycheck deductions for medical, optional life, and critical illness coverage that you are enrolled in will be reduced to the non-tobacco user rate as soon as administratively possible. *See the "Contributions" section for more information about the tobacco user rates for medical and any alternatives that may apply*.

To enroll in the tobacco cessation program, go online to **guidanceresources.com** and enter "Biscuit" as the Company ID, or call 1-800-688-6330.

## Filing A Claim

You generally do not need to file claims for wellness benefits. However, if you believe that you or your eligible spouse was improperly denied access to the tobacco cessation benefit, you should contact ComPsych at 1-800-688-6330 to initiate the appeals process.

Due to the nature of the wellness benefit, claims will be considered post-service claims.

For purposes of claim denials and appeals, see the "Claims and Appeals Procedures" section of this SPD as it relates to post-service claims.

# Plan Information

**Plan Name**

The Health and Welfare Plan for Home Office and Field Management Employees of Cracker Barrel Old Country Store, Inc.

**Plan Number**

511

**Type of Plan**

A welfare benefit plan under ERISA providing medical and prescription drug, dental, vision, life insurance, AD&D, long-term disability, EAP, wellness, health care (including limited purpose) and dependent care FSA benefits.

**Type of Funding**

Benefits are funded through the general assets of the Company, through contracts of insurance, and/or through employee contributions.

The medical, prescription drug, dental and wellness benefits are self-insured. The vision, life insurance, AD&D, long-term disability, critical illness and Cracker Barrel Connect EAP are fully insured.

Employees and the Company contribute to the cost of the medical benefits. The Company pays the full cost of the basic life, basic AD&D, long-term disability and Cracker Barrel Connect EAP.

Employees pay the full cost of the dental, vision, optional life, critical illness, identity theft, health care and dependent care FSA benefits.

**Claims Administrators**

**Medical:**
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Suite 0002
Chattanooga, TN 37402-0002
1-844-383-2275

**Health Basics Plan**
**Medical & Prescription:**
Select Benefit Administrators, a division of Symetra Life Insurance Company (SBA)
PO Box 440
Ashland, WI 54806
1-866-357-1778

**Prescription Drug:**
Express Scripts
One Express Way
St. Louis, MO 63121
1-800-978-6227

**Dental:**
Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228-1699
1-800-223-3104

**Vision:**
Davis Vision By MetLife
Attn: Claims Processing
881 Elkridge Landing Rd
Linthicum Heights, MD 21090
1-877-393-8885

**Flexible Spending Accounts**:
Chard Snyder
P.O. Box 249
Fort Washington, PA 19034-9998
1-800-982-7715

**Life Insurance and AD&D:**
The Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, CT 06155
1-888-563-1124

**Long Term Disability**
The Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, CT 06155
1-888-301-5615

**Critical Illness – Voluntary Plan**
The Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, CT 06155
1-866-547-4205

**Critical Illness - Health Basics Plan**
Select Benefit Administrators, a division of Symetra Life Insurance Company (SBA)
PO Box 440
Ashland, WI 54806
1-866-357-1778

**Group Accident – Health Basics Plan**
Symetra Select Benefit, a division of Symetra Life Insurance Company (SBA)
PO Box 440
Ashland, WI 54806
1-866-357-1778

**Behavioral Health**
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Suite 0002
Chattanooga, TN 37402-0002
1-844-383-2275

**Cracker Barrel Connect Employee Assistance Program (EAP)**
ComPsych
NBC Tower
455 N Cityfront Plaza Drive, 13th Floor

Chicago, IL 60611-5322
1-800-688-6330

**Tobacco Cessation Wellness**
ComPsych
NBC Tower
455 N Cityfront Plaza Drive, 13th Floor
Chicago, IL 60611-5322
1-800-688-6330

**Identity Theft Protection – Voluntary Plan**
Allstate
1-800-789-2720

***Plan Year***

January 1 to December 31

***Plan Administrator***

Cracker Barrel Old Country Store, Inc.
305 Hartmann Drive
PO Box 787
Lebanon, TN 37088-0787
1-615-444-5533

***Plan Sponsor***

Cracker Barrel Old Country Store, Inc.
305 Hartmann Drive
PO Box 787
Lebanon, TN 37088-0787
1-615-444-5533

***Plan Sponsor's EIN***

62-0812904

***Participating Employers:***

Cracker Barrel Old Country Store, Inc.
CBOCS Supply, Inc.
CBOCS West, Inc.
CBOCS Pennsylvania, LLC
CBOCS Properties, Inc.
CBOCS Distribution, Inc.
CBOCS Texas, LLC

CB Music LLC
Rocking Chair, Inc.
Agincourt Industries, LLC d/b/a Maple Street Biscuits
CBOCS NY, LLC
CBOCS MD 1 LLC
CBOCS MD 2 LLC
CBOCS MD 3 LLC
MAPLE STREET BISCUIT RESTAURANTS, LLC

***Agent of Service of Legal Process:***

Cracker Barrel Old Country Store, Inc.
Legal Department
Attn: General Counsel
305 Hartmann Drive
PO Box 787
Lebanon, TN 37088-0787

This SPD describes the Plan in a summary manner. It is not a full statement of all Plan details. Additional governing Plan details are contained in the official Plan documents and insurance contracts or certificates of coverage, which together with this SPD govern operation of the Plan. In the event of any conflict between this SPD and the applicable Plan document, the official Plan document will govern.

# Administrative

The Company is the Plan Administrator and named fiduciary. The Plan Administrator is authorized to control and manage the operation and administration of the Plan. The Company, as named fiduciary, has delegated to the Claims Administrators responsibility for administering the Plan's claims procedures and for exercising other fiduciary functions described in the certificates of coverage.

In exercising their fiduciary functions, the Plan fiduciaries have discretionary authority to determine eligibility for benefits and to interpret the terms of the Plan. The Company has delegated claim determination authority to the Claims Administrators. Using their discretionary authority, the Plan fiduciaries may correct defects, make findings of fact, rectify any omission, or reconcile any inconsistency or ambiguity in the Plan.

Pursuant to the Plan, the Company can amend or replace the group insurance contract through which benefit claims are paid under the Plan. The Company also can amend the Plan, including to change the benefits offered or the required premium amounts. The Company's decision to amend or replace the group insurance contract or to amend the Plan is not a fiduciary decision that must be made solely in the interest of the employees but is a business decision that can be made solely in the Company's interest. Plan amendments include amendments to terminate coverage for some or all employees. If the Plan is terminated, the rights of a participant covered under the Plan are limited to the payment of eligible expenses incurred prior to termination.

## Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

- You have the right to examine, without charge, at the Plan Administrator's office and other specified worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You may obtain copies of all documents governing the operation of the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator. The Company may make a reasonable charge for the copies.
- You are entitled to receive a summary of the Plan's annual financial report (Form 5500 series) each year without charge.
- You are entitled to continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. *See the Continuation Coverage (COBRA) section of this SPD on the rules governing your COBRA continuation rights*.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plans, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan members and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you may take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the Plan fiduciary misuses the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose and the court finds your claim frivolous, the court may order you to pay these costs and fees.

If you have any questions about the Plan, contact the Benefits Call Center at 1-833-589-0714. If you do not receive a satisfactory response, you may contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Note: the rights described above apply to benefits that are subject to ERISA which include medical, prescription drug, dental, vision, health care FSA, limited health care FSA, life insurance, long-term disability insurance, AD&D, EAP and wellness benefits. The dependent care FSA, HSA and pre-tax premium payment plan are not subject to ERISA, so the above statement does not apply to those benefits.

## Claims Appeal Procedures

The Claims Appeal Procedures apply to the following benefits in the Plan:

- Health Savings Advantage Plan (medical, behavioral health, Cracker Barrel Connect EAP and prescription drug benefits)
- Traditional Health Care Plan (medical, behavioral health, Cracker Barrel Connect EAP and prescription drug benefits)
- Value Health Plan (medical, behavioral health, Cracker Barrel Connect EAP and prescription drug benefits)
- Health Basic Plan (preventive care, medical (MEC) and Cracker Barrel Connect EAP benefits)
- Health Care FSAs and Limited Health Care FSAs
- Tobacco cessation program

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

See the *Certificates of Coverage* for the claims and appeals procedures for vision, life insurance and AD&D, long-term disability, and critical Illness benefits as well as Health Basics Plan (fixed-payment indemnity benefits, outpatient prescription drug indemnity benefits, critical illness benefit, group accident benefit).

For purposes of these claims appeal provisions, “claim for benefits” means a request for benefits under the Plan. The term includes pre-service, post-service and urgent care claims.

- A pre-service claim is a claim for benefits under the Plan that is conditioned, in whole or in part, on approval of the benefits in advance of the service.
- A post-service claim is any other claim for benefits under the Plan for which you have received the service. Due to their nature, claims for EAP, health care FSAs and tobacco cessation wellness benefits are treated as post-service claims.

- An urgent care claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
  - Could seriously jeopardize your life or health or your ability to regain maximum function, or
  - In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment.
- A pharmacy care claim is:
  - Clinical: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.
  - Administrative: A request for coverage of a medication that is based on the Plan's benefit design.

If your claim is denied or if your medical (including behavioral health) or prescription drug coverage is rescinded, you will be provided with a written notice, and you are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow satisfies the minimum requirement for a full and fair review under applicable federal regulations.

**Notice of Denial of Claim/Adverse Benefit Determination**

The Claims Administrator's notice of the adverse benefit determination (denial) will include:

- Information sufficient to identify the claim involved, including the date of service, provider's name and claim amount
- The specific reason(s) for the denial, including any denial code and its corresponding meaning
- A reference to the specific Plan provision(s) on which the determination is based
- A description of any additional material or information needed to perfect your claim
- An explanation of why the additional material or information is needed
- A description of the Plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under Section 502(a) of ERISA if you appeal and the claim denial is upheld
- Information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and either the specific rule, or a statement that the rule was relied upon and that a copy of the rule will be provided free of charge upon request
- Information about the scientific or clinical judgment for any determination based on medical necessity, experimental treatment, or similar exclusion, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision
- A description of the expedited review process applicable to urgent care claims
- A statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or other entity established by federal law to assist individuals with the claims and appeals process
- A statement that upon request and free of charge, the diagnosis and treatment codes (and their corresponding meanings) that are applicable to your claim will be provided
- In addition to the above, for adverse benefit determinations for claims for disability coverage filed after April 1, 2018, the notice will include:

- A discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following, if applicable: (i) the views of health care professionals treating you and vocational professions who evaluated you that you presented to the Plan; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination; and (iii) a disability determination made by the Social Security Administration about you that you presented to the Plan; and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

**Urgent/concurrent care claims**: the notice will also include a description of the applicable urgent/concurrent review process. The Claims Administrator may also notify you or your authorized representative within 72 hours orally and then furnish a written notification. If you do not provide enough information for the Claims Administrator to determine what benefits are payable, you will be notified of the deficiency within 24 hours of receiving your claim. You will have a reasonable amount of time, not less than 48 hours, to provide the additional necessary information. You will then be notified of the Claims Administrator's determination as soon as possible, but not later than 72 hours after receipt of the additional information.

***Ongoing treatment***: If you are receiving ongoing treatments (i.e. treatment over a period of time or a specified number of treatments) that have been previously approved, any reduction or termination of ongoing treatments is an adverse benefit determination (including rescissions of coverage for medical claims). The Claims Administrator must notify you within a reasonable time prior to the reduction or termination of services to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. If you request to extend urgent care beyond the approved period of time or number of treatments, you will be notified of the Claims Administrator's decision as soon as possible, taking into account medical exigencies, but no later than 24 hours after receiving your claim, provided that your request was made at least 24 hours in advance of the end of the approved ongoing treatment. If your request to extend ongoing treatment does not involve urgent care, your claim will be treated as either a pre-service or post-service claim, as applicable.

***Pre-Service and post-service claims:*** If your claim is denied, you will be notified of the denial within 15 days (5 days for initial coverage review of home delivery pharmacy claims) of the date the claim was filed for pre-service claims and 30 days for post-service claims, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. For pre-service and post-service claims, if the Claims Administrator asks you for additional information to complete your claim, you have 45 days to provide the requested information.

If the Claims Administrator needs additional time to review your claim or review the additional information you are requested to provide, the timeframe for deciding your claim may be extended. If the Claims Administrator needs an extension, you will receive a notice before the end of the initial claim denial period explaining when you can expect to receive your decision. The extension period cannot last longer than 15 days after the end of the initial claim determination period.

**Appeals**

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage).

The Plan offers two mandatory levels of appeal. First and second level internal appeals are mandatory. This means that you must commence and complete the first and second level appeals process before you may seek any other internal or external remedy, including court action. The time frame allowed for Claims Administrator to complete its review is dependent upon the type of review involved (for example, pre-service, concurrent, post-service, urgent).

**First Level Internal Appeals**

You or your authorized representative must file your first level appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

For a claim involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. You or your authorized representative must contact the Claims Administrator at the number on the back of your identification card and provide at least the following information:

- The identity of the claimant
- The date(s) of the medical service
- The specific medical condition or symptom
- The medical provider's name
- The service or supply for which approval of benefits was sought
- Any reasons why the appeal should be processed on a more expedited basis

All other requests for appeals should be submitted in writing by you or your authorized representative. You or your authorized representative must submit a request for review to:

| Claims Administrator | Appeal Levels |
|---|---|
| Medical Claims and Behavioral Health | |
| BlueCross BlueShield of TN<br>1 Cameron Hill Cir, Suite 0002<br>Chattanooga, TN 37402-0002 | 1st Level Appeal: BlueCross BlueShield of TN<br>2nd Level Appeal: Cracker Barrel Benefits Appeals Committee |
| Prescription Claims | |
| Clinical Review:<br>Express Scripts<br>Attn: Clinical Appeals Department<br>P.O. Box 66588<br>St. Louis, MO 63166-6588<br>FAX: 1-877-852-4070<br><br>Administrative Review:<br>Express Scripts<br>Attn: Administrative Appeals Department<br>P.O. Box 66587<br>St. Louis, MO 63166-6587<br>FAX: 1-877-328-9660 | Initial coverage review: Prescribing physician submits Prior Authorization<br>1st, 2nd Level and 3rd Level External Appeals: Express Scripts<br>4th Level: Cracker Barrel Benefits Appeals Committee |
| Delta Dental of Tennessee | |
| Customer Service Toll-Free Number:<br>800-223-3104 | 1st Level: Delta Dental, 2nd Level: Cracker Barrel Benefits Appeals Committee |
| EAP Claims and Tobacco Cessation Program | |
| ComPsych<br>NBC Tower<br>455 N. City Front Plaza Drive, 13th Floor<br>Chicago, IL 60611-5322 | 1st Level Appeal: ComPsych<br>2nd Level Appeal: Cracker Barrel Benefits Appeals Committee |
| Health Care FSA Claims | |
| Chard Snyder<br>P.O. Box 249<br>Fort Washington, PA 19034-9998 | 1st Level Appeal: Chard Snyder<br>2nd Level Appeal: Cracker Barrel Benefits Appeals Committee |
| Health Basics (MEC) | |
| Symetra<br>P.O. Box 440<br>Ashland, WI 54806 | 1st Level Appeal: Symetra<br>2nd Level Appeal: Cracker Barrel Benefits Appeals Committee |

First level internal appeals are reviewed by the Claims Administrator. These appeals are reviewed by an appropriate individual who did not make the initial benefit determination and who is not subordinate to such person, or a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

When the Claims Administrator considers your appeal, the Claims Administrator will not rely upon the initial benefit determination. If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who

was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination. The health care professional whose advice was obtained in connection with your appeal shall be identified.

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and/or appeal and allow you to submit opinions and comments. "Relevant" means that the document, record, or other information:

- Was relied on in making the benefit determination
- Was submitted, considered, or produced in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination
- Demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan and applied consistently for similarly situated claimants
- Is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination

The Claims Administrator will also provide you with, free of charge, any new or additional evidence considered, relied upon, or generated in connection with your claim. You will also be allowed to review your claim file and to present evidence and testimony as part of the internal claims and appeals process.

***Notifications of the Outcome of the Appeal***

**If you appeal a claim involving urgent/concurrent care,** the Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

**If you appeal any other pre-service claim**, the Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

**If you appeal a post-service claim**, the Claims Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

***Appeal Denial and Notice of Denial of Appeal***

If your appeal is denied, the denial will be considered an adverse benefit determination. The written notification from the Claims Administrator will include all of the following information:

- Information sufficient to identify the claim involved, including the date of service, the provider's name, and the claim amount
- The specific reason(s) for the denial, including any denial code
- A reference to the specific Plan provision(s) on which the decision is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits

- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring civil action under Section 502(a) of ERISA
- Information regarding the external review process and instructions on how to request an external review
- If an internal rule, guideline or protocol, or other similar criterion ("rule") was relied upon in making the determination to deny your appeal, either the specific rule or a statement that the rule was relied upon and that a copy of the rule will be provided free of charge upon request
- If the denial is based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your circumstances, or a statement that such explanation will be provided free of charge upon request
- A statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or other entity established by federal law to assist individuals with the claims and appeals process

Upon your request and free of charge, you will also be provided with any diagnosis and treatment codes (and their corresponding meanings) applicable to your medical (including behavioral health) claim.

In addition to the information applicable to all benefit claims and listed at the beginning of this section, above, in the case of an adverse benefit determination on review for claims for disability coverage filed after April 1, 2018, your written notice will also include the following:

- A description of any contractual limitations period that applies to your right to bring an action under Section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for your claim; and
- A discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following, if applicable: (i) the views of health care professionals treating you and vocational professionals who evaluated you, and that you presented to the Plan; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination; and (iii) a disability determination made by the Social Security Administration about you that you presented to the Plan.

**Second Level Internal Appeals (Fourth Level for Pharmacy Claims)**

If you are not satisfied with the decision in response to the first level internal appeal, you may submit a second level internal appeal.

You must submit the second level internal appeal within 90 calendar days of receiving the Claims Administrator's decision in response to the first level internal appeal.

You should describe the reasons why you disagree with the first level internal appeal decision and provide any further information you think is relevant. You may submit a second level internal appeal to:

**Benefits Appeals Committee**
**Cracker Barrel Old Country Store, Inc.**

**305 Hartmann Drive**
**Lebanon, TN 37087**

If the second level internal appeal is urgent, you must identify to the Appeals Committee that it is urgent and describe the circumstances that make the appeal urgent.

Second level internal appeals are reviewed by the Company's appeals committee. These appeals are reviewed by persons not involved in making the initial decision or the first level appeal decision and who are not subordinate to such persons. The Company's appeals committee may also use independent organizations to provide medical specialists practicing in the same or similar specialty as consultants for determining a second level appeal.

The same procedures and timeframes that applied to your first level appeal will also apply to your second level appeal.

**Effect of Final Appeal Determination**

Once you have submitted a claim and completed all available levels of internal appeal described above, you will have exhausted the appeals process. If you want to further challenge a benefit denial, you may have the right to request an external review and you will have the right to sue the Plan in federal court.

If the Claims Administrator (or the Appeals Committee for second level internal appeals) does not comply with all of the procedures described above, you will generally be treated as though you had exhausted the internal appeals process. As a result, you may request an external review or sue the Plan even though you have not completed all required levels of internal appeals.

However, if the violation of these procedures is "de minimus," you will not be treated as though you exhausted the internal appeals process.

The violation will be considered de minimus if it is not likely to cause prejudice or harm to your claim, it was for good cause or due to matters beyond the Plan's control and was in the context of an ongoing, good faith exchange of information between you and the Plan.

**External Review**

External reviews are available only for claims that involve medical judgment (clinical reasons or exclusions for experimental or investigational services or unproven services), claims that involve rescission of coverage, or as otherwise required by applicable law. Once you have submitted such a claim and completed all available levels of appeal described above, you can request that your claim be reviewed by an independent review organization ("IRO").

You or your representative may request a standard external review by sending a written request to the address set out in the final adverse benefit determination.

You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the same administrator as listed in the chart above. A request must be made within 180 days after the receipt of a notice of a final adverse benefit determination (the denial of your second level internal appeal).

An external review request should include all of the following:

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

An external review will be performed by an IRO. The Claims Administrator has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review
- An expedited external review

**Standard External Review**

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

- A preliminary review by the Claims Administrator of the request.
- A referral of the request by the Claims Administrator to the IRO.
- A decision by the IRO.

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

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

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

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of the receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

The Claims Administrator will provide to the assigned IRO the documents and information considered in making the Appeals Committee's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by the Appeals Committee
- All other information or evidence that you or your Physician submitted.

If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and the Claims Administrator will include it with the documents forwarded to the IRO.

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

Upon receipt of a Final External Review Decision reversing the Appeals Committee's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

**Expedited External Review**

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

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

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.

- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

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

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

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

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

You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

## For Cracker Barrel Connect EAP

You generally do not need to file claims for the Cracker Barrel Connect EAP benefits. However, if you believe you or your family member was improperly denied access to an EAP benefit, you should contact ComPsych at 1-800-688-6330 to initiate the appeals process. For purposes of claim denials and appeals, see the "Claims and Appeals Procedures" applicable to post-service claims as described above.

## For Tobacco Cessation

Tobacco Cessation Wellness services are post-service claims subject to the review procedures and time limits applicable to post-service claims as described above (unless limited to medical and prescription drug benefits). Contact ComPsych at 1-800-688-6330 to initiate the appeals process.

### For Health Care FSA and Limited Health Care FSA

Health Care FSA and Limited Health Care FSA claims are post-service claims subject to the review procedures and time limits applicable to post-service claims as described above, unless noted to apply only to medical claims (including behavioral health) and prescription drug, dental and vision claims. Health care FSA appeals should be written to:

Chard Snyder
P.O. Box 249
Fort Washington, PA 19034-9998

Optional arbitration arising out of a claim for benefits is also available for the Health FSA and Limited Health FSA.

### For Dependent Care FSA

As indicated earlier in this summary, the dependent care FSA is not subject to ERISA. For this benefit, a request for review of a denied claim must be made in writing within 60 days after receiving notice of the initial denial of the claim.

The decision on review will be made within 60 days after the receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.

Requests for appeal of a denied dependent care FSA claims should be made to:

Chard Snyder
P.O. Box 249
Fort Washington, PA 19034-9998

### For Health Basics Plan Fixed-Payment Indemnity, Outpatient Prescription Drug Indemnity, Critical Illness and Group Accident

*For claims and appeal procedure details, see the Certificates of Coverage for your fixed-payment indemnity, outpatient prescription drug indemnity, critical illness and group accident benefits.*

### For Life Insurance, AD&D, Long-Term Disability and Critical Illness

The life insurance, AD&D and long-term disability program are fully insured plans underwritten and insured by The Hartford. Claims and appeals should be filed in accordance with the claims procedure provided in the Certificates of Coverage. The insurers are responsible for reviewing and making payment on benefit claims.

The denial or termination notice you receive from the insurance company will state your rights as an employee or beneficiary to appeal the decision. The insurance company's decision is final and binding unless determined by a court to be arbitrary and capricious. *For claims and appeal procedure details, see the Certificates of Coverage for your life insurance and AD&D, long-term disability benefits and Critical Illness.*

As insurer, The Hartford is the appropriate named fiduciary for these specific benefits and has the final decision about the benefits payable under these insurance contracts.

## Eligibility Appeals

Eligibility determinations with respect to the Plan that are not part of a claim for benefits under the Plan are not governed by ERISA claims procedures, but instead shall be made in accordance with the following reasonable procedures, except as otherwise set forth in an applicable benefit booklet.

In general, the following appeals process applies to events related to eligibility determination and enrollment windows. Examples include:

- If you were denied enrollment in one or more benefit plans because you did not enroll within a newly eligible or open enrollment window.
- If you were denied enrollment in one or more benefit plans because you did not enroll within a qualified life event enrollment window.
- Your dependent verification documentation was denied.
- Your qualified life event documentation was denied.
- Any other eligibility related event resulting in denial of benefit enrollment.

**First Level of Appeal**

Employees may provide an appeal to WEX by calling 1-833-589-0714. Employees must start the process within 180 calendar days after they are notified of the denial. The appeal should include the employee's name, employee ID, dependent name (if applicable), and a summary of the situation and facts surrounding the request, such administrative and technical issues, timing and dates, and communications with management or vendors related to the situation. The employee may be required to upload documentation to www.mybenefitelections.com. WEX will provide an eligibility decision within 30 calendar days of receipt. If special circumstances require an extension of time for processing the request, you will receive a written notice before the end of the initial 30-day period, and this extension will not exceed an additional 30 days. The notice will explain why an extension of time is necessary and when the Plan Administrator expects to render a decision.

**Second Level of Appeal**

If you disagree with the first level appeal response, you may file a second level appeal within 60 calendar days of receiving the first level appeal decision. The second level appeal should include the same documentation outlined above, information regarding the first level appeal decision, and a written letter describing the reasons why you disagree with the first level appeal, along with any further information relevant to the situation. The second level appeal should be sent to:

**Benefits Appeals Committee**
**Cracker Barrel Old Country Store, Inc.**
**305 Hartmann Drive**
**Lebanon, TN 37087**

Second level internal appeals are reviewed by the Company's appeals committee. These appeals are reviewed by persons not involved in making the initial decision or the first level appeal decision and who are not subordinate to such persons.

The second level appeal will be reviewed by the appeals committee and a response will be provided to you within 60 calendar days of receipt via either the email address on file or via written letter. If necessary, the period may be extended for an additional 60 days. In this case, you will be notified in writing prior to the extension and a decision shall be made as soon as possible, but no later than 120 days after receipt of the request for review.

*You must fully follow and exhaust the Plan's eligibility appeal procedures before you can file a lawsuit in state or federal court. Except as otherwise provided in the applicable benefit booklet(s), a suit for benefits under the Plan must be brought within two years following (i) the date on which the claim for eligibility arose or, if later, (ii) the date on which the Plan's procedures with respect to that eligibility determination were exhausted.*

## Qualified Medical Child Support Order (QMCSO)

The Company is required to provide medical (including behavioral health), prescription drug, dental and vision coverage to your dependent children if the Plan receives a valid qualified medical child support order (QMCSO) requiring coverage in these plans. A qualified medical child support order is an order issued by a court or by an administrative agency pursuant to state law directing a person to provide health coverage for an otherwise eligible dependent child, even if the person is the non-custodial parent. A medical child support order must include all of the following to be QMCSO:

- Child's name and address for whom coverage must be furnished
- Description of the coverage to be furnished
- Length of time for which coverage must be furnished
- The benefit option for which the coverage must be provided

The order may not require the Plan to provide benefits not otherwise available under the Plan. If you are not a participant in the Plan, be aware that the Plan Administrator may be required to enroll you as a participant and your dependent without your consent in order to comply with the order. You will be required to pay appropriate contribution amounts and the Company may withhold from your paycheck any contributions required for such coverage.

To notify Cracker Barrel of a qualified medical child support order, call the Benefits Call Center at 1-833-589-0714. You may obtain, without charge and upon request, a copy of the Plan's QMCSO procedures from the Plan Administrator.

Please note: if you believe that a dependent child is no longer required to be covered under your Plan contrary to the terms of the QMCSO, you must provide the Plan Administrator with a court order providing that the dependent may be removed from coverage.

## Continuation of Coverage During a Leave of Absence

Coverage for some benefits may continue during certain periods that you are not actively employed. These periods include:

- When you are on an authorized leave of absence, including a military leave of absence.
  - Coverage will continue for up to a maximum of six months unless state or federal law dictates otherwise. Employees whose coverage cancels upon 6 months from the start of their leave will be eligible to re-enroll in any benefit elections upon their return to work from leave.

If eligible to continue coverage during your leave of absence, you must make arrangements to pay the required participant contributions for as long as you are eligible to continue coverage.

When your eligibility for coverage ends during your leave of absence, you may have the right to continue your group health plan coverage under COBRA or USERRA, as applicable. For information regarding continuing group health plan coverage under COBRA or USERRA, *see the Administrative section of this book, or call the Benefits Call Center at 1-833-589-0714*.

### Life Insurance

If you are absent from work, you may be able to continue your life insurance coverage for a specified time period, as long as you make the required premium payments. The reasons and time periods are as follows:

- Due to sickness or injury, you may be able to continue your life insurance coverage for six months.
- Due to FMLA leave, you may be able to continue your life insurance coverage for the period permitted by state or federal FMLA.
- Due to any other scheduled and authorized leave of absence, including a military leave, you may be able to continue your life insurance coverage for six months.

Continuation of coverage is subject to certain time limits and conditions as stated in the group policy.

Typically, in order to be eligible to become insured or receive an increase in your amount of insurance, you must be actively at work performing your customary duties at your normal place of business. If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your amount of insurance would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work.

## Continuing Life Insurance after Termination

If your life insurance coverage ends for a reason other than failure to pay premiums or termination of the group contract, you have the right to apply for continued coverage for you and your dependents under The Hartford Portability Rider. Certain conditions apply.

Continuing your coverage under the Portability Rider means you apply for term life coverage under the group contract and pay The Hartford directly. You may elect the Portability Rider for your Basic Life, Optional Employee Life, Optional Spouse and Child Life insurance coverage.

**Conversion Privilege**

In certain circumstances, you may convert your life insurance coverage to an individual life policy. Conversion includes all Basic and Optional Life Coverage. It does not include any additional benefits, such as Accelerated Death and AD&D. To convert your life insurance, you must apply and pay the first premium within 31 days of the date any part of your life insurance under the Policy terminates.

*See your Certificate of Coverage for complete details regarding portability and conversion.*

## Continuation of Coverage under COBRA

Continuation of Coverage under COBRA applies to the following benefits in the Plan:

- Health Savings Advantage Plan (medical, behavioral health, Cracker Barrel Connect EAP and prescription drug benefits)
- Traditional Health Care Plan (medical, behavioral health, Cracker Barrel Connect EAP and prescription drug benefits)
- Value Health Plan (medical, behavioral health, Cracker Barrel Connect EAP and prescription drug benefits)
- Health Basics Plan (preventive care medical (MEC), Cracker Barrel Connect EAP, fixed-payment indemnity*, outpatient prescription drug indemnity* and group accident benefits*)
- Health Care FSAs and Limited Health Care FSAs
- Dental
- Vision
- Cracker Barrel Connect EAP

**Fixed-payment indemnity, outpatient prescription drug indemnity and group accident benefits are not required to be offered under COBRA but may be continued as part of the Health Basics Plan – as described in the Certificate of Coverage for each benefit.*

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you and your spouse or dependent children may elect to temporarily continue the coverage described above under the Plan respectively, in certain instances where coverage would otherwise end because of a "qualifying event".

Your covered spouse or dependent children (qualified beneficiaries) have the right to elect COBRA coverage even if you do not elect it.

Qualifying events are as follows:

- **In the event of your termination of employment or reduction in hours**: You and your covered spouse or dependent children.
- **In the event of your death, divorce or legal separation:** Your covered spouse or dependent children.
- **In the event your dependent children cease to qualify as a covered dependent:** The dependent children.

In addition, a child who is born to you, or adopted or placed for adoption with you during the COBRA continuation period, is also a qualified beneficiary if the child is added within 30 days of the qualifying event.

Nonresident aliens, with no U.S. source earned income are not considered qualified beneficiaries.

**Length of Continuation Coverage**

You and your covered spouse and dependent children may continue coverage under the Plan for up to 18 months if you lose coverage because your:

- Employment terminates for any reason other than your gross misconduct
- Hours worked are reduced so that Plan coverage ends

However, certain events may extend the 18-month COBRA continuation period, such as:

- If your covered spouse or dependent children experience a second qualifying event while on COBRA coverage due to your employment termination or reduction in hours, they may elect to extend the COBRA continuation period for up to an additional 18 months, for a total of 36 months of COBRA continuation coverage from the date of the employment termination or reduction in hours, provided you notify the Plan Administrator within 60 days of the event. For example, assume that you elect COBRA coverage because of your employment termination. If you died during the first 18 months of coverage, your spouse and dependent children may elect to continue COBRA coverage for up to 36 months from your date of employment termination.
- If you or your covered spouse or dependent children are disabled (as determined by the Social Security Administration) on the date of the qualifying event or at any time during the first 60 days of COBRA continuation coverage due to employment termination or a reduction in hours, each qualified beneficiary (whether disabled or not) may extend COBRA continuation coverage for up to 11 months, for a total of 29 months of COBRA continuation coverage. To qualify for this disability extension, you must notify the COBRA administrator before the end of the original 18-month COBRA continuation period, and within 60 days after the latest of:
  - The date of Social Security issues a disability determination
  - The date on which the qualifying event occurred
  - The date on which you or your covered spouse or dependent children lost coverage under the Plan as a result of the qualifying event

- If, during the additional 11-month continuation period, Social Security determines the qualified beneficiary is no longer disabled, you must notify the COBRA administrator within 30 days of the determination.
- If a second qualifying event occurs at any time during the 29-month disability continuation period, each qualified beneficiary (whether disabled or not) may further extend COBRA continuation coverage for an additional seven months, for a total of 36 months of COBRA continuation coverage from the date of the initial qualifying event.
- If you become entitled to Medicare while employed and then a second qualifying event happens within 18 months, your covered spouse and dependent children may elect COBRA continuation coverage for an additional 18 months, for a total of 36 months of COBRA continuation coverage from the date of the initial qualifying event.

Your covered spouse and dependent children may continue medical coverage under the Plan for up to 36 months if their coverage would be reduced or terminated because you:

- Die
- Become divorced or legally separated

In addition, dependents who no longer meet the eligibility requirements of a dependent may continue coverage for up to 36 months, beginning from the date of the qualifying event.

**Giving Notice That a COBRA Event Has Occurred**
To qualify for COBRA continuation coverage, you must notify the Benefits Call Center within 60 days of the event if coverage ends due to:

- Divorce or legal separation
- A child's loss of dependents status

If you notify the Benefits Call Center within 60 days of the event, COBRA coverage will be effective the date of the qualifying event. The COBRA administrator will provide you or your covered spouse or dependent children with information about COBRA continuation rights if coverage ends due to:

- Your death
- Your loss of employment
- Your reduced hours

**Electing and Paying for COBRA Continuation Coverage**

You and/or your covered spouse and dependent children must elect to continue coverage within 60 days of the later of the date:

- Of the qualifying event
- The Company notifies you or your covered spouse or dependent children of your right to continue coverage as a result of a qualifying event
- The date the coverage would otherwise cease if COBRA coverage is not elected

You will be required to pay 102 percent of the full cost of coverage. Premiums will be adjusted during the continuation period if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, you may be required to pay up to 150 percent of the full cost of coverage during the extended coverage period.

**Please note**: You will be required to pay 100 percent of the full cost of coverage for the continuation of preventive services (MEC), fixed-payment indemnity medical benefits, outpatient prescription drug indemnity benefits and group accident benefits under the Health Basics Plan.

Your first COBRA payment will be due 45 days after the election to continue coverage is received by the COBRA administrator.

**Waiving COBRA Continuation Coverage**

If a qualified beneficiary initially waives COBRA coverage and then elects coverage within the 60-day election period, COBRA coverage will be retroactive to the date of the qualifying event. The maximum COBRA continuation coverage period begins on the date of the qualifying event.

**When COBRA Continuation Coverage Ends**

COBRA continuation coverage will end for a qualified beneficiary on the earliest of:

- The date on which the applicable continuation period (18/36/29 months) ends
- The date required payments are not made
- The end of the month for the first of the following events to occur after COBRA election:
  - The qualified beneficiary becomes covered under another group plan
  - The qualified beneficiary becomes entitled to Medicare
- The date the Plan is terminated for all of the Company's employees
- In the case of a qualified beneficiary who was determined to be disabled within the first 60 days of continuation coverage for purposes of the Social Security Act, the end of the month the qualified beneficiary is determined to be no longer disabled.

**Continuation Coverage for a Health Care or Limited Health Care FSA**

If your employment terminates for any reason other than your gross misconduct while you were contributing to a health care FSA, you or a qualified beneficiary may continue contributions, on an after-tax basis, until the end of the calendar year in which your employment terminated. You may submit claims through March 31 of the following year for eligible health care expenses incurred through December 31 of the prior year. If you do not elect COBRA continuation coverage for your health care FSA, you will only be able to submit claims for reimbursements that were incurred prior to your termination of employment. In that case, any claims should be submitted within 90 days of losing eligibility for the plan. If you do not have qualifying reimbursement claims prior to your termination and you do not elect COBRA for your FSA, any remaining balance in your FSA will be forfeited.

**Current Address and Additional Information**

It is important that you keep the Plan Administrator informed of your current address and the current address of all persons who are or may become qualified beneficiaries. You may obtain additional information regarding questions you might have on your COBRA rights from the Plan Administrator.

## Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services.

**Reemployment Rights**

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service
- You have five years or less of cumulative service in the uniformed services while with that particular employer
- You return to work or apply for reemployment in a timely manner after conclusion of service
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

In the event that you are reemployed by the Company, you shall be entitled to resume coverage under the Plan. The time for returning to work depends on the length of your leave for military service. The term “military service” means the Armed Forces of the United States, including the Army National Guard and the Air National Guard when you are engaged in active duty for training, in active duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

**Health Insurance Protection**

If you leave your job to perform military service, we will continue your existing coverage under the Plan as though you were actively at work for up to six months. After six months, you will have the right to elect, within 60 days of the date your eligibility for coverage as an active employee ends, to continue your existing group health plan coverage (medical, dental, vision, and health FSA) under the Plan for you and your dependents for up to 24 months while in the military at the applicable contribution rate.

Even if you don’t elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

**Enforcement**

The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) are authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at www.dol.gov/vets. An interactive online USERRA Advisor can be viewed **www.dol.gov/elaws/userra**.

If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation.

You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS and may be viewed on **www.dol.gov/vets/programs/userra/poster.htm.**

## Coordination of Benefits (C.O.B.)

The medical/prescription drug and dental plans each have a coordination of benefits provision that determines how benefits are coordinated with any other health coverage under which a participant or dependent is covered. Additional health coverage would include another health care plan, Medicare or other insurance coverage resulting from personal injury worker's compensation. The coordination of benefits provision ensures you receive the correct level of benefits under each Plan.

To establish how coordination of benefits works, it must first be determined which plan is primary, and which plan is secondary. The primary plan is the plan that pays benefits first. The plan that pays benefits next is called the secondary plan. The Cracker Barrel Plan will generally be considered primary for you. The following rules determine which plan is primary and which plan is secondary:

1. This Plan will always be secondary to medical payment coverage or personal injury coverage under any auto liability or no-fault insurance policy.
2. The plan that covers the patient as an employee, rather than as a dependent, will be considered primary.
3. If a child is covered under both parents' plans, except in the case of a dependent child whose parents are divorced or separated, the parent whose birthday falls earlier in the year will be considered to have the primary plan for covering the dependent child. If both parents have the same birthday, the parent whose plan has covered the child longer will be considered the primary plan. If the other plan does not have this provision regarding birthdays, the rule in the other plan will determine the order of benefits.
4. If a child is covered under both parents' plans, and the parents are divorced or separated, if a court has established financial responsibility for a child's health care expenses, the plan of the parent with the financial responsibility will be considered primary. If the parent of the child who has financial responsibility does not have coverage, but the parent's spouse does, the spouse's plan is primary. If there is no such court decree, the primary plan will be determined in the following order of priority:
    - The plan of the parent with custody

- The plan of the spouse of the parent with custody
- The plan of the parent not having custody
- The plan of the spouse of the non-custodial parent

5. If a court decree has given both parents joint custody and has not stated which parent is financially responsible for a child's health care expenses, the birthday rule will establish the primary plan.
6. The plan that covers the patient as an employee or as a dependent of an employee will be considered primary before a plan that covers the patient as a former employee or as a dependent of a former employee.
7. If a person has coverage both under COBRA and under another plan, the other plan will be considered primary over a COBRA plan.
8. If none of the above rules determines the primary plan, the plan that covered the member the longest will be considered the primary plan.

When this Plan is primary, it will pay up to the amount established for the service provided. All remaining expenses may be submitted to a secondary plan, the other plan's coordination provision will determine how that plan will pay.

When this Plan is secondary, the Plan will pay the amount that it would have paid had it been primary, minus the amount paid by the other plan (such that coordination might result in the Company plan paying zero benefits).

From time to time you may receive correspondence asking you to furnish information about any other health care coverage for you or your dependents.

### Medicare

If you remain actively employed after reaching age 65, you or your spouse who is over age 65 may choose to remain covered under this Plan or you may choose to drop your Company coverage and designate Medicare as the primary payor of benefits. If you choose to remain covered under this Plan, this Plan will be the primary payor of benefits and Medicare will be secondary. If you choose Medicare as primary, coverage under this Plan will end. If you do not specifically choose one of the options, this Plan will continue to be primary. If you are under age 65 and your spouse is over age 65, your spouse can make his or her own choice.

## General Provisions

### Assignment of Benefits

The Plan is intended to be used exclusively to provide benefits to you and, under certain circumstances, to your survivors. Except as provided in the Plan, the benefits under this Plan:

- Are not in any way subject to your debts or other obligations or the debts or other obligations of any person covered under this Plan.
- May not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered; and

- Shall not be subject to being taken by your creditors or the creditors of any person covered under this Plan by any process whatsoever.

Any attempt to cause the benefits under this Plan to be so subjected will not be recognized, except to the extent required by law (e.g., as required by the tax withholding provisions of applicable law) or as allowed for life and AD&D insurance, which is assignable by you prior to loss.

Similarly, except as expressly provided in the Plan (including, with respect to a particular benefit, in the applicable benefit booklet or other coverage document), any other rights and/or obligations under the Plan to or with respect to you or any person covered under this Plan may not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered, and any attempt to cause such right or obligation to be so subjected will not be recognized except to the extent required by law (such as by the designation of any authorized representative pursuant to the Plan's claims procedures).

The Plan may (and in the case of in-network medical services, typically will) pay health care benefits directly to the provider on the employee or dependent's behalf, but this is not an assignment of benefits, and the provider will not be considered an assignee (or to have received an assignment of benefits) under the Plan. Additionally, an employee or dependent may designate an authorized representative for purposes of the claim, review the appeal procedures, but the authorized representative will not be considered an assignee (or to have received an assignment of benefits) under the Plan.

## Conformity with Statutes

Any provision of the Plan which is in conflict with statutes which are applicable to the Plan is hereby amended to conform to the minimum requirements of said statutes.

## Applicable Law

The Plan shall be governed by ERISA and all other applicable laws that are not preempted by ERISA. Except as required by ERISA or any other applicable law, the validity, construction and administration of the Plan shall be determined under the laws of the State of Tennessee. Any action brought to enforce any claim to obtain any benefit under the Plan shall be litigated in the U.S. District Court for the Middle District of Tennessee.

## Incapacity

If, in the opinion of the Plan Administrator, an employee or dependent for whom a claim has been made is incapable of furnishing a valid receipt of payment due, and in the absence of written evidence to the Plan of the qualification of a guardian or personal representative for his or her estate, the Company may on behalf of the Plan, at his or her discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the Plan's Obligation to the extent of such payment.

## Disputed Payments

If the Plan Administrator is in doubt concerning the entitlement of any person to any benefit claimed, the Plan Administrator may suspend such benefit until the Plan Administrator has determined, based on objective evidence satisfactory to the Plan Administrator, whether such person is entitled to such benefit. The Plan Administrator may also file an appropriate legal determination of the entitlement of any benefit under the Plan, at its discretion.

## Legal Actions

No action at law or in equity shall be brought to recover on the benefits from the Plan unless such individual has exhausted the claims and appeal process in accordance with the requirements of the Plan and filed the civil action within the later of the time period specified in the applicable Certificate of Coverage or two years from the date he or she receives a final adverse determination of his or her claim on review, as provided in the claims and appeal procedures. You do not need to request an external review, if applicable, before filing suit.

## Limits on Liability

Liability under the Plan is limited to the services and benefits specified, and the Company shall not be liable for any obligation the employee or dependent incurred in excess thereof. The liability of the Plan shall be limited to the benefits payable under the terms of the Plan and shall not include any liability for suffering or general damages or be construed to impose any further costs or to give any person other than employee or dependents any rights or remedies under the Plan.

## Lost Distributees

Any benefit payable under the Plan shall be deemed forfeited if the Plan Administrator is unable to locate the employee or dependent to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the employee or dependent for the forfeited benefits within the time prescribed in each individual plan's claim filing procedure section of this document.

## Medicaid Eligibility and Assignment of Rights

The Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a state Plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as an employee or dependent or in determining or making any payment of benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid Plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and the Plan has a legal liability to make payments for the same services, supplies or treatment, payment under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the Plan.

## Misstatements/Misrepresentation

Any misstatement in age, sex, length of employment, marital status, dependent status, date of employment or birth of a dependent, or any other incorrect information relating to you or your dependents, shall be corrected when it becomes known that any such misstatement of fact has occurred. If you or your dependents are enrolled in the Plan based on any misstatement and thus, are not eligible for coverage under the Plan, you and/or your ineligible dependents will be removed from coverage under the Plan prospectively when it becomes known that any such misstatement of fact has occurred.

Any intentional misrepresentation of material fact or act, practice or omission causing fraud will result in coverage for an employee or dependent to be canceled retroactively to the date the covered employee or covered dependents became ineligible for coverage. The Plan will provide 30 days advance written notice to the participant that his or her coverage will end on the date identified in the notice. A participant's failure to notify the Plan Administrator of a change in eligibility status will constitute fraud. The Plan Administrator shall have the right to recover from any party, including the employee, and the employee shall indemnify the Plan for the amount of, any benefits paid from the Plan as the result of any such fraud or misstatement which constitutes an intentional misrepresentation of material fact.

## Modifications or Amendments to the Plan

The Company intends to provide benefits under the Plan indefinitely. However, the Company may at any time:

- Change the contributions you must pay for benefits.
- Amend, suspend, or terminate the benefits provided to you in the Plan.

If the Company, through its acting management, decides that the Plan benefits should be amended or the Plan terminated for any reason, a designated representative of the Company will prepare a written notice approved and signed by the Plan Administrator or any other person to whom the Company gives authority to amend or terminate the Plan benefits.

The notice will be given to you within the time allowed by federal and state law. Your Plan Administrator can tell you who is responsible for approving Plan amendments or a Plan termination and the time in which notice of amendments or termination must be provided to you.

If the Plan is amended or terminated, it will not affect the payment of any claims for expenses incurred prior to the time the change is made.

## Nature of Obligation to Continue Employer Contributions

Although it is the intention of the Company that this Plan shall be continued, the Plan is entirely voluntary on the part of the Company, and the continuance of the Plan and the payments thereunder are not assumed as a contractual obligation of the Company or any employer.

## No Right to Employment

Nothing contained in the Plan, or this summary, may be construed to give an employee any right to employment by the Company for any duration whatsoever.

## Plan Assets

Except as otherwise required by ERISA, other applicable law, and regulations thereunder, no assets of this Plan shall be required to be held in trust. The Company may, however, in its sole discretion, establish one or more trusts to hold such assets and such trusts may or may not, as determined by the Company, contain such provisions as are necessary to qualify them for exemption from applicable federal, state, local and other taxes.

## Physical Examinations Required by the Plan

The Plan, at its own expense, shall have the right to require an examination of a person covered under the Plan when and as often as it may reasonably require during the pendency of a claim.

## Workers' Compensation Not Affected

The Plan is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

## Subrogation and Reimbursement

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

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

The right to reimbursement means that if a third party causes or is alleged to have caused a sickness or injury for which you or a dependent receives a settlement, judgment, or other recovery from any third party, you or a dependent must use those proceeds to fully return to the Plan 100 percent of any benefits you or a dependent received for that sickness or injury.

**Reimbursement Example**: Suppose you or a dependent is injured in a boating accident that is not your or your dependent's fault, and you or a dependent receives benefits under the Plan as a result of your or your dependent's injuries.

In addition, you or a dependent receives a settlement in a court proceeding from the individual who causes the accident. You or a dependent must use the settlement funds to return to the Plan 100 percent of any benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you or a dependent to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages
- Your or a dependent's employer (for example Workers' Compensation cases)
- Any person or entity who is or may be obligated to provide benefits or payments to you or a dependent, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Worker's Compensation coverage, other insurance carriers or third party administrators
- Any person or entity that is liable for payment to you or a dependent on any equitable or legal liability theory

You (and your dependent) agree as follows:

- You and your dependent will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.
- Your or your dependent's failure to cooperate with the Plan is considered a breach of the Plan's terms. As such, the Plan has the right to terminate your or your dependent's benefits, deny future benefits, take legal action against you or your dependent, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been causes or caused by any third party to the extent not recovered by the plan due to you, your dependent or your representative not cooperating with the Plan. If the Plan incurs attorney's fees and costs in order to collect third party settlement funds held by you, your dependent or your representative, the Plan has the right to recover those fees and costs from you, your dependent or your representative. You, your dependent and your representative will also be required to pay interest on any amounts you, your dependent or your representative hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you or your dependent receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- Regardless of whether you or your dependent has been fully compensated or made whole, the Plan may collect from you or your dependent the proceeds of any full or partial recovery that you, your dependent or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine", claim of unjust enrichment, Common Fund Doctrine or claim for attorney's fees, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If you or your dependent receives any payment from any party as a result of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you or your dependent shall hold those funds in trust, either in a separate bank account in your or your dependent's name or in your attorney's trust account. You and your dependents agree that you and your dependents will serve as a trustee over those funds to the extent of the benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your or your dependent's own negligence.
- Upon the Plan's request, you and your dependent will assign to the Plan all rights of recovery against third parties, but only to the extent of the benefits the Plan has paid for the sickness or injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your or your dependent's name, which does not obligate the Plan in any way to pay you or your dependent part of any recovery the Plan might obtain up to the amount of benefits the Plan has paid on your or your dependent's behalf.
- You or your dependent may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the full and complete authority and discretion to interpret the language of this document and to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your or your dependent's wrongful death or survival claim, the provisions of this section apply to your or your dependent's estate, the personal representative of your or your dependent's estate, and your or your dependent's heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your dependent, you or your dependent's estate, the personal representative of your dependent's estate, your or your dependent's heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100 percent of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a Sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you or a dependent is covered under this Plan, the provisions of this section continue to apply, even after you or your dependent is no longer covered.
- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determination with respect to the subrogation amounts and reimbursements owed to the Plan.
- If you or your dependent does not cooperate or comply with the Plan's subrogation and reimbursement rights, the Plan has the right to recover from you or your dependent its fees and costs incurred in enforcing the Plan's subrogation and reimbursement rights.

## Right of Recovery

The Plan also has the right to recover benefits it has paid on you or your dependent's behalf that were:

- Made in error
- Due to a mistake in fact
- Advanced during the time period prior to meeting the calendar year deductible
- Advanced during the time period prior to meeting the out-of-pocket maximum for the calendar year
- Made in excess of any amount of benefits due

Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your dependent during the time period of meeting the deductible and/or meeting the out-of-pocket maximum for the calendar year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by:

- Submitting a reminder letter to you or a dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a dependent to discuss any outstanding balance owed to the Plan.

# Notice of Privacy Practices

*Revised effective September 23, 2013*

**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 is your Notice of Privacy Practices from The Health and Welfare Plan for Store Hourly Employees of Cracker Barrel Old Country Store, Inc. and The Health and Welfare Plan for Home Office and Field Management Employees of Cracker Barrel Old Country Store, Inc. (both of which will be referred to in this Notice as the "Plan"). Under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), the Plan is required by law to maintain the privacy of health information that identifies you called protected health information ("PHI"). The Plan is also required by law to provide you with notice of its legal duties and privacy practices regarding your PHI. The Plan is committed to the protection of your PHI and your privacy is a priority of the Plan.

If any of your group health benefits under the Plan are insured or are provided through a health maintenance organization ("HMO"), an additional notice regarding the insurance company or HMO's privacy practices is required by law to be sent directly to you by the insurance company or HMO. Thus, in some circumstances you may receive more than one notice regarding privacy practices regarding your group health benefits.

PHI is any information that:

- is individually identifiable (i.e., contains your name or other distinguishing information).
- is created, transmitted, or maintained by the Plan, whether in oral, written, or electronic form; and
- relates to (i) your past, present, or future physical or mental health or condition, (ii) the provision of healthcare to you, or (iii) the past, present or future payment for the provision of healthcare to you.

The Plan may use or disclose your PHI (including to the Plan Sponsor, Cracker Barrel Old Country Store, Inc.), as described below.

***How the Plan May Use and Disclose Medical Information About You***

The Plan may use or disclose PHI without an authorization in the following circumstances:

**For Treatment:** The Plan may use or disclose your PHI in connection with your medical treatment. For example, the Plan may disclose to your specialist the name of your primary care physician so that the specialist may request your medical records from your primary care physician.

**For Payment:** The Plan may use or disclose your PHI in connection with obtaining or arranging payment for your health care. This includes, but is not limited to, making coverage determinations and administering tasks such as billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review, and preauthorizations. For example, the Plan may tell a hospital whether you are covered by the Plan or the percentage of your costs that will be paid by the Plan.

**For Health Care Operations:** The Plan may use or disclose your PHI in connection with the administration of health care under the Plan. Health care operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, activities relating to creating or renewing insurance contracts, and other administrative activities necessary to operate the Plan. For example, the Plan Administrator may examine claims history to project future benefit costs. However, the Plan may not use or disclose any PHI that is genetic information for purposes of underwriting.

**To Family Members and Friends:** In limited circumstances, the Plan may disclose PHI to your friend(s) or family members if: (1) you are present and do not object to the disclosure; or (2) you are not present, and the Plan determines that the disclosure would be in your best interest.

**To Business Associates:** The Plan may disclose PHI to its business associates to perform certain plan administration functions. For example, business associates may include claims administrators, consultants, accountants and attorneys. Business Associates may receive, create, maintain, and/or disclose your PHI without your authorization, but only after the Business Associate agrees in writing with the Plan to limit its uses and disclosures to proper purposes and to implement appropriate safeguards regarding your PHI.

**To Personal Representatives:** The Plan may also disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, so long as you provide the Plan with a written notice of authorization and any supporting documents (i.e., healthcare power of attorney or designation of personal representative). However, the Plan does not have to disclose information to a personal representative if the Plan has a reasonable belief that (1) you have been, or may be subjected to domestic violence, abuse or neglect by such person; (2) treating such person as your personal representative could endanger you; or (3) it is not in your best interest to treat the person as your personal representative.

**To the Plan Sponsor:** The Plan may disclose your PHI without your written authorization to Cracker Barrel Old Country Store, Inc. ("Cracker Barrel") in certain circumstances. First, the Plan may disclose enrollment information to Cracker Barrel. Second, the Plan may disclose summary health information to Cracker Barrel so that Cracker Barrel can obtain premium bids or modify, amend, or terminate the Plan. Third, the Plan may disclose PHI to Cracker Barrel to perform Plan administration functions, and Cracker Barrel will not further use or disclose that PHI except as permitted or required by the Plan documents and by law. Only employees involved in the administration of the Plan will have access to your PHI to perform Plan administration functions, including (but not limited to) enrollment, payroll deductions, evaluating potential new insurers or service providers to the Plan, assisting participants with claims disputes or questions, and coordinating COBRA continuation coverage.

**In Additional Circumstances:** Although less likely, the use or disclosure of your PHI is permitted without your written authorization under the following circumstances:

| Required by law | When required by law |
|---|---|
| Public health purposes | When permitted for certain public health purposes, such as product recalls and control of communicable diseases, or to otherwise prevent or lessen a serious and imminent threat to the health or safety of a person or the public. |
| Victims of abuse, neglect or domestic violence | When authorized by law to report information about abuse, neglect, or domestic violence when the Plan reasonably believes you are a victim of abuse, neglect, or domestic violence and that the disclosure is necessary to prevent serious harm to you or other potential victims. Generally, you must be informed if the Plan makes a disclosure like this. |
| Public health oversight activities | To a public health oversight agency for oversight activities authorized by law, such as audits, investigations, inspections and licensure necessary for the government to monitor the health care system, government programs, and compliance. |
| Judicial and administrative proceedings | When required for judicial or administrative proceedings in response to a court or administrative order, or in response to a subpoena, discovery request or other lawful process, but if the requesting party is not the court, the requesting party must have made a good faith attempt to inform you of the proceeding and permit you to raise an objection or obtain an order protecting the information requested. |
| Law enforcement purposes | When required or permitted for law enforcement purposes or specialized government functions such as military activities. |
| Decedents | To coroners, funeral directors, and organ procurement organizations in accordance with such entities' needs for PHI about a particular decedent. |
| Specialized government functions | To military command authorities and authorized officials for national security purposes, such as protecting the President of the United States, conducting intelligence, counter-intelligence, other national security activities and when requested by foreign military authorities (only in compliance with U.S. law) and to correctional institutions when requested by a correctional institution or law enforcement for health, safety and security purposes. |
| Research purposes | For research (subject to approval by institutional or private privacy review boards and subject to other certain conditions). |
| Workers' compensation | When authorized by and to the extent necessary to comply with a workers' compensation law or other similar programs established by law. |
| HHS investigations | When required by the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining compliance with the HIPAA Privacy Rule. |

**Uses and Disclosures that Require Your Authorization**

Other than disclosures to you, the Plan will ask you for your written authorization before using or disclosing your PHI for any purpose not described above, including uses and disclosures of PHI for marketing purposes, disclosures that would constitute a sale of PHI, and most uses and disclosures of psychotherapy notes. If you signed an authorization form, you may revoke it in writing at any time, except to the extent that action has been taken in reliance on the authorization before the Plan Administrator received your written notice revoking your authorization.

**Minimum Necessary Standard**

The Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request. The "minimum necessary" standard will not apply, however, to certain disclosures, such as disclosures of your PHI to you.

**Your Rights Regarding Your PHI**

You have certain rights with respect to your PHI, including:

**Right to Inspect and Copy Your PHI.** You have the right to inspect and receive a copy of your PHI that is used to make decisions about your treatment or payment for your care. For PHI for which you have a right of access, you have the right to receive your PHI in an electronic format if it is readily producible in such format, and to direct the Plan to transmit a copy of your PHI to an entity or person you designate, provided the designation is clear, conspicuous and specific. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request.

**Right to Amend Your PHI.** You have the right to request, in writing, that an amendment be made to your PHI if you believe any part of your PHI is incorrect or incomplete. Your request must include a reason to support your request. If your request is denied, the Plan will provide you with an explanation of the reason for the denial. The Plan may deny your request if you ask the Plan to amend information that: (i) is not part of the medical information kept by or for the Plan; (ii) was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; (iii) is not part of the information that you would be permitted to inspect and copy; or (iv) is already accurate and complete. If the Plan denies your request for an amendment, you have the right to file a statement of disagreement with the Plan and any future disclosures of the disputed information will include your statement of disagreement.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures of PHI made by the Plan. The accounting will not include disclosures (1) that were made for treatment, payment, or health care operations purposes; (2) that were authorized by you; (3) that were made to friends or family members in your presence or because of an emergency; (4) that were made for national security purposes; or (5) that were incidental to otherwise permissible disclosures. Your request must be in writing and state a time period, which may not be longer than six (6) years nor start more than six (6) years before the date of your request. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first list you request within a 12 month period will be provided free of charge. Additional lists will be subject to a reasonable charge.

**Right to Receive Notification of a Breach of Unsecured PHI**. You have the right to receive notice if your unsecured PHI is disclosed in violation of HIPAA unless there is a low probability that the PHI has been compromised. If it is determined from the Plan's risk assessment that a breach has occurred, you will be notified without unreasonable delay and no later than 60 days after discovery of the breach. The notification will include information about what happened and what may be done to mitigate any harm.

**Right to Request Restrictions**. You have the right to request that the Plan limit the PHI the Plan uses or discloses about you for treatment, payment, or healthcare operations. You also have the right to request a restriction or limit on your PHI that the Plan discloses to someone who is involved in your care or involved in the payment for your care, like a family member or friend. The Plan will consider your request, but it is not required to agree to your request for restrictions. To request restrictions, your request must be in writing, and you must provide the Plan (i) with the information you want to limit; (ii) whether you want to limit the Plan's use, disclosures, or both; and (iii) to whom you want the limits to apply (for example: your spouse).

**Right to Request Confidential Communications.** You have the right to receive, upon your request, communications of your PHI in a confidential and alternative manner or at an alternative address if you would be endangered by the usual method of communication. To request PHI in a confidential and alternate way, you must make your request in writing and specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your PHI could endanger you. You do not have to provide the specific reason that you believe the disclosure of your PHI could endanger you.

**Right to Receive a Paper Copy of this Notice of Privacy Practices.** You have the right to receive a paper copy of this Notice of Privacy Practices at any time by contacting the Privacy Officer at the address or telephone number listed below. This Notice will also be posted on the Plan Sponsor's benefits intranet site.

**Changes to this Notice of Privacy Practices**

This Plan is required to abide by the terms of the Notice currently in effect. This notice takes effect on September 23, 2013. However, the Plan reserves the right to change the terms of this Notice of Privacy Practices and to the Plan's privacy policies from time to time. If the Plan makes a change, the Plan will (i) post its revised Notice on the Plan Sponsor's benefits intranet site and distribute the revised version of this Notice or information about the material change to affected individuals in the next annual mailing to participants, or (ii) provide its revised notice, or information about the material change and how to obtain the revised notice within 60 days of the material revision to the notice to those affected individuals who do not have access to the benefits intranet site.

**Privacy Officer and Further Information**

For more information about your right described in this Notice of Privacy Practices, you may contact the HIPAA Privacy Officer, Cracker Barrel Old Country Store, Inc. at 305 Hartmann Drive, PO Box 787, Lebanon, TN 37088-0787, (615) 444-5533.

**How to File a Complaint**

If you have questions or comments about the Plan's Notice of Privacy Practices or the Plan's privacy policies and procedures, please contact the Plan's HIPAA Privacy Officer at the address or phone number listed above.

If you would like to file a complaint with the Privacy Officer about the Plan's use or disclosure of your PHI or the Plan's privacy policies and procedures (including its breach notification policies and procedures), please submit your complaint in writing to the HIPAA Privacy Officer at the address listed above.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services by submitting a detailed written description of the issue to your regional Office for Civil Rights. Your description must name the covered entity (the Plan) and what action (or lack of action) you believe has violated HIPAA. Your complaint must be submitted within 180 days of when you knew or should have known of the issue unless this deadline is waived by the Office for Civil Rights. You can find the address for your regional office at www.hhs.gov/ocr/privacy/hipaa/complaint/index.html. You will not be penalized or retaliated against for filing a complaint about the Plan's privacy practices.

*Benefits described are either part of The Health and Welfare Plan for Home Office and Field Management Employees of Cracker Barrel Old Country Store, Inc. (the "Plan") or part of the Cracker Barrel Old Country Store, Inc. Section 125 Cafeteria Plan (the "Section 125 Cafeteria Plan").*



2024 Summary Plan Description
Cracker Barrel HOFM/ETC
Maple Street Biscuit Leadership & Family Support