2025 Administrative Summary Plan Description

BIMBO Bakeries USA

BIMBO QSR

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Introduction

The Bimbo Bakeries USA Health & Welfare Plan (Plan) provides benefits for eligible associates (and their dependents) of Bimbo Bakeries USA (BBU) and Bimbo QSR (referred to collectively as "Company"). This Administrative Summary Plan Description (SPD) outlines provisions of the Plan as of January 1, 2025. The Company reserves the right to change, amend, suspend or terminate any or all of the benefits under this Plan, in whole or in part, at any time and for any reason at its sole discretion. Note that by adopting and maintaining these benefits, the Company has not entered into an employment contract with any associate. Nothing in the legal plan documents or in the SPDs gives any associate the right to be employed by the Company or to interfere with the Company's right to discharge any associate at any time.

This document serves an important function related to the Plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA), a Federal law applying to employee benefit plans. ERISA requires that employers provide eligible employees with a description of the various benefit plans it maintains. Such information is to be included in an SPD for each Plan. Notwithstanding any other provision in this SPD, the Company intends to operate the Plan in compliance with the transparency, surprise billing and other applicable requirements in the relevant provisions of the Consolidated Appropriations Act, 2021 ("CAA") and the Transparency-In-Coverage Regulations as they become effective, based on a good faith, reasonable interpretation of the statute, existing regulations and other official guidance. As additional, final guidance becomes available and applicable, the Company will modify this SPD accordingly and/or provide a Summary of Material Modifications.

IMPORTANT: This document and other descriptive benefits material provided to you by the Company and its various benefit providers summarize the benefits available to you under the Plan in an easily understandable manner. There may be other Plan materials (such as a contractual agreement with a health care or other service provider) that contain more detailed provisions. Every effort has been made to ensure that all of these materials contain a consistent description of the Plan's benefits; however, if there is any conflict or inconsistency between these materials, the Plan controls and it is the Plan Administrator's responsibility to interpret the conflicting provisions and determine what Plan benefits will be provided. Keep in mind that the Plan, any changes to it, or any payments to you under its terms, do not constitute a contract of employment with the Company and do not give you the right to be retained in the employment of the Company. No one speaking on behalf of the Plan or the Plan sponsor can alter the terms of the Plan. You and your beneficiaries may obtain copies of the Plan and its related documents or examine these documents by contacting the Plan Administrator at the number and address listed in ***General Information****.*

How the Plan Works

The Plan provides health and welfare benefits. If you are eligible to participate in the Plan, you may enroll as a newly eligible associate or during the Company's **Annual Enrollment** period. For more information on when you can enroll or make changes to your benefit elections, please see **Enrolling for Coverage** and **HIPAA Special Enrollment Rights**.

The Company pays a significant portion of the cost of benefits under this Plan. The amount that you pay, if any, depends on the options you elect. Your contributions are deducted from your paycheck. You pay the full cost to participate in all voluntary benefit options and only you contribute to the Flexible Spending Accounts. If you and the Company share in the cost of a Plan, your contributions will be deducted from your compensation. Contributions for medical/prescription drug, dental, vision, health care and dependent care flexible spending accounts and Health Savings Account are deducted before Federal income tax and Social Security taxes are taken out and will therefore reduce your taxable income. Generally, but not in all cases, these payroll deductions will reduce state taxes as well. Depending on location, payroll deductions may also be exempt from local income tax. Supplemental life and AD&D insurance, long-term disability (if you elect a buy-up) and contributions for voluntary options (group legal, hospital indemnity, critical illness and accident insurance) are deducted on an after-tax basis.

Social Security and unemployment benefits are based on your taxable earnings. Since taxable earnings are reduced by before-tax contributions, any benefits that you might be entitled to receive from Social Security and unemployment may be reduced. Current tax savings should more than offset any potential loss of future benefits.

Eligibility

Associates

Salaried and Non-union Hourly Associates

You are eligible to participate in the Plan if you are a full-time active associate, defined as:

- **Salaried:** You are hired with the expectation that you will work a regular schedule of at least 30 hours per week. Your coverage begins the first day of the month following or coinciding with your date of hire, provided that you have enrolled for benefits coverage through the Benefits Center.
- **Non-union hourly:** You are hired with the expectation that you will work a regular schedule of at least 30 hours per week. Your coverage begins the first day of the month following or coinciding with a 60-day eligibility period, provided that you have enrolled for benefits coverage through the Benefits Center.

  If your hours vary and you are not regularly scheduled to work at least 30 hours per week, you may still be eligible for benefits if you worked an average of 30 hours per week over the course of a measurement period (which is considered to be full-time under the Affordable Care Act) that takes place before the Plan year begins. This is called the "Lookback Method" where the Company looks back at your prior service to determine whether you might be considered full-time. If you average at least 30 hours per week during the 12-month period beginning the month after your date of hire, you will be eligible for benefits on the first day of the month following 13 full calendar months after your date of hire. With each new Plan year, you will be eligible for benefits if you average at least 30 hours per week over the course of a measurement period that takes place before the Plan year begins.

Employee Assistance Program (EAP) and Pelago: All Company associates and their dependents are eligible for the EAP and Pelago. Associates do not need to be eligible for, or enrolled in, Company benefits to take advantage of the EAP or Pelago.

Basic Critical Illness: The Company provides all associates who are enrolled in either the Standard HSA or Enhanced HSA medical plan with Company-paid $3,000 basic critical illness coverage.

The following exception applies:

- **Medical coverage:** Part-time associates hired prior to July 19, 2016, and who were grandfathered for medical benefits eligibility may continue to be covered under the plan. However, part-time associates who waive coverage cannot re-enroll without meeting the hours requirement as determined using the Lookback Method. Associates working less than 30 hours per week are considered part-time.

Transfers

If you transfer to a salaried or non-union hourly position from one that was governed by a Collective Bargaining Agreement (CBA), your new benefits will be effective on your transfer date provided that you have enrolled for benefits coverage through the Benefits Center. You have 31 days to make your new elections. In some instances, benefits coverage under your CBA may continue for a period of time after your transfer date. If this is the case, you may continue coverage under your CBA until it ends. At that time, you would be responsible for notifying the Benefits Center of your loss of coverage under the CBA and then enroll for your new benefits coverage. You have 31 days from the date you lose coverage to enroll in Company coverage.

Rehired Salaried and Non-union Hourly Associates

If you were an associate, your employment with the Company terminated, and you are rehired by the Company, your coverage begins immediately — there is no waiting period. You have 31 days to make your new elections.

Ineligible Associates

The following individuals are ineligible to participate in the Plan:

- Associates covered under a collective bargaining agreement (CBA) and their dependents are not eligible to participate in this Plan unless the CBA provides for the associates' participation
- Temporary associates, unless determined to be a benefit-eligible associate through the Lookback Method
- Those individuals who perform services for the Company pursuant to an arrangement with a leasing organization, including but not limited to "leased associates"
- Those individuals who are not on Company payroll (such as consultants and independent contractors), whether or not they are later determined to be associates of the Company
- Other non-regular associates as determined in accordance with the Company's personnel policies and practices
- Interns

If an individual who is not eligible for benefits is subsequently reclassified as, or determined to be, an associate by the Internal Revenue Service (IRS), any other governmental agency or authority, a court, or any other individual or entity, or if the Company is required to reclassify such an individual as an associate as a result of such reclassification or determination (including any reclassification by the Company in settlement of any claim or action relating to the individual's employment status), the individual shall not become eligible to participate in the Plan by reason of such reclassification or determination. If a person who is not classified by the Company as an eligible associate otherwise satisfies these eligibility rules and is subsequently reclassified by the Company as an eligible associate, the person, for purposes of this Plan, shall be deemed an eligible associate from the later of the actual or the effective date of such reclassification.

Dependents

You may cover your eligible spouse and child(ren).

Your Spouse

Your spouse under a legally valid existing marriage recognized by a state (includes common law spouses in Colorado only) or territory of the United States between persons of the same-sex or opposite-sex, unless a divorce decree exists.

Your Child(ren)

Your natural child, stepchild or legally adopted child or a child for whom you are the legal guardian until the end of the month he/she reaches age 26, regardless of student, marital or residential status.

An adopted child, who is younger than 26 years of age at the time of adoption, shall be considered eligible from the date the child is placed for adoption.

A child for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

A child who is unmarried, incapable of self-sustaining employment and dependent upon you for support due to a mental and/or physical disability (which occurred prior to age 26), as determined by the Social Security Administration, or due to other loss of dependent's eligibility will remain eligible for coverage under this Plan beyond the date coverage would otherwise end.

Proof of incapacitation must be provided within 31 days of the child's loss of eligibility and thereafter as requested by the Plan Administrator or claims processor. For disabilities not considered permanent by the Plan Administrator or the designated claims processor, proof of incapacitation will be requested each year thereafter. Eligibility may not be continued beyond the earliest of the following:

- Cessation of the mental and/or physical disability
- Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination

Proof of Dependent Status

The Plan Administrator will require proof of dependent status. Every eligible associate may enroll eligible dependents. However, if both you and your spouse are associates, you may choose to have one of you covered as the associate, and the other covered as the dependent of the associate, or you may choose to have both of you covered as associates. Eligible children may be enrolled as your dependents or your spouse's, but not both.

You must contact the Benefits Center within 31 days of the date you become eligible for coverage or within 31 days of acquiring a dependent through marriage, birth, adoption or legal guardianship to enroll your dependents for coverage under the Plan. If your enrolled dependent becomes ineligible for coverage, you must contact the Benefits Center.

When you enroll your dependents, you will be asked to verify them within 45 days of enrolling by providing documents verifying their status.

Spouse Documentation:

One of the three combinations below:

1. Government issued Marriage Certificate ***and*** Federal Tax Return within the last two years listing spouse
2. Government issued Marriage Certificate ***and*** Proof of Joint Ownership issued within the last six months (if married more than 12 months)
3. Government issued Marriage Certificate ONLY (if married within the last 12 months)

Note: Standard "Proof of Joint Ownership" includes:

- Mortgage statement
- Bank statement (bank account verification letter showing active status)
- Active lease agreement
- Homeowners insurance
- Renters insurance
- Credit card statement (includes department stores and care credit)
- Property tax
- Current year state tax return listing spouse/partner
- Current year mortgage interest/mortgage insurance
- Warranty deed
- Auto loans
- Current year Federal Tax Return listing the spouse/dependent as a dependent

Common Law Spouse (Colorado ONLY) Documentation:

One of the three combinations below:

1. Notarized Common Law Spouse Affidavit and Federal Tax Return within the last two years listing spouse
2. Notarized Common Law Spouse Affidavit and Proof of Joint Ownership issued within the last six months
3. Notarized Common Law Spouse Affidavit ONLY (if less than 12 months)

Biological Child Documentation:

Government issued Birth Certificate (including parents' names) or official hospital notice if birth certificate is not available

Adopted Child Documentation:

Adoption Certificate (including child's DOB), adoption placement agreement or petition for adoption (including DOB)

Note: May be the adopted child of spouse. Spouse documentation is required to verify.

Stepchild Documentation:

Child of Legal Spouse:

One of the three combinations below:

1. Government issued Birth Certificate (including parents' names) and Government issued Marriage Certificate and Federal Tax Return within the last two years listing spouse
2. Government issued Birth Certificate (including parents' names) and Government issued Marriage Certificate and Proof of Joint Ownership issued within the last six months
3. Government issued Birth Certificate (including parents' names) and Government issued Marriage Certificate ONLY (if married within the last 12 months)

Child of Common Law Spouse (Colorado ONLY):

One of the two combinations below:

1. Government issued Birth Certificate (including parents' names) and Notarized Common Law Spouse Affidavit and Federal Tax Return within the last two years listing spouse
2. Government issued Birth Certificate (including parents' names) and Notarized Common Law Spouse Affidavit and Proof of Joint Ownership issued within the last six months

Legal Ward (up to age 26) Documentation:
Government issued Birth Certificate and court ordered document of legal custody

Note: May be the QMCSO of spouse. Spouse documentation required to verify.

False or misrepresented eligibility information will cause both your coverage and your dependents' coverage to be irrevocably terminated (retroactively to the extent permitted by law), and could be grounds for associate discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation. If your coverage is terminated retroactively due to fraud or misrepresentation, you will forfeit any contributions made.

You are responsible for submitting all information required for enrollment under the Plan to the Benefits Center by the deadline. If a dependent is not enrolled by the deadline, the dependent cannot be enrolled until the next **Annual Enrollment** period unless you experience a change in status event as described in **Making Changes During the Year** or there is a change in status as described in **HIPAA Special Enrollment Rights**.

Coverage Levels

You may choose one of the following coverage levels for your medical/prescription drug, dental and vision benefits, hospital indemnity, critical illness and accident insurance:

- You Only — Choose this category if you need coverage only for yourself
- You + Spouse — Choose this category if you need coverage for yourself and your spouse
- You + Child(ren) — Choose this category if you need coverage for yourself and your dependents (at least one child)
- You + Family — Choose this category if you need coverage for yourself and your dependents (spouse and/or at least one child)

When Coverage Begins

Your eligible dependent(s) will become covered under the Plan on the later of the dates listed below, provided you have enrolled them in the Plan within 31 days of meeting the Plan's eligibility requirements.

- The date your coverage becomes effective.
- The date the dependent is acquired, provided any required contributions are made and you have applied for dependent coverage within 31 days of the date acquired.
- As long as the mother is covered under the Company medical plan, newborn children shall be covered from birth for the first 31 days. You must apply for dependent coverage within 31 days of birth for coverage to continue after the first 31 days.
- Coverage for a newly, or to be, adopted child shall be effective on the date the child is placed for adoption. You must apply for dependent coverage within 31 days of placement for coverage to continue after the first 31 days.

For more information on enrolling your dependents, please see **Enrollment** and **HIPAA Special Enrollment Rights**.

Paying For Coverage

The Company pays the full cost of your:

- Basic Term Life and Basic AD&D Insurance coverage
- Short-term Disability coverage
- Basic Long-term Disability coverage
- Basic Critical Illness coverage*
- Employee Assistance Program
- Pelago

You and the Company share in the cost of your health care benefits and you pay the full cost of all other benefits. Your cost for coverage depends on which benefits you choose and whether you cover your dependent(s). For medical/prescription drug, dental, vision, Health Care and Dependent Care Flexible Spending Accounts (FSAs) and Health Savings Account (HSA), you pay your portion of the cost with before-tax dollars deducted from your paycheck, while contributions for all other benefits are paid with after-tax dollars.

**Only if enrolled in either the Standard or Enhanced HSA Medical Plan.*

To see how much each of the Company benefits costs, please review the Personalized Enrollment Worksheet you received in your home mail when you were newly hired or during **Annual Enrollment** which shows your coverage options and their costs. Depending on which benefits you select, the option you select and your category of coverage (e.g., you only, you and spouse, you and child/children, or you plus family), you may be required to make a contribution through payroll deductions. The amount of the contribution for each category of coverage can be found by visiting **myBBUbenefits.com** or by calling the Benefits Center at **1-888-60-myBBU** (1-888-606-9228).

Note: All EAP services are free (up to the amount defined by the contract), confidential, and available to you and your eligible dependents. Additional sessions over the amount defined by the contract may be available for an additional cost which would be payable by the user (associate and/or their family member).

Spousal Surcharge

If your spouse (other than a spouse also employed by the Company) is eligible for medical coverage through his or her own employer, other than the Company, but chooses to enroll for medical coverage through the Company, an annual surcharge ($1,000) divided equally among paychecks will be applied to your medical contributions.

If you cover a spouse under the Company medical plan, you will need to complete an online certification when you enroll, indicating whether or not your spouse is eligible for medical coverage through his or her own employer.

Enrollment

Enrolling for Coverage

Initial Enrollment

When you first become employed by the Company, or first become eligible to participate in the Plan, if later, you will receive a packet that includes a New Hire Guide with instructions on how to enroll for benefits, a Personalized Enrollment Worksheet that shows your coverage options and their costs and legal notices. You must enroll for benefits through the Benefits Center by the deadline listed on your Personalized Enrollment Worksheet.

Annual Enrollment

Annual Enrollment is the period during which you may change benefit plans, add or drop dependents or enroll in the Plan if you did not previously do so. Annual Enrollment typically occurs each fall.

In most cases, if you fail to make an election or to change benefit elections during the Annual Enrollment period, you will automatically be defaulted to the prior year's elections provided those options are still available. Please note that you must make new Health Care Flexible Spending Account (FSA) and Dependent Care FSA elections each year. However, the options under the Plan are subject to change, and accordingly, you must review the Annual Enrollment materials to determine whether a new election is required to continue any benefit election.

The effective date of coverage elected during Annual Enrollment is the following January 1.

Note: When you enroll in the Group Legal Plan, your coverage will be extended to your eligible dependents, including your legal spouse and children. If you enroll for coverage you must participate for the entire calendar year.

Making Changes During the Year

Change in Status Events

Except for a change in status event or during a special enrollment period, the Annual Enrollment period is the only time you may change benefit options.

Change in status rules apply to before-tax benefits, which include: medical/prescription drug, dental, vision, Health Care and Dependent Care FSAs and HSA.

Status changes must be consistent with the life event and include:

- A change in status such as:
  - A change in your legal marital status.
  - Becoming legally responsible for a child.
  - The termination or commencement of employment by you or your spouse.
  - Your dependent satisfies (or ceases to satisfy) dependent eligibility requirements.
- A change in the cost of medical, dental, or vision coverage under the Plan.
- A change in your or your spouse's employment status that results in gaining or losing eligibility for coverage, including:
  - Beginning or ending employment.
  - A strike or lockout.
  - Starting or returning from an unpaid leave of absence.
  - A change from part-time to full-time employment or vice versa.
- Eligibility for enrollment as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), see **HIPAA Special Enrollment Rights**.
- A court order, judgment or decree.
- Entitlement to or loss of entitlement to Medicare or Medicaid.

Note: If an associate who is eligible for benefits coverage through a union, transfers to an eligible salaried or non-union hourly position, that associate and their eligible dependents will become immediately eligible to enroll in all Company benefit options under this plan.

- A change in status due to the commencement or termination of leave qualifying under the Uniformed Services Employment Reemployment Rights Act (USERRA).
- The restriction or loss of coverage.
- The addition to or improvement in coverage.
- A change in coverage in your spouse or dependent child(ren)'s plan (either during that employer's annual enrollment period or due to a mid-year election change permitted under the Internal Revenue Code).
- The loss of other group health plan coverage sponsored by a governmental or educational institution, including a state children's health insurance program (CHIP), medical care program of an Indian Tribal government, state health benefits risk pool, or a foreign government group health plan.
- A reduction in hours of service, provided that you remain eligible for such coverage, if:
  - You were reasonably expected to work 30 hours per week and you experience a change in employment, after which you are reasonably expected to work less than 30 hours per week.
  - You intend to enroll yourself and any dependents dropping coverage in another health plan (satisfying the definition of minimum essential coverage) effective no later than the first day of the second month after you drop Company coverage.
  - Note: Even if you lose benefits eligibility during the year as a result of a reduction in your hours of service, you may not change your Health Care FSA election for that calendar year.
- Your enrollment in a health plan offered through the Health Insurance Marketplace (Marketplace). You (and any dependents whose coverage is dropped at this time) must intend to enroll in Marketplace coverage that is effective no later than the day immediately following the last day your coverage under this Plan is dropped. You are not permitted to change your Health Care FSA election because you intend to enroll in a plan offered through the public Marketplace. To satisfy the "consistency rule," except for election changes due to a HIPAA Special Enrollment, changes as a result of a reduction in hours of service, and changes because of your enrollment in a health plan offered by the public Marketplace, the changes you make to your coverage must be "on account of and correspond with" the event.

Family and Medical Leave

If you take unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), you may cancel an existing election to participate in the Plan for the remainder of the Plan year. To cancel coverage, contact the Benefits Center. If you cancel an existing election to participate in the Plan while you are on FMLA leave, you will not be entitled to receive payment on any claims incurred following your election to cancel participation. Upon return from such leave, you may choose to be reinstated in the Plan on the same terms as prior to taking FMLA leave, but you may not retroactively elect coverage for claims incurred following your election to cancel participation.

Other Events that Allow You to Make Changes

If a Qualified Medical Child Support Order (QMCSO) requires the Plan to provide coverage to your child, then the Plan Administrator may automatically change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of the QMCSO, if you desire. If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.

HIPAA Special Enrollment Rights

If you are declining enrollment in the Company's medical plans for yourself or your dependents (including your spouse) because of Other Health Insurance Coverage or group health plan coverage, you may be able to later enroll yourself and your dependents in some coverages under this Plan without waiting for the next **Annual Enrollment** period, if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). "Other Health Insurance Coverage" includes other group health plan insurance, Medicaid coverage, or a state's Children's Health Insurance Program (CHIP). Additionally, you and/or your dependent(s) may be able to enroll in a Company-sponsored medical plan if you and/or your dependent(s) became eligible for state premium assistance under Medicaid or CHIP or lose Medicaid or CHIP coverage because you are no longer eligible.

However, you must request enrollment within 31 calendar days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage). You must request enrollment within 60 days of an event that involves loss of Medicaid or CHIP coverage or eligibility for state premium assistance. Note that this 60-day extension doesn't apply to an enrollment opportunity other than one that is due to a Medicaid/CHIP eligibility change. If you fail to request enrollment within the required time limit, you will not be able to enroll until the next **Annual Enrollment** period or unless you have a status change.

In addition, 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. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. If you request a change due to a special enrollment event within the applicable timeframe, coverage will be effective on the date of birth, adoption or placement for adoption. For all other events, coverage will be the later of the date of the event or the first of the month following the submission of the request.

Whether or not you are covered under the Plan, if you are eligible for coverage and experience a change in family status, you may request special enrollment for yourself, if applicable, and any new dependent. In the case of birth or adoption of a dependent child, you may also enroll your spouse and/or other children who were previously not covered by the Plan. For the purposes of this provision, a change in family status includes:

- Marriage
- Birth of a dependent child
- Adoption or placement for adoption of a dependent child
- Establishment of legal guardianship

You must request a special enrollment within 31 days of the change in family status. Contact the Benefits Center to make this request.

Provided that you notify the Benefits Center within 31 days of the event, the effective date of coverage for those enrolled as the result of a special enrollment is:

- In the case of marriage, the date of marriage
- In the case of a dependent's birth, the date of birth (the Plan provides automatic coverage for the first 31 days)
- In the case of adoption or placement for adoption, the date of such adoption or placement for adoption
- In the case of legal guardianship, the date of such legal guardianship

The Company requires documentation proving dependency, including birth certificates, tax records or record of legal proceedings severing parental/spousal rights.

Coverage

Subrogation/Reimbursement

General Principle

When you or your dependent receive Plan benefits which are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your dependent shall reimburse the Plan for the related benefits received out of any funds or monies you or your dependent recovers from any third party.

Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if you or your dependent has not been paid or fully reimbursed for all damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan will not pay attorney's fees or costs associated with the claim or lawsuit without express written authorization from the Company.

Participant Duties and Actions

By participating in the Plan, you and your dependents consent and agree that a constructive trust, lien or equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you and your dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once you or your dependent has any reason to believe that you or he/she may be entitled to recovery from any third party, you or your dependent must notify the Plan.

You and your dependent consent and agree that you or he/she shall not assign your or his/her rights to settlement or recovery against a third person or party to any other party, including attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Company.

When You Have Coverage Elsewhere

If you or a covered dependent is covered by more than one group health care plan (for example, your spouse's plan), the Company Medical/Prescription Drug Plan (Plan), like many employer-sponsored plans, has a "coordination of benefits" feature to prevent duplication of payments. The plan that is primarily responsible for a person's expenses — that is, the plan that pays benefits first — is considered the primary coverage for that person.

Covered expenses (medical/prescription drug) that are not reimbursed by the primary plan will be submitted to the deductible and coinsurance portion of the Plan for payment. You can choose to use any available funds in your HSA to cover eligible expenses. For additional information, you can contact Health Equity or a tax advisor.

For Associate

The Plan is your primary coverage, if you participate.

For Spouse

The plan provided by his/her employer is primary if he/she is enrolled for that coverage. The Plan is primary only if he/she does not participate in any other employer-sponsored coverage. See **How the Plan Coordinates Coverage** for more information.

The rules apply only when the covered person is covered by both plans and the expense is considered a covered expense under the Plan. The amount paid by the Plan when combined with amounts paid by a primary plan will not exceed the amount of benefits the Plan would pay if it were primary. If under the rules above it is not possible to determine which plan pays benefits first, the plan that covered the individual for the longest period of time will pay benefits first.

For Dependent Children

If your children are covered by more than one employer-sponsored health plan, the "birthday rule" determines which plan (yours or your spouse's) is primary. The plan covering the person whose birth date (month and day) falls earlier in the calendar year is primary for the children. If both individuals have the same birthday, the plan covering the person for the longer period is primary. If primary coverage cannot be determined under any of the rules in the documents that make up the Plan, the plan covering the person the longest will be primary. See **How the Plan Coordinates Coverage** for more information.

How the Plan Coordinates Coverage

If…	Then…
You have coverage under the Plan as an associate who is not laid off or is not retired and you also have coverage under another plan as a laid off or retired associate	The Plan pays benefits first.
You have coverage under the Plan due to continuation rights under state or Federal law (e.g., COBRA) and also have coverage under another plan as an employee (or as an employee's dependent)	The other plan pays benefits first.
The Plan pays benefits second and Plan coverage is greater than your spouse's plan	The Plan pays the difference between the benefits from the other plan and benefits from the Plan.
The Plan pays benefits second and Plan coverage is equal to or less than your spouse's plan	The Plan will pay no additional benefits.
Your birth date (month, day) occurs first in the calendar year	The Plan pays benefits first. After the Plan pays, you can then submit bills to the other plan.
Your spouse's birth date (month, day) occurs first in the calendar year	The other plan pays benefits first. Expenses not covered under the other plan may be covered by the Plan, up to the amount the Plan would have paid if it were primary. If the primary plan pays benefits equal to or greater than those of the Plan, the Plan will pay no additional benefits.
You and your spouse both have the same birth date (month, day)	The plan covering you or your spouse for the longer period of time will pay first.
You are legally separated or divorced and two plans cover your dependent child	Benefits for the child are determined in this order: • First, the plan of the parent with custody of the child will pay; • Then, the plan of the spouse of the parent with custody of the child will pay; and • Finally, the plan of the parent not having custody of the child will pay. However, if there is a court decree specifying which parent is responsible, the benefits of that plan are determined first.

When Medicare Applies

Medicare is a federally-sponsored program of health care coverage and is not offered through or administered by the Company. If you or your spouse reaches age 65 while you are still actively employed by the Company and you or your spouse also enroll in Medicare, the Plan will continue as the primary source of medical coverage. Medicare will supplement coverage after benefits from the Plan have been determined.

Different rules apply to disabled persons. Generally, if you become disabled, Medicare will become your primary source of coverage and the Plan may supplement coverage after benefits from Medicare have been determined. However, since coordination with Medicare is governed by Federal law and regulation, please contact Blue Cross and Blue Shield of Illinois (BCBSIL) for more details concerning your particular situation.

You or your spouse may also be eligible for prescription drug coverage under Medicare Part D. Because drug coverage under the Plan is at least as good as standard Medicare Part D prescription drug coverage in 2025, (this is called creditable coverage), if you keep your coverage under this Plan, you will not have to pay a late penalty if you later decide to enroll in Medicare Part D. When you lose coverage under the Plan, you will have an opportunity to enroll in Medicare Part D. If you are an active associate or family member of an active associate and you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. If you waive or drop Company coverage and enroll in Medicare prescription drug coverage, Medicare will be your only payer. You may enroll back into Company coverage during an **Annual Enrollment** period if you are eligible for a special enrollment under HIPAA, or if you experience a qualifying change in status, assuming you remain eligible. You should also know that if you drop or lose your current coverage with the Company, you only have 63 days to join a Medicare drug plan to avoid paying a higher premium. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. You can request more information about Medicare from your local Social Security office.

Situations Affecting Your Coverage

If...	Then...
You take a Family and Medical Leave of Absence	• Under the Family and Medical Leave Act of 1993 (FMLA), you may be eligible for up to 12 weeks of unpaid leave in a rolling 12-month period if you have a serious illness; adopt or have a child; or need to care for a seriously ill spouse, child or parent. • Your medical/prescription benefits will be continued during your FMLA leave, with the Company paying the same portion of the costs it normally pays. You will be responsible for paying your portion of the cost of medical benefits. To continue this coverage, you will be required to make the appropriate contributions. If you are no longer being paid via Company payroll you will receive an invoice each month from WageWorks. If you are using Paid Time Off during your leave, you will not receive an invoice from WageWorks. • Contact the Benefits Center for more information on eligibility and coverage under FMLA.
You take a Military Leave of Absence	• You may elect to continue your coverage in effect on the day immediately prior to the start of your leave, if you are absent from work due to military service leave qualifying under the Uniformed Services Employment and Reemployment Rights Act (USERRA). • Your coverage will continue until the earlier of the following occurs: the date you fail to return to active employment as required under USERRA or 24 months. To continue coverage, you must continue to pay the required contributions under the Plan. You will receive an invoice each month from WageWorks.
You take an approved leave of absence	• Your coverage will continue as long as you continue to pay the required contributions under the Plan.
You become disabled and cannot work	• Your coverage may continue; however, contact the Benefits Center for specific information about continuation provisions and contributions that apply. If you are on short-term disability, medical benefits continue with the Company paying the same portion of the cost it normally pays. You will be responsible for paying your portion of the cost for medical benefits. • Salaried associates: While on STD, your payroll will continue for the first 90 days and deductions are taken as normal as long as you are paid via Company payroll. Once you transition to LTD, you will receive direct bill invoices from WageWorks to make payments. • Hourly associates: While on STD and LTD you will be paid via MetLife, therefore you will be billed directly beginning the first of the month following your last day worked.
Your or your spouse's child is recognized in a Qualified Medical Child Support Order (QMCSO)	• The child shall be referred to as an alternate recipient if the child of yours or your spouse is recognized in a Qualified Medical Child Support Order (QMCSO) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan, even if the child is not residing in your household. Alternate recipients are eligible for coverage whether or not you have elected coverage under the Plan. • If you are eligible for Plan coverage but you are not covered when an order is determined to be a QMCSO, you will be required to enroll in the Plan. The Plan Administrator shall establish written procedures for determining whether a medical child support order is a QMCSO and for administering the provision of benefits under the Plan pursuant to a valid QMCSO. The Company will enroll you and your dependent into the requested plans as determined by the QMCSO. If there are two options, the Company will enroll you in the lower cost plan. • Get a copy of the applicable procedures, available from the Benefits Center free of charge. The Plan Administrator reserves the right to seek clarification with respect to the order from the court or administrative agency that issued the order, up to and including the right to seek a hearing before the court or agency.
You retire	• You may generally elect and pay for COBRA continuation coverage under this Plan for up to 18 months from when you retire. You make contributions for coverage directly to WageWorks.
You leave the Company	• Coverage ends. You and your dependents may generally elect and pay for COBRA continuation coverage for up to 18 months from the last day of the month in which your employment is terminated. You make contributions for coverage directly to WageWorks.
You die	• Covered dependents may elect and pay for COBRA continuation coverage for up to 36 months from the last day of the month in which you die. They make contributions for coverage directly to WageWorks. If you are an active associate at the time of your death, your enrolled dependents are entitled to a survivor benefit: their coverage under the medical/dental/vision plans will continue at no cost for three months after your date of death.

Termination of Coverage

Except as provided in the Plan's **General Notice of COBRA Continuation Coverage Rights** section, your coverage will terminate on the earliest of the following dates:

- The date the Company terminates the Plan
- The last day of the month you cease to meet the Plan's eligibility requirements
- The day after your date of termination from the Company for Life and AD&D, Disability, Employee Assistance Program, Group Legal, Flexible Spending Accounts, Critical Illness, Hospital Indemnity and Accident Insurance
- The last day of the month in which termination occurs for Medical/Prescription Drug, Dental, and Vision coverage

Except as provided in the Plan's **General Notice of COBRA Continuation Coverage Rights** section, your dependent's coverage will terminate on the earliest of the following dates:

- The date the Company terminates the Plan
- The date your coverage terminates
- End of month in which your dependent ceases to meet the Plan's eligibility requirements
- The date you cease to make any required contributions on your dependent's behalf
- The date the Company discontinues dependent coverage for any and all dependents

Claim Filing and Appeals Procedures

Medical Claim Filing and Appeals Procedures

To receive benefits under the Plan, you must file a claim with the Claim Administrator. To file a claim, usually all you have to do is show your ID card to a hospital, physician or other provider. They will file your claim for you. Remember, it is your responsibility to ensure that the necessary claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your claim, it will be processed and the benefit payment will usually be sent directly to the provider. You will receive a statement telling you how your benefits were calculated. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order (QMCSO), to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own claims. This is primarily true when you are receiving services or supplies from providers other than a hospital or physician. An example would be when you have had ambulance expenses.

To file your own claim, follow these instructions:

1. Complete a Claim Form. Contact the Claim Administrator at **1-877-239-7449** to request the form or download it from **www.bcbsil.com** (posted under Form Finder).
2. Attach copies of all bills to be considered for benefits. These bills must include the provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the claim charge.
3. Mail the completed Claim Form with attachments to:
   Blue Cross and Blue Shield of Illinois
   P. O. Box 805107
   Chicago, IL 60680-4112

Claims must be filed no later than 12 months after the date a service is received. Claims not filed within 12 months from the date a service is received will not be eligible for payment. If you have any questions about filing claims, contact BCBSIL Customer Service at the number on the back of your ID card.

Claims Determinations and Appeals Process

Initial Claim Determination

The Claim Administrator will usually pay all claims within 30 days of receipt of all information required to process a claim. The Claim Administrator will usually notify you, your valid assignee or your authorized representative, when all information required to pay a claim within 30 days of the claim's receipt has not been received. If you fail to follow the procedures for filing a pre-service claim, you will be notified within five days, or within 24 hours in the case of a failure regarding an urgent care/expedited clinical claim. Notification may be oral unless the claimant requests written notification.

If a Claim Is Denied or Not Paid in Full

If a claim for benefits is denied in whole or in part, you will receive a notice from the Claim Administrator within the following time limits:

1. For non-urgent pre-service claims, within 15 days after receipt of the claim by the Claim Administrator. A "pre-service claim" is any non-urgent request for benefits or for a determination, when advance approval is required before receiving medical care.
2. For post-service claims, within 30 days after receipt of the claim by the Claim Administrator.

If the Claim Administrator determines that special circumstances require an extension of time for processing the claim, for non-urgent pre-service and post-service claims, the Claim Administrator shall notify you or your authorized representative in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period. If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from receipt of the notice within which to provide the requested information.

3. If the claim for benefits is denied in whole or in part, you or your authorized representative shall be notified in writing of the following:
   a. The reasons for denial;
   b. A reference to the benefit plan provisions on which the denial is based, or the contractual, administrative, medical policy or protocol for the determination;
   c. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
   d. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), diagnosis, treatment and denial codes with their meanings and the standards used (upon request, diagnosis/treatment codes with their meanings and standards used are also available);
   e. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
   f. In certain situations, a statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s);
   g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
   h. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
   i. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
   j. An explanation of the scientific or clinical judgment relied on in the determination as applied to a claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
   k. In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care/expedited claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification;
   l. Contact information for applicable office of health insurance consumer assistance or ombudsman.

4. For benefit determinations relating to urgent care/expedited clinical claim, such notice will be provided no later than 24 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.

5. For a benefit determination relating to care that is received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

   An "urgent care/expedited clinical claim" is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

   If the Plan fails to strictly adhere to all of the requirements of the internal claims and appeals process with respect to your medical claims, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies without waiting for further Plan action. However, this will not apply if the error was de minimus, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets the exception.

Additionally, if your claim is an urgent care claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed.

Inquiries and Complaints

An inquiry is a general request for information regarding claims, benefits, or membership. A complaint is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with inquiries and complaints. Issues may include, but are not limited to, claims and quality of care.

Prior to making a benefit determination on review, the Claim Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Medical Plan (or at the direction of the Plan) in connection with the claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

When your complaint relates to dissatisfaction with a claim denial (or partial denial), then you have the right to a claim review/appeal as described in the Claim Appeal Procedures.

For Medical claims, the Claim Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claim Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claim Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

To pursue an inquiry or a complaint, you may contact BCBSIL Customer Service at the number on the back of your ID card, or you may write to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

When you contact Customer Service to pursue an inquiry or complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information, you will be contacted. If a response will be delayed due to the need for additional information, you will be contacted. If an inquiry or complaint is not resolved to your satisfaction, you may appeal to the Claim Administrator.

An appeal is an oral or written request for review of an adverse benefit determination or an adverse action by the Claim Administrator, its employees or a participating provider.

The following is the contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For complaints and general Inquiries:

Illinois Department of Insurance Office of Consumer Health Insurance
320 West Washington Street
Springfield, IL 62767
Toll-free phone: **1-877-527-9431**
Fax number: **1-217-558-2083**
Email address: **Consumer_complaints@ins.state.il.us**
Web: **mc.insurance.illinois.gov/messagecenter.nsf**

Claim Appeal Procedures

If you have received an adverse benefit determination, you may have your claim reviewed on appeal. An "adverse benefit determination" means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit in response to a claim, pre-service claim or urgent care claim, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an adverse benefit determination. A rescission of coverage is also an adverse benefit determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

The Claim Administrator will review its decision in accordance with the following procedures. The following review procedures will also be used for Claim Administrators.

i. Coverage determinations that are related to non-urgent care that you have not yet received if approval by your Plan is a condition of your opportunity to maximize your benefits and,
ii. Coverage determinations that are related to care that you are receiving at the same time as the determination. Claim reviews are commonly referred to as "appeals."

Within 180 days after you receive notice of an adverse benefit determination, you may call or write to the Claim Administrator to request a claim review. The Claim Administrator will need to know the reasons why you do not agree with the adverse benefit determination. To file an appeal or if you have questions, please call **1-800-538-8833** (TTY/TDD:711), send a fax to **1-888-235-2936**, or send a secure email to BCBSIL's Message Center by logging into Blue Access for Members (BAM) at **bcbsil.com**. You may also send your request to:

The Claim Administrator
Claim Review Section
P.O. Box 2401
Chicago, IL 60690

In support of your claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an adverse benefit determination or at any time during the claim review process.

The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have any questions about your rights, with whom to file a compliant or wish to take up your matter with the IDOI, you may use either address below:

IDOI Consumer Division
320 W. Washington St.
Springfield, IL 62767
1-217-782-4515

or

IDOI Consumer Division
122 S. Michigan Ave., 19th Floor
Chicago, IL 60603
1-312-814-2420
Web: **insurance.Illinois.gov**

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial adverse benefit determination. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim, and must file an appeal or appeals, and the appeals must be finally decided by the Claim Administrator or the Company.

Urgent Care/Expedited Clinical Appeals

If your appeal relates to an urgent care/expedited clinical claim, or health care services, including but not limited to procedures or treatments ordered by a health care provider, the denial of which could significantly increase the risk to the claimant's health, then you may be entitled to an appeal on an expedited basis. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and with an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an urgent care/expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claim Administrator shall render a determination on the appeal within 24 hours after it receives the requested information.

Other Appeals

Upon receipt of a non-urgent pre-service or post-service appeal, the Claim Administrator will send you a written decision for appeals that need medical review within 30 calendar days after your appeal request is received, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

If You Need Assistance

If you have an urgent care claim or any questions about the claims procedures or the review procedure, write or call the Claim Administrator at **1-800-538-8833**. The Claim Administrator offices are open from 8:45 a.m. to 4:45 p.m. CT, Monday through Friday.

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, IL 60680-4112

If you need assistance with the internal claims and appeals or external review processes, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at **1-877-527-9431**, or call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at **1-866-444-EBSA** (1-866-444-3272).

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed up by a written notice of the determination.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

4. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final determination on internal and external appeal;
5. An explanation that you and your provider may file appeals separately and at the same time, and that deadlines for filing appeals or external review requests are not delayed by appeals made by your provider unless you have chosen your provider to act for you as your authorized representative;
6. In certain situations, a statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s);
7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
8. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
9. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
10. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
11. A description of the standard that was used in denying the claim and a discussion of the decision.
12. When the notice is given upon the exhaustion of an appeal submitted by a health care provider on his/her own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;
13. When the notice of final adverse determination is given upon the exhaustion of internal appeals by the member, a statement that all internal appeals have been exhausted and the member has four months from the date of the letter to file an external review;
14. A statement indicating whether the adverse determination relates to a member appeal (filed by the member or authorized representative who may be the health care provider) or a provider appeal (pursuant to the provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and to file an external review regardless of the status of a provider appeal.

If the Claim Administrator's or the Company's decision is to continue to deny or partially deny your claim or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the Standard External Review.

You may file a complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the complaint. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file a civil action in a state or Federal court.

Forum Selection

In the event of any dispute relating to or arising from this Plan, the jurisdiction and venue for the dispute is the United States District Court for the Northern District of Illinois. If, and only if, the United States District Court for the Northern District of Illinois lacks subject-matter jurisdiction over such dispute, the jurisdiction and venue for the dispute is the Circuit Court of Cook County, Illinois.

Standard External Review

You or your authorized representative may make a request for a standard external review or expedited external review of an adverse benefit determination or final internal adverse benefit determination by an Independent Review Organization (IRO). The external review is at no charge to you.

For Medical benefits, you may have the right to request an external review of a claim involving medical judgment, as determined by the external reviewer, or; a coverage rescission; or, in the event there is a question as to whether the claim should have been subject to surprise billing protections, as required by the No Surprises Act provisions of the CAA. You must request the external review within four months of the date you receive an adverse benefit determination. If your request for an external review is determined eligible for such a review, an independent organization will review the Claims Administrator's decision and provide you with a written determination.

A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator's internal review/appeal process.

1. **Request for external review.** Within four months after the date of receipt of a notice of an adverse benefit determination or a final internal adverse benefit determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. **Preliminary review.** Within five business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
   a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the plan at the time the health care item or service was provided;
   b. The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
   c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **Exhaustion** section for additional information about exhaustion of the internal appeal process; and
   d. You or your authorized representative has provided all the information and forms required to process an external review.

   You will be notified within one business day after we complete the preliminary review whether your request is eligible or if further information or documents are needed. You will have the remainder of the four-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration toll-free at **1-866-444-EBSA** (1-866-444-3272).
3. **Referral to independent review organization.** When an eligible request for external review is completed within the time period allowed, the Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by a similar nationally recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The IRO must provide the following:

   a. Utilization of legal experts where appropriate to make coverage determinations under the plan.
   b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice with additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
   c. Within five business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.
   d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external

review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

e. Review of all the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
   1. Your medical records;
   2. The attending health care professional's recommendation;
   3. Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
   4. The terms of your Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
   5. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
   6. Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
   7. The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

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

g. The notice of final external review decision will contain:
   1. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
   2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
   3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
   4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
   5. A statement that the determination is binding except to the extent that other remedies may be available under Federal law to either the Claim Administrator and you or your authorized representative;
   6. A statement that judicial review may be available to you or your authorized representative; and
   7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

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

4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1. **Request for expedited external review.** The Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:
   a. An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
   b. A final internal adverse benefit determination if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility. Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment under the Medical benefit plan, you may begin an expedited external review before the Plan's internal appeals process has been completed.
2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the **Standard External Review**. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in the **Standard External Review**.
3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the **Standard External Review**. The Claim Administrator must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.
   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.
4. **Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the **Standard External Review**, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the final internal adverse benefit determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or has failed to comply with the internal claims and appeals process. In the event you have been deemed to have exhausted the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA. External review may not be requested for an adverse benefit determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

Prescription Drugs Claim Filing and Appeals Procedures

You can request that a medication be covered or be covered at a higher benefit. Express Scripts reviews both clinical and administrative coverage review requests.

- Clinical coverage review request: Request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan (i.e. medications that require a prior authorization).
- Administrative coverage review request: Request for coverage of a medication that is based on the Plan's benefit design.

Coverage Review and Appeals Requests

How to Request an Initial Coverage Review

To Request a Clinical Coverage Review	To Request an Administrative Coverage Review
Your prescriber must submit the request electronically. Information about electronic options can be found at **express-scripts.com/PA**.	You or your representative must submit the request in writing using the Benefit Coverage Request Form, obtained by calling the Customer Service phone number on the back of your ID card. Mail or fax the completed form to: Express Scripts Attn: Benefit Coverage Review Department PO Box 66587 St. Louis, MO 63166-6587 Fax: **1-877-328-9660**

How to Request a Level One Appeal

When an initial coverage review has been denied, a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why you disagree with the initial denial
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical Appeal Requests	Administrative Appeal Requests
Express Scripts Attn: Clinical Appeals Department PO Box 66588 St Louis, MO 63166-6588	Express Scripts Attn: Administrative Appeals Department PO Box 66587 St Louis, MO 63166-6587
Fax: **1-877-852-4070**	Fax: **1-877-328-9660**

How to Request a Level Two Appeal

When a level one appeal has been denied, a request for a level two appeal may be submitted by you or your authorized representative within 90 days from receipt of notice of the level one appeal adverse benefit determination. To initiate a level two appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why you disagree with the denial
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical Appeal Requests	Administrative Appeal Requests
Express Scripts Attn: Clinical Appeals Department PO Box 66588 St Louis, MO 63166-6588	Express Scripts Attn: Administrative Appeals Department PO Box 66587 St Louis, MO 63166-6587
Fax: **1-877-852-4070**	Fax: **1-877-328-9660**

Urgent Claims and Appeals

If your situation meets the definition of urgent under the law at any stage of the claims process, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the *opinion of your provider*, your life or health or the ability for the patient to regain maximum function may be in serious jeopardy or you may experience severe pain that cannot be adequately managed without medication while you wait for a decision on the review.

- **Initial Review:** Expedited review must be requested by the provider by phone at **1-800-753-2851**. Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.
- **Level One or Level Two Reviews:** If you or your provider believes your situation is urgent, the expedited review must be requested by phone or fax:

Clinical Appeal Requests	Administrative Appeal Requests
Phone: **1-800-753-2851**	Phone: **1-800-946-3979**
Fax: **1-877-852-4070**	Fax: **1-877-328-9660**

How to Request an External Review

The right to request an independent external review may be available for a denial involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts who were not involved in the prior determination of the claim. The request must be received within four months of the date of the final internal denial. If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day. External review requests need to be mailed or faxed to Express Scripts.

Express Scripts
Attn: External Review Requests
PO Box 66587
St. Louis, MO 63166-6587
Phone: **1-800-946-3979**
Fax: **1-877-328-9660**

Coverage Review and Appeals Processing

How a Coverage Review Is Processed

To make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, you must submit information to Express Scripts to support the request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of Claim	Decision Timeframe	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days (retail) 5 days (home delivery)	Patient: automated call (or letter) Prescriber: electronic or fax (letter if fax not successful)	Patient: letter Prescriber: electronic or fax (letter if fax not successful)
Standard Post-Service*	30 days		
Urgent	72 hours**	Patient: automated call and letter Prescriber: electronic or fax (letter if fax not successful)	Patient: live call and letter Prescriber: electronic or fax (letter if fax not successful)

* *If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber stating that the information must be received within 45 days or the claim will be denied.*

***Assumes all necessary information is provided. If not provided within 24 hours of receipt, a 48-hour extension will be granted.*

How a Level One Appeal or Urgent Appeal Is Processed

Express Scripts completes appeals per business policies that are compliant with state and Federal regulations. Appeal decisions are made by a pharmacist, physician, panel of clinicians, trained prior authorization staff member or independent third party utilization management company. Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe	Notification of Decision	
		Approval	Denial
Standard Pre-Service	15 days	Patient: automated call (or letter) Prescriber: electronic or fax (letter if fax not successful)	Patient: letter Prescriber: electronic or fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent	72 hours	Patient: automated call and letter Prescriber: electronic or fax (letter if fax not successful)	Patient: live call and letter Prescriber: electronic or fax (letter if fax not successful)

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

How a Level Two Appeal Is Processed

Express Scripts completes appeals per business policies that are compliant with state and Federal regulations. Appeal decisions are made by an Express Scripts pharmacist, specialist or panel of clinicians. Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe	Notification of Decision	
		Approval	Denial
Standard Pre-Service	15 days	Patient: automated call (or letter) Prescriber: electronic or fax (letter if fax not successful)	Patient: letter Prescriber: electronic or fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent	72 hours	Patient: automated call and letter Prescriber: electronic or fax (letter if fax not successful)	Patient: live call and letter Prescriber: electronic or fax (letter if fax not successful)

How a Standard External Review is Processed

Express Scripts will review the external review request within five business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within one business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within five business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the Claim Administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Life and AD&D Insurance Claim Filing and Appeals Procedures

Securian provides benefits and administers claims under the group Life Insurance and AD&D Insurance Plan. Benefits are determined and paid entirely by Securian. To file a claim your beneficiary should contact the Benefits Center at **1-888-60-myBBU** (1-888-606-9228). The Benefits Center will contact Securian, which will then work with your beneficiary to complete the claim paperwork and process. Please note that any claims relating to eligibility to participate will be handled by the Benefits Center.

You must provide notice — either written, authorized electronic (i.e., fax, email) or telephonic — of your claim within 31 days after a covered loss occurs or begins. If proper notice is not given, a claim may be invalidated or reduced unless it is shown that proper notice was given as soon as was reasonably possible. Notice should include the insured's name and policy number and the covered person's name, address, and policy and certificate number.

Notice of Adverse Benefit Determinations

If your claim is denied, you will receive a written or an electronic notice within 90 days after receipt of your claim (180 days if special circumstances apply and you are notified of the extension in writing within the initial 90-day period and informed of the anticipated benefit determination date). The explanation will include the following:

- The specific reasons for the denial
- The specific reference to the Plan documentation that supports these reasons
- The additional information you must provide to perfect your claim and the reasons why that information is necessary
- The procedure available for a further review of your claim, including a statement regarding your right to bring action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA) if your claim is denied on review
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request), if applicable.

Appeals

You have a right to appeal a denied claim for benefits by filing a written request for review of your claim with Securian after receipt of the notice informing you that your claim has been denied. Securian will conduct a full and fair review of your claim and appeal. You or your representative may review Plan documents and submit written comments with your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

Securian's review will take into account all comments, documents and other claim-related information that you submit regardless of whether that information was submitted or considered in the initial benefit determination.

Securian will reach a determination regarding your appeal 60 days after its receipt (120 days if Securian determines that special circumstances require an extension and, before the expiration of the initial 60 days, you are notified in writing of the circumstances warranting the extension and the anticipated determination date).

Notice of Benefit Determination on Appeal

You will receive a written or an electronic notice of the benefit determination upon review. In the event your claim is denied on appeal, the notice will provide:

- The specific reason or reasons for the denial of the appeal.
- Reference to the specific Plan provisions on which the benefit determination 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, if applicable, and a statement of your right to bring an action under Section 502(a) of ERISA.
- If an internal rule or guideline was relied on in making the adverse determination, either the specific rule or guideline, or a statement that such a rule or guideline was relied on in making the adverse determination and a copy of such rule or guideline will be provided free of charge upon request.

In the event that your appeal is denied, you have the right to bring legal action under Section 502(a) of ERISA, provided that you file any lawsuit or similar enforcement proceeding, commenced in any forum, regarding the Plan within 12 consecutive months after the date of receiving a final determination on review of your claim or, if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit.

Disability Claim Filing and Appeals Procedures

For information on how to file a claim for short-term disability (STD) benefits, contact MetLife at **1-833-622-0135**. You must also notify your supervisor and Human Relations Manager.

For information on how to file a claim for long-term disability (LTD) benefits, contact MetLife at **1-833-622-0135**.

STD coverage must be approved, except if you are receiving workers' compensation benefits, before LTD coverage will be considered. Any required claim forms will be sent to you by MetLife without any action by you, except if you are receiving workers' compensation benefits and your STD claim was denied, then you must contact MetLife to request the required LTD claim forms. You should submit the claim with the required proof of disability within 90 days of the date you become disabled, or as soon as reasonably possible.

MetLife has the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage of benefits under the Plan and to make any related finding of fact. All decisions made by MetLife are final and binding on you and your beneficiaries, to the extent permitted by law.

Initial Claims Determinations

A disability claim is any claim that requires a determination of short-term disability or long-term disability coverage. A disability claim is filed as of the date MetLife first receives notice that you are seeking disability benefits under the Plan, regardless of whether this notice is sent in writing (electronically or on paper) or by calling MetLife. When filing a claim, you must include the date of the disability/loss and your name and address.

MetLife has 45 days from the date it receives a claim for disability benefits to determine whether benefits are payable under the Plan. Each claim is reviewed on a case-by-case basis. If additional information is required, MetLife will notify you, in writing, stating what information is needed and why it is needed. If you do not provide the missing information by the date requested, MetLife will close your claim. If your claim for benefits is approved, MetLife will pay the appropriate benefit.

You can contact MetLife about claims using the information below:

- MyBenefits Employee Web address: **mybenefits.metlife.com**
- Claims phone number: **1-833-622-0135**
- Claims mailing address:
  MetLife Disability
  P.O. Box 14590
  Lexington, KY 40512-4590
- Claims fax number: **1-800-230-9531**

If a Claim Is Denied or Not Paid in Full

If your claim for benefits is denied in whole or in part, you or your authorized representative shall be notified in writing of the following:

1. The reasons for denial.
2. A reference to the benefit Plan provisions on which the denial is based.
3. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary.
4. A description of MetLife's review procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action (for LTD benefits only) under section 502(a) of ERISA after your appeals and after you receive an adverse decision on appeal.
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   a. The views presented by you to MetLife of the health care professionals treating you and the vocational professionals who evaluated you;
   b. The views of medical or vocational experts whose advice was obtained on behalf of MetLife in connection with your adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and
   c. A disability decision regarding you, and presented by you to MetLife, made by the Social Security Administration.
6. Either the specific internal rules, guidelines, protocols, standards, or other similar Plan criteria MetLife relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar Plan criteria do not exist.
7. If the adverse decision is based upon medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request;
8. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits; and
9. A notice provided in a culturally and linguistically appropriate manner for the LTD Plan, to the extent required by ERISA.

Claim Appeal Procedures

STD Appeals

If MetLife denies your STD claim, you have a right to appeal the decision. Submit your request in writing within 180 days from the date of the denial letter. Include the reason(s) you believe the claim was improperly denied or your benefits reduced, and send any additional information, documents or records that you believe are necessary for MetLife to consider. (Please note that a leave decision is not subject to this appeal right.) You may speak to a MetLife representative by calling **1-833-622-0135** Monday through Friday from 8:00 a.m. to 11:00 p.m. ET.

Please write the claim number located in the upper right-hand corner of the denial letter on any documentation you send to MetLife.

MetLife will give you free copies of any documents or records they have that are relevant to your claim if you request them in writing.

Submit your appeal by:

- Mail: MetLife Disability, P.O. Box 14592, Lexington, KY 40512-4592
- Fax: **1-844-380-0569**
- Email: **disabilityappeals@metlife.com**

LTD Appeals

If MetLife denies your LTD claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of associate
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim. After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and reference any specific Plan provision(s) on which the denial is based. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Other Claim Filing Procedures

Critical Illness, Hospital Indemnity and Accident Insurance	Securian provides benefits and claims under the group Critical Illness Insurance, Hospital Indemnity and Accident Insurance programs. Benefits are determined and paid entirely by Securian. For more information on how to file a claim, contact Securian at: Securian P.O. Box 64114 St. Paul, MN 55164-0114 **1-855-750-1906** **securian.com** Learn more at **securian.com/bimbo-bakeries-insurance**.
Dental	To submit a claim for services you paid up front from visiting an out-of-network dentist, you must complete a **PPO claim form**. You can download and print the form. Complete it and have the dentist sign it, and then mail it to: Delta Dental of Pennsylvania P.O. Box 2105 Mechanicsburg, PA 17055-6999 Be sure to include a detailed billing statement listing all services provided. If completing the form electronically, please make sure the #3 Company drop down is on Delta Dental of Pennsylvania. Note: A provider's office will submit in-network claims.
Vision	Your claim will automatically be processed by Vision Service Plan (VSP). If you visit an out-of-network provider, you will need to submit a claim form along with the paid receipt to the address provided on the claim form. Claim forms can be found at **myBBUbenefits.com** under Plan Documents.
Flexible Spending Accounts	You can submit a claim for reimbursement from your health care and/or dependent care FSA through HealthEquity at **healthequity.com/bbu**, or you can call **1-877-636-5123** and request a paper reimbursement form.
Personal Time Off	Contact your supervisor or Human Relations Manager.

Continued on the next page >

Other Claim Filing Procedures (continued)

New York State Paid Family Leave	To file a claim for New York State Paid Family Leave, contact MetLife at **1-833-622-0135**, online at **mybenefits.metlife.com**, or by mail at: MetLife Disability P.O. Box 14590 Lexington, KY 40512-4590 Fax number: **1-800-230-9531**. For more information about New York State Paid Family Leave, contact the New York State Paid Family Leave helpline at **1-844-337-6303**, Monday through Friday, 8:30 a.m. to 4:30 p.m. ET. New York State Paid Family Leave must be approved. If you have a foreseeable situation, you must give the Company 30 days advance notice of your leave. If your event is not foreseeable, you must notify the Company as quickly as possible. If you fail to do so without unusual circumstances justifying the failure, your New York State Paid Family Leave can be delayed or partially denied. You must complete the appropriate form and provide documentation in support of your request.
Group Legal	For information on how to file a claim for group legal benefits, contact MetLife Legal Plans at **1-800-821-6400**. If you are denied coverage by MetLife Legal Plans or by any Plan Attorney, you may appeal by sending a letter to: MetLife Legal Plans, Inc. Director of Administration 1111 Superior Avenue Suite 800 Cleveland, OH 44114-2507 The Director will issue MetLife Legal Plans' final determination within 60 days of receiving your letter. This determination will include the reasons for the denial with reference to the specific plan provisions on which the denial is based, a description of any additional information that might cause MetLife Legal Plans to reconsider the decision, an explanation of the review procedure, and notice of the right to bring a civil action under Section 502(a) of ERISA.

Notice of Claim: Unless otherwise provided in this SPD or the booklets provided by the insurance companies, claims for benefits should be submitted to the claims processor within 12 months after the occurrence or commencement of any services covered by the Plan, or as soon thereafter as reasonably possible.

General Provisions

Assignment

Covered persons cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a hospital, physician, or other provider, if any, shall be done as a convenience to the covered person and shall not constitute an assignment of benefits under the Plan. Participating providers normally bill the Plan directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The covered person's portion of the negotiated rate, after the Plan's payment, will be billed to the covered person by the participating provider. This Plan will pay benefits to the responsible party of an alternate recipient as designated in a Qualified Medical Child Support Order.

Benefits Not Transferable

Except as otherwise stated herein, no person other than an eligible covered person is entitled to receive benefits under this Plan. Any right to benefits is not transferable.

Clerical Error

No clerical error on the part of the Company, the Plan Administrator or the claims processor shall operate to defeat any of the rights, privileges, services, or benefits of any associate or any dependent(s) hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder.

Incapacity

If, in the opinion of the Plan Administrator, a covered person for whom a claim has been made is incapable of furnishing a valid receipt of payment due him/her, and in the absence of written evidence to the Plan of the qualification of a guardian or personal representative for his/her estate, the Plan Administrator may, on behalf of the Plan, at his/her discretion, make any and all such payments to the provider of services or other person providing for the care and support of the covered person. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment.

Legal Actions

No action at law or inequity shall be brought to recover on the benefits from the Plan until the claimant has exhausted his/her appeal rights described under **Claim Filing and Appeals Procedures**. No such action shall be brought after the expiration of two years from the date the expense was incurred, or one year from the date a completed claim was filed, whichever occurs first.

Limitation on Liability

Liability under the Plan is limited to the services and benefits specified, and the Plan shall not be liable for any obligation of the covered person incurred in excess of those services and benefits. The liability of the Plan shall be limited to the reasonable cost of covered expenses and shall not include any liability for suffering or general damages.

Lost Distributees

Any benefit payable under the Plan shall be deemed forfeited if the Plan Administrator is unable to locate the covered person to whom payment is due, provided, however, that benefits shall be reinstated if a claim is made by the covered person for the forfeited benefits within the time prescribed in **Claim Filing and Appeals Procedures**.

Medical 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 a covered person or in determining or making any payment of benefits to that individual. The Plan will pay benefits with respect to that individual in accordance with any assignment of rights made by or on behalf of the 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 the individual under a State Medicaid Plan and this 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 the individual to make payment for such services, supplies or treatment under the Plan.

Misrepresentation

If the covered person or anyone acting on behalf of a covered person makes a false statement on the application for enrollment, or withholds information with an intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, all costs of collection, including legal fees and court costs, from the covered person, or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided. Any material misrepresentation on the part of the covered person in making application for coverage, or any application for reclassification of the covered person, or for service under the Plan shall render the coverage under this Plan null and void.

Physical Examinations

The Plan, at its own expense, shall have the right to require an examination of a person covered under this Plan when and as often as it may reasonably require during the pendency of a claim.

Plan Administrator

The Plan is administered by the Plan Administrator. The Plan Administrator is also the "named fiduciary" of the Plan under ERISA. In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan, and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to delegate certain of its powers and duties to a third party. The Plan Administrator has delegated certain administrative and fiduciary functions under the Plan to the claims processor and other third-party service providers. The Plan Administrator (or its delegate) shall have the authority to make all decisions relative to the operation of the Plan including, but not limited to, the approval or denial of certification of hospital or medical services, supplies and treatment, the interpretation of the terms of the Plan; and the determination of eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be final and binding on all parties and generally will not be overturned by a court of law.

Plan Is Not a Contract

The Plan shall not be deemed to constitute a contract between the Company and any associate or to be a consideration for, or an inducement or condition of, the employment of any associate. Nothing in the Plan shall be deemed to give any associate the right to be retained in the service of the Company or to interfere with the right of the Company to terminate the employment of any associate at any time.

Recovery of Overpayment

Whenever payments have been made from the Plan in excess of the maximum amount of payment authorized by the terms of the Plan, the Plan will have the right to recover these excess payments. If the Plan makes any payment that, according to the terms of the Plan, should not have been made or that was proper when made but should have been returned to the Plan under the Subrogration/Reimbursement **General Principle**, the Plan may recover that incorrect payment, whether or not it was made due to the Plan's own error, from the person or entity to whom it was made or from any other appropriate party. The Plan or its designee may withhold or offset future benefit payments, sue to recover such amounts, or use any other lawful remedy to recoup any such amounts.

Right to Receive and Release Information

Subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan Administrator, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits (and the payment of those benefits) pursuant to this section. You must provide the Plan with any information requested in order to coordinate your benefits.

Status Change

If an associate or a dependent has a status change while covered under this Plan (e.g., dependent to associate, COBRA to active) and no interruption in coverage has occurred, the Plan will provide continuous coverage with respect to limitation on deductible(s), coinsurance and maximum benefit.

Workers' Compensation

This Plan is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

Qualified Medical Child Support Orders

The Plan may be required to cover your child due to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child. A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your Federal income tax return, and children who don't reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

To request a copy of the plan's procedures governing QMSCO, contact the Benefits Center.

Special Notices

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, as amended (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (SPD). The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation of coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Company, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request materials 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 that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court.
- If the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Advance Notice of Rescission

The Plan cannot retroactively cancel or terminate an individual's coverage, except in cases of deliberate fraud and other limited circumstances. The Plan will give affected individuals at least 30 days' advance written notice. The notice will confirm the rescission of coverage, the date coverage ends and the reason for rescission.

Women's Health and Cancer Rights Act of 1998

The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- All stages of reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions which apply to other medical and surgical benefits provided under this Plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the plan descriptions.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Uniformed Services Employment and Reemployment Rights Act

If you are absent from work due to a military service leave qualifying under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may elect to continue the type of coverage in effect on the day immediately prior to the start of such leave. Such coverage will continue until the earlier of the following occurs: the date you fail to return to active employment as required under USERRA or 24 months.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid for medical coverage before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire cost of coverage for active associates (i.e. the associate's share plus the Company's share).

If you decide to waive coverage under the Plan during a military leave qualifying under USERRA and return to employment following the leave (within the time period specified by USERRA), you will be reinstated in the Plan. Once you resume coverage, the Plan does not cover any expenses you incur relating to any illness or injury incurred in, or aggravated during, the performance of military service.

For additional information on military leaves, such as how to request a leave and other rights and obligations, as well as their impact on benefits, please contact your Human Relations Business Partner.

New York State Paid Family Leave

If you take a paid leave of absence under the New York State Paid Family Leave (PFL) program, you and your covered dependents will continue the type of coverage in effect on the day immediately prior to the start of such leave. If you have worked for at least 26 consecutive weeks and are eligible for PFL, you will be entitled to receive partial wage replacement of up to 12 weeks to care for a seriously ill family member, bond with a new child or handle matters related to a family member's active military duty. You will have job retention and reinstatement rights during the paid family leave and your health benefits will remain unchanged from the level before the leave began. The Plan will continue to pay for your health coverage the same as if you had continued to work during the leave. You will still be required to make your premium payments either via Company payroll if you are being paid by the Company or via direct bill if you are being paid from MetLife. In situations where your request qualifies for leave under PFL, FMLA, and Company-provided disability insurance coverage, the Plan may count these leave entitlements concurrently.

For additional information on PFL, such as how to request a leave and other rights and obligations, as well as their impact on benefits, please contact MetLife at **1-833-622-0135** or visit **mybenefits.metlife.com**.

Fixed Indemnity Plan Notice

IMPORTANT: The Company offers Critical Illness and Hospital Indemnity Insurance, which are fixed indemnity policies, NOT health insurance. These fixed indemnity policies may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much each of these policies will pay each year.
- These policies aren't a substitute for comprehensive health insurance.
- Since these policies aren't health insurance, they don't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- You can get health insurance through the Company. Refer to your Benefits Guide for more information.
- Visit **HealthCare.gov** or call **1-800-318-2596** (TTY: **1-855-889-4325**) to find health coverage options.
- If you can get health insurance through a family member's job, contact their employer.

Questions about these policies?

- For questions or complaints about these policies, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you are enrolled in these policies through the Company, or a family member's job, contact the Benefits Center for policies through the Company or your family member's employer if you have coverage through them.

General Notice of COBRA Continuation Coverage Rights

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. Group health coverage includes medical/prescription drug, dental and vision coverage, as well as the employee assistance program. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for this coverage.

Who Is Eligible?

As an Associate

If you are an associate, you will become a qualified beneficiary if you lose your coverage under the Plan due to one of these qualifying events:

- Your hours of employment are reduced
- Your employment ends for any reason, except for gross misconduct

As a Covered Spouse

If you are the legal spouse of an associate, you will become a qualified beneficiary if you lose your coverage under the Plan due to one or more of these qualifying events:

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reason other than his or her gross misconduct
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both) and is not an active associate
- You become divorced from your spouse

As a Covered Dependent Child

Your dependent children will become qualified beneficiaries if they lose their coverage under the Plan due to one or more of these qualifying events:

- The associate dies
- The associate's hours of employment are reduced
- The associate's employment ends for any reason other than his/her gross misconduct
- The associate becomes divorced
- The child stops being eligible for coverage under the Plan as a "dependent child"
- The associate becomes enrolled in Medicare benefits (Part A, Part B, or both) and is not an active associate

As a Newly Acquired Dependent Child

If you are a qualified beneficiary and have a newborn child, you adopt a child or a child is placed for adoption with you while you are covered under COBRA, that child can also receive COBRA for the duration of your COBRA continuation coverage. You must notify the COBRA Administrator in writing within 31 days of the birth, adoption or placement for adoption for the child to be covered as of the date of the birth, adoption or placement for adoption. You will also be required to provide proof of dependent status (see page 5). In this case, the child will have the same rights as any dependent covered immediately prior to your COBRA eligibility. (A child is considered "placed for adoption" with you when you have assumed and retained a legal obligation for total or partial support of the child in anticipation of adoption).

Written notice about a new dependent must include information about the qualified beneficiary receiving COBRA coverage as well as the new child who will be receiving COBRA coverage. The COBRA Administrator also may ask you to provide documentation supporting the birth, adoption or placement for adoption of the new child.

If you don't notify the COBRA Administrator within 31 days of the qualifying event, you won't be offered the option to elect COBRA coverage for the new child.

Note: Other newly acquired dependents (such as a new spouse) won't be considered qualified beneficiaries but may be added to your COBRA coverage as dependents, according to Plan rules that apply to active associates.

If a Qualifying Event Occurs

When the qualifying event is the end of employment or reduction in hours of employment, or the death of an active associate, the Benefits Center is automatically notified.

What You Need to Do

Under COBRA, you, your spouse or your other eligible dependents have the responsibility to inform WageWorks of a divorce or child's loss of dependent status under the Plan, or enrollment in Medicare (Part A, Part B or both) if the associate is not an active associate.

Notice must be provided to WageWorks, in accordance with the procedures described below, by the latest of the following to occur:

- Within 31 days from the date of the divorce or loss of dependent status; or if later
- The date coverage would normally be lost because of the event; or if later
- The date on which the qualified beneficiary is informed through the Summary Plan Description or the COBRA General Notice of his/her obligation to provide notice and the procedures for such notice.

You also must provide information about the associate or qualified beneficiary requesting COBRA coverage and any required documentation about the qualifying event that gave rise to the individual's right to COBRA coverage.

If you or the qualified beneficiary fails to notify WageWorks in accordance with these procedures or to provide supporting documentation within the timeframes listed above, COBRA rights will be forfeited.

When you inform WageWorks that one of these events has happened (and the required documentation has been received), you will be notified as to whether or not you have the right to elect COBRA coverage.

Documentation Required

When you provide notice of the qualifying event, you or the qualified beneficiary must submit documentation supporting the occurrence of the qualifying event. See page 5 for a summary of acceptable documentation.

How Is COBRA Continuation Coverage Provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered associates may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the associate, enrollment of the associate in Medicare (Part A, Part B, or both), your divorce, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the associate's hours of employment, and the associate became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the associate is 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered associate becomes entitled to Medicare within 18 months before termination or reduction of hours. For example, if a covered associate becomes entitled to Medicare eight months before the date on which his/her employment terminated, COBRA continuation coverage for his/her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment or reduction of the associate's hours of employment, COBRA continuation coverage lasts for up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended — if an associate experiences a second COBRA-qualifying event, or if an associate becomes eligible for disability.

How to Apply for COBRA

If you want to apply for COBRA, contact WageWorks. Once WageWorks has received all required information and documentation from the Company, you will be informed about whether or not you have the right to choose COBRA coverage and will receive instructions and additional information about COBRA.

If you have questions about COBRA coverage once you have received the election forms or you have elected COBRA, please contact WageWorks at **1-877-630-7215** (Fax: **1-877-775-9399**) or **mybenefits.wageworks.com**.

WageWorks, Inc.
P.O. Box 226101
Dallas, TX 75222-610

Electing COBRA

Generally, when you become eligible for continuation coverage and have been notified of the right to elect COBRA — or if applicable, you have notified WageWorks about a qualifying event in a timely manner — the COBRA Administrator will provide you with information about your COBRA rights and how to elect coverage online.

Note: Remember, in the case of divorce or ineligibility of a dependent child, you are responsible for notifying WageWorks in accordance with Plan procedures within the timeframes required. If you do not provide notice and all required documentation, you may lose your right to elect COBRA coverage.

You must elect COBRA coverage within 60 days of the loss of coverage caused by the qualifying event, or if later, within 60 days of the date the COBRA notice is sent.

Simply fill out the COBRA election form and return it to the COBRA Administrator. You will have an additional 45-day period from the date you send your election form to pay the premium necessary (retroactive to the date benefits terminated) to avoid any gap in coverage. After that, you must pay the premium by a certain date each month. Please check with the COBRA Administrator for this date.

Failure to pay premiums on a timely basis may result in permanent termination of COBRA coverage.

If You Don't Make an Election within the 60-Day Time Period

An associate or family member who does not choose COBRA coverage within the time period described here will lose the right to elect COBRA coverage. You and your eligible family members also will be required to reimburse the Plan for any claims mistakenly paid after the date coverage would normally have been lost.

Coverage Options

If you choose COBRA coverage, the Company is required to give you coverage that, as of the time coverage is elected, is the same coverage you and your eligible dependent(s) had on the day before the qualifying event. After your initial election, you'll have the same opportunity to change coverage as active associates have. This also means that if the coverage for "similarly situated" associates or family members is modified, your coverage will be modified in the same way. "Similarly situated" refers to a current associate or dependent who has not had a qualifying event.

Your COBRA rights are provided as required by law and will change accordingly if the law changes.

Separate Elections

Each qualified beneficiary has a separate right to elect COBRA coverage. This means that a spouse or dependent child is entitled to elect COBRA coverage even if you don't make an election. However, you or your spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

How Will COBRA Work for Medical Plan Participants?

The Company Medical Plan will follow standard COBRA regulations. If a Plan participant elects COBRA, he/she will receive the amount that was in the HSA, if any, the day before becoming a COBRA participant to use for eligible health care expenses. Any credits made toward the annual deductible during that Plan year are credited toward the COBRA beneficiary's new deductible at the time of a qualifying event. If the COBRA beneficiary(s) decreases his/her coverage level (e.g., You + Family to You Only), there is no change to the HSA dollar amount for the remainder of the Plan year. The COBRA beneficiary has the same HSA he/she had the day before the qualifying event. However, the COBRA beneficiary will be subject to a new deductible with any claims incurred before the qualifying event credited to his/her new deductible.

When a new Plan year begins, those who elect to remain in the Plan will not receive a Company HSA contribution.

If Your Covered Family Members Have a Qualifying Event

Keep in mind that you and your qualified family members may make separate and independent COBRA elections. That means if your covered spouse or covered dependent chooses the same coverage level as you, he/she begins COBRA with medical plan components exactly as they stood the day before the qualifying event. That is, he/she will have the exact same HSA amount, deductible amount and out-of-pocket maximum amount as you had on the day before the qualifying event. If the COBRA beneficiary chooses to remain in the medical plan when a new Plan year begins, he/she can make contributions to the HSA, but will not receive a Company contribution, and will be subject to a new annual deductible and out-of-pocket maximum — along with all other annual limits based on the coverage level chosen.

Cost of COBRA Coverage

Under the law, you may be required to pay up to 102% of the cost of COBRA coverage for yourself and your dependents. You will generally pay for your coverage on an after-tax basis.

If your coverage is extended from 18 months to 29 months for disability, you may be required to pay up to 150% of the cost of COBRA coverage beginning with the 19th month of coverage.

The cost of group health coverage periodically changes. If you elect COBRA coverage, the COBRA Administrator will notify you of any changes in the cost. Premiums are established in a 12-month determination period and will increase during that period:

- If the Plan has been charging less than the maximum permissible amount;
- If the qualified beneficiary changes his/her coverage level; or
- In the case of a disability extension.

COBRA Premium Payment Deadlines

The initial payment for COBRA coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis. You have a grace period of at least 30 days for the payment of the regularly scheduled premium.

You are responsible for making sure that the amount of your payment is correct. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Length of COBRA Coverage

If elected, COBRA coverage begins on the date your coverage as an active associate ends. For dependents who no longer satisfy the requirements for dependent coverage, COBRA coverage begins on the date their dependent coverage ends (i.e. the last day of the month in which the dependent loses eligibility).

However, coverage won't take effect unless COBRA coverage is elected as described in **Electing COBRA** and the required premium is received. The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage.

If you lose group health coverage because of a termination of employment or reduction in hours, COBRA coverage may continue for you and your covered dependents for up to 18 months.

COBRA coverage for your covered dependents may continue for up to 36 months if coverage would otherwise end because:

- You die,
- You divorce, or
- Your dependent child loses eligibility for coverage.

Extension of COBRA Coverage for Additional Qualifying Events

Additional qualifying events (such as a death or divorce) may occur while COBRA coverage is in effect. These events may extend an 18-month continuation period to 36 months for your covered dependents, but in no event will coverage last beyond 36 months from the date the qualified dependent first became eligible to elect continuation coverage. These events can be second qualifying events only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

If an additional qualifying event occurs within the first 18 months of coverage, you must notify the Plan within 60 days of the second qualifying event in accordance with the procedures described in **Electing COBRA** or your coverage cannot be extended.

If termination of employment or reduction of hours follows Medicare enrollment, the COBRA coverage period for your spouse and dependent children is 36 months from the Medicare enrollment date or 18 months from the subsequent termination or reduction of hours, whichever is longer.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely manner, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some point before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must make sure that the COBRA Administrator is notified of the Social Security Administration's determination within 60 days of the determination and before the end of the 18-month period of COBRA continuation coverage.

If a child is born to you or is placed for adoption with you while you are continuing coverage and the child is determined to be disabled within the first 60 days of COBRA coverage, the child and all family members with COBRA coverage arising from the same qualifying event may be eligible for a total of up to 29 months of COBRA coverage.

Social Security Administration Determination of Disability

Notice by the Social Security Administration of a determination of disability or a determination that an associate or covered family member is no longer disabled must be provided to the COBRA Administrator in writing. The notice must include a copy of the Social Security Administration Award Determination Notice and information about the associate or covered family member requesting a disability COBRA coverage extension or notifying the COBRA Administrator that he/she is no longer disabled.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage for a maximum of 36 months provided the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and dependent children receiving COBRA continuation coverage if the associate or former associate dies, enrolls in Medicare (Part A, Part B or both) or gets divorced. The extension is also available to a dependent child when the child stops being eligible under the Plan as a dependent child. In each case, however, the extension of COBRA continuation coverage will only apply if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the COBRA Administrator, (see **COBRA Questions**) is notified of the second qualifying event within 60 days of the second qualifying event.

Continuing Coverage in Special Cases

COBRA and the Family Medical Leave Act (FMLA)

Taking an approved leave under FMLA isn't considered a qualifying event that would make you eligible for COBRA coverage. However, a COBRA qualifying event occurs if:

- You or your dependent is covered by the Plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave); and
- You don't return to employment at the end of the FMLA leave or you terminate employment during your leave.

Your COBRA coverage may begin on the earlier of the following:

- When you inform the Company that you are not returning to work; or
- The end of the FMLA leave, if you don't return to work.

COBRA and USERRA

Associates and dependents who lose health coverage due to the associate's military leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) may elect to continue coverage for up to 24 months. Any individual who elects to continue such coverage will be required to make after-tax contributions equal to the same portion of the total cost that the associate contributed prior to the leave. Failure to make the required contributions when due will result in termination of coverage and COBRA procedures will apply.

QMCSO

A child of the covered associate who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Company during the covered associate's period of employment with the Company is entitled to the same rights to elect COBRA as an eligible dependent child of the covered associate.

Early Termination of COBRA Coverage

The law provides that your COBRA coverage may be cut short before the expiration of the 18-, 29- or 36-month period for any of the following reasons:

- The Company no longer provides group health coverage to any of its associates;
- The full premium for COBRA coverage isn't paid on time (within the applicable grace period);
- The qualified beneficiary becomes covered – after COBRA coverage is elected – under another group health plan;
- You first become entitled to Medicare after the date COBRA coverage is elected; or
- Coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled.

Converting Coverage

Your health care coverage cannot be converted to individual health insurance policies when your COBRA coverage ends.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Can I Enroll in Medicare Instead of COBRA Continuation Coverage after my Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit **medicare.gov/medicare-and-you**.

Health Care Flexible Spending Account (FSA) COBRA Coverage

COBRA coverage for the Health Care FSA, if elected, will consist of the Health Care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-or-lose rule will continue to apply. All qualified beneficiaries who were covered under the Health Care FSA will be covered together for Health Care FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care FSA annual coverage limit and a separate COBRA premium.

COBRA Questions

If you have any questions about COBRA coverage or the application of the law, contact WageWorks. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available at **dol.gov/ebsa** or call their toll-free number at **1-866-444-3272**.

Also, you must notify WageWorks in writing immediately if:

- Your marital status has changed;
- You, your spouse or a dependent has a change in address; or
- A dependent loses eligibility for dependent coverage under the terms of the Plan.

All initial notification about qualifying events and questions about Company group health care plans should be directed to WageWorks (COBRA Administrator) at:

WageWorks, Inc.
1-877-630-7215

Keep Your Plan Informed of Address Changes

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

[1] ***https://www.medicare.gov/basics/get-started-with-medicare/sign-up***

General Information

Full Plan Name

Bimbo Bakeries USA Health & Welfare Plan

Plan Sponsor

Bimbo Bakeries USA
355 Business Center Drive
Horsham, PA 19044
1-877-524-5218

Plan Administrator

Bimbo Bakeries USA Pension and Benefits Committee
355 Business Center Drive
Horsham, PA 19044
1-877-524-5218

Agent for Service of Legal Process

Plan Administrator
Bimbo Bakeries USA
355 Business Center Drive
Horsham, PA 19044
1-877-524-5218

For Questions About the Plan

Benefits Center
1-888-60-myBBU (1-888-606-9228)

The Company's Employer Identification Number

75-2490530

Plan Number

532

Type of Plan

Health and Welfare Plan providing the following benefits: medical, prescription drugs, critical illness, hospital indemnity, accident insurance, dental, vision, flexible spending accounts, employee assistance program, life insurance, accident death and dismemberment, short-term disability, long-term disability, group legal, business travel accident. The medical and prescription drug plan constitutes a group medical plan for purposes of Federal law.

Type of Administration

The determination and/or processing of claims for medical and prescription drugs under the terms of the Plan is provided through a third party contracted by the Company and is referred to in this summary as the claims processor. Eligibility for severance benefits is determined by the Company and processed by the Benefits Center. Each of these claims is provided from the general assets of the Company.

Source of Plan Contributions

Contributions for Plan expenses are obtained from the Company and from covered persons. The Company evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the Company and the amount to be contributed by covered persons. Where the Company and associates share the cost of coverage, the Company shall contribute the difference between the amount associates contribute and the amount required to pay benefits under the Plan. The Plan Administrator will notify associates annually as to what the associate contribution rates will be. The Company, in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse the Company for their contributions, unless otherwise provided in that group insurance contract or required by applicable law.

Funding Method

Plan benefits and administration expenses are paid directly from the Company's general assets. Contributions received from covered persons are used to cover Plan costs and are expended immediately.

Plan Year

The Plan year is January 1 – December 31.

Plan Amendment and Modification

The Pension and Benefits Committee may modify or amend the Plan at any time in its sole discretion. Any amendment may include, but is not limited to, the right to (1) change or eliminate benefits, (2) increase or decrease associate contributions, (3) increase or decrease deductibles, and (4) change the class(es) of associates and/or dependents covered by the Plan. Any such amendments or modifications which affect covered persons will be communicated to covered persons. Any such amendments shall be in writing, setting forth the modified provisions of the Plan and the effective date of the modifications, and shall be signed by the Company's designee. Any such modification or amendment shall be made by or pursuant to formal action taken by the Company's Board or by the execution of a written amendment by the Pension and Benefits Committee.

Plan Termination

The Pension and Benefits Committee reserves the right to terminate the Plan at any time and for any reason. Upon termination of the Plan, the rights of covered persons to benefits are limited to claims incurred up to the date of termination. Any termination of the Plan will be communicated to covered persons.

Future of the Plan

The Company intends to continue the Plan indefinitely. However, the Company reserves the right to amend, modify or terminate the Plan or part of the Plan at any time for any reason. The Company takes such action through board of directors' resolutions or through an administrative committee or other persons authorized by the board of directors.

If a health benefit plan such as the Bimbo Bakeries USA Health & Welfare Plan is terminated, you will not receive any further benefit under the Plan other than payments of benefits for losses or covered expenses incurred before the Plan was terminated.

Employment Rights Not Implied

Participation in the Plan does not give you the right to remain employed by the Company or any participating division or subsidiary. In addition, participation does not give you a right to any benefit to which you are not entitled under the terms of the Plan.

Procedures for Filing Claims

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, see **Claim Filing and Appeals Procedures**. The designated claims processor for each of the benefits is set forth below:

Benefit	Claims Processor
Medical	To pursue an inquiry or a complaint, you may contact BCBSIL Customer Service at the number on the back of your ID card, or write to: Blue Cross and Blue Shield of Illinois 300 East Randolph Chicago, IL 60601 **1-877-239-7449** **bcbsil.com** The Company has contracted with BCBSIL to provide claims services under the Plan. Benefits are "self-insured" (that is, paid from the Company's general assets) and are not guaranteed under the contract.
Prescription Drug	Express Scripts **1-866-544-2941** **express-scripts.com** The Company has contracted with Express Scripts to provide claim services under the Plan. Benefits are "self-insured" (that is, paid from the Company's general assets) and are not guaranteed under the contract.
Telemedicine	MDLive **1-888-676-4204** **mdlive.com** The Company has contracted with MDLive to provide claims services under the Plan. Benefits are paid entirely through participant copays and coinsurance and are not guaranteed under the contracts.
Critical Illness, Hospital Indemnity and Accident Insurance	Securian P.O. Box 64114 St. Paul, MN 55164-0114 **1-855-750-1906** **securian.com/bimbo-bakeries-insurance** Securian provides critical illness, hospital indemnity and accident insurance benefits and claims services under the Plan. Benefits are determined and paid entirely by Securian.
Dental	Delta Dental of PA One Delta Drive Mechanicsburg, PA 17055 **1-800-471-5612** **deltadentalins.com** The Company has contracted with Delta Dental of PA to provide claims services under the Plan. Benefits are "self-insured" (that is, paid from the Company's general assets) and are not guaranteed under this contract.

Benefit	Claims Processor
Vision	Vision Service Plan **1-800-877-7195** **vsp.com** The Company has contracted with Vision Service Plan to provide claims services under the Plan. Benefits are "self-insured" (that is, paid from the Company's general assets) and are not guaranteed under the contracts.
Spending/Savings Accounts: • **Health Savings Account** • **Flexible Spending Accounts**	HealthEquity **1-877-636-5123** **healthequity.com/bbu** The Company has contracted with HealthEquity to provide administrative services (such as claims review) under these accounts.
New York State Paid Family Leave	MetLife **1-833-622-0135** **mybenefits.metlife.com** The Company has contracted with MetLife to provide administrative and determination of claim services under the Plan.
Group Legal	MetLife Legal Plans 1111 Superior Avenue 8th Floor Cleveland, OH 44114 **1-800-821-6400** **legalplans.com** MetLife Legal Plans provides legal services benefits and claims services under the Plan. Benefits are determined and paid entirely by MetLife Legal Plans.
Short-Term Disability	MetLife Disability **1-833-622-0135** **mybenefits.metlife.com** The Company has contracted with MetLife to provide determination of claim services under the Plan. Benefits are "self-insured" (that is, paid from the Company's general assets) and are not guaranteed under the contract.
Long-Term Disability	MetLife Disability **1-833-622-0135** **mybenefits.metlife.com** The Company has contracted with MetLife to provide long-term disability benefits and claims services under the Plan. Benefits are determined and paid entirely by the insurance company and are guaranteed under the policy.
Life, Accidental Death and Dismemberment, Supplemental Life and Dependent Life	Securian Life **1-866-293-6047** **securian.com/bimbo-bakeries-insurance** The Company has contracted with Securian Life to provide life and accidental death and dismemberment benefits and claims services under the Plan. Benefits are determined and paid entirely by the insurance company and are guaranteed under the policy.
COBRA Administration	Contact WageWorks at **1-877-630-7215** with any questions.