Plan Document and
Summary Plan Description for the
Pepsi-Cola Bottling Co. of Corbin Kentucky, Inc.
Employee Benefits Plan

- Your Health Care Benefits
- Your Life Insurance and AD&D Benefits
- Your Disability Benefits

EFFECTIVE DATE: 01/01/2019

Introduction

Pepsi-Cola Bottling Co. of Corbin Kentucky, Inc. (the "Employer" or "Company") is pleased to offer benefits through the Pepsi-Cola Bottling Co. of Corbin Kentucky, Inc. Employee Benefits Plan. These benefits are a valuable and important part of your overall compensation package.

This booklet provides important information about the Benefit Program(s) covered under the Plan. It serves as the Plan document and the Summary Plan Description ("SPD") for the Pepsi-Cola Bottling Co. of Corbin Kentucky, Inc. Employee Benefits Plan ("the Plan"). It is written to comply with the written plan document and disclosure requirements under the Employee Retirement Income Security Act ("ERISA") of 1974, as amended.

The "Benefit Programs" covered by this Plan are shown in Appendix A. For fully insured Benefit Programs, the insurance contracts or policies (including amendments and riders), plan descriptions, benefit summaries, schedule of benefits and other descriptive documents relating to each Benefit Program (collectively, the "insurance certificates") are incorporated herein by reference only to the extent they are the source of eligibility, benefits, claims procedures, or other substantive provisions of the Benefit Programs. This booklet is not intended to give any substantive rights to benefits that are not already provided by the insurance certificate for an insured benefit. If the terms of this booklet conflict with the substantive terms of an insurance certificate for an insured Benefit Program, the terms of the insurance certificate will control, unless otherwise required by law.

This Plan document/SPD replaces all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference. We encourage you to read this booklet and insurance certificates and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

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Plan Overview

The Plan provides benefits to eligible employees and their dependents through each Benefit Program listed in Appendix A. Fully insured benefits are payable solely by the Insurer listed for the respective Benefit Program. Self-insured benefits are paid by the Employer through its general assets.

Your Eligibility

You are eligible for the Benefit Program(s) shown in Appendix A if you are a full-time active employee normally scheduled to work a minimum of 30 hours per week.

Unless otherwise communicated to you in writing by the Company, the following individuals are not eligible for benefits: part-time employees, employees of a temporary or staffing firm, payroll agency or leasing organization, independent contractors and other individuals who are not on the Employer payroll, as determined by the Employer.

The Employer's determination of eligibility is conclusive and binding for Plan purposes. No reclassification of a person's status, for any reason, by a third party (whether by a court, governmental agency or otherwise) will change a person's eligibility for benefits under the Plan.

Eligible Dependents

The definition of eligible dependents and other provisions, such as whether you may enroll your eligible dependents in a Benefit Program, are defined in the insurance certificates for each Benefit Program. Those provisions, and the definition of a dependent for each Benefit Program, are incorporated by reference herein.

Unless otherwise defined by the insurance certificate for a Benefit Program, and for self-insured Benefit Programs, your eligible dependents include:

- your legal spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status;
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan;

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child lawfully placed for adoption with you);
- your stepchild;
- a foster child who has been placed with you by an authorized placement agency or by judgment decree or other court order;
- a child for whom you are the court-appointed legal guardian;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

If you have any questions regarding dependent coverage under a Benefit Program, check with the Insurer or Claims Administrator. It is your responsibility to notify the Employer if your dependent becomes ineligible for coverage.

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Employer, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.

When Coverage Begins

To be eligible for a Benefit Program, you must satisfy the eligibility requirements described for that Benefit Program in the applicable insurance certificates and other materials provided for that Benefit Program. Unless otherwise stated in those materials, your coverage begins the first of the month following 60 days of employment.

Certain benefits, such as disability or life insurance, may require you to be actively at work in order to be initially eligible for a Benefit Program and for any change in coverage to take effect. See the materials provided by your Insurer to determine when this applies to you.

If your employment with the Company terminates and you are later rehired or if you return from a leave of absence, special rules apply to determine when you will be eligible for the Plan's health care benefits. In general, under these rules, if you go at least 13 consecutive weeks without working for the Company and you then return, you will be treated as a new employee. Other rules may apply in different situations (for example, if you work for an educational organization or if the Company uses a rule of parity, different rules may apply). If you are treated as a continuing employee, the coverage and rules that would have applied to you if you had not experienced the break in service will apply upon your return. These rules are complex. For more specific information on your eligibility for coverage, contact the Plan Administrator.

Unless stated otherwise in your insurance certificate for an insured Benefit Program, and for self-insured Benefit Programs, coverage for your eligible dependents begins on the same day as your initial eligibility provided you timely enroll your dependents in coverage. If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you can add your new dependent to your coverage as long as you enroll the dependent within 30 days of the date on which they became eligible. If you wait longer than 30 days, you may be required to wait until the Plan's next open enrollment period to enroll your new dependent for coverage.

Look-back Measurement Method for Determining Full-time Employee Status

The Company uses the look-back measurement method to determine who is a full-time employee for purposes of the Plan's health care benefits. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations.

The look-back measurement method applies to:

- All employees

The look-back measurement method involves three different periods:

- Measurement period
- Stability period
- Administrative period

The measurement period is a period for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full time.

If you are an ongoing employee, this measurement period is called the “standard measurement period.” Your hours of service during the standard measurement period will determine your eligibility for the Plan’s health care benefits for the stability period that follows the standard measurement period and any administrative period.

If you are a new employee who is variable hour, seasonal or part-time, this measurement period is called the “initial measurement period.” Your hours of service during the initial measurement period will determine your eligibility for the Plan’s health care benefits for the stability period that follows the initial measurement period and any administrative period.

If you are a new non-seasonal employee who is expected to work full time, the Company will determine your status as a full-time employee who is eligible for the Plan’s health care benefits based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

The stability period is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are considered a full-time employee who is eligible for health care benefits during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is “locked in” for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the Company. There are exceptions to this general rule for employees who experience certain changes in employment status.

An administrative period is a short period between the measurement period and the stability period when the Company performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period may last up to 90 days. However, the initial measurement period for new employees and the administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee’s start date (totaling, at most, 13 months and a fraction of a month).

Special rules may apply in certain circumstances, such as when employees are rehired by the Company or return from unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is a summary of how the rules work. More complex rules may apply to your situation.

The Company intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

Proof of Dependent Eligibility

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan’s Benefit Programs. If you are asked to verify a dependent’s eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled.

Your Contribution for Coverage

Each year, the Employer will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Any required contribution amount will be provided to you by the

Employer in your enrollment materials. You may also request a copy of any required contribution amounts from the Plan Administrator.

For most benefits you pay the employee cost of Plan premiums through pre-tax payroll deductions each pay period; however, some Benefit Programs may require premiums to be paid with after-tax dollars.

You must elect coverage for yourself in order to cover your eligible dependents. Your coverage for certain Benefit Programs may also be subject to deductibles, copayments, coinsurance, or other fees as described in the materials for the coverage you select.

Enrolling for Coverage

Initial Enrollment

As a newly eligible employee, you will receive an Election Form and enrollment information when you first become eligible for benefits. For each Benefit Program, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Employer to deduct any required premiums from your pay through salary reduction. If you do not enroll for coverage when initially eligible, you will be deemed to have elected no coverage or the default coverage designated by the Employer for a Benefit Program.

The elections you make will remain in effect until the next December 31, unless a permitted election change event occurs (see below). Your insured benefits may have a different coverage period. Your enrollment materials and Election Form will tell you if a different 12-month coverage period applies to your elections for an insured benefit. After your initial enrollment, you will enroll during the designated annual open enrollment period.

Annual Open Enrollment Period

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your enrollment materials and Election Form will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. In general, the elections you make will take effect on January 1 and stay in effect through December 31, the Plan Year, unless you have a qualifying change in status. The Plan Year may differ from the policy year of an insured benefit. Your enrollment materials and Election Form will tell you if a different 12-month coverage period applies to your elections for an insured benefit. Also, you should refer to the insurance certificate provided by the Insurer for more information on how your benefits are affected by the policy year, including whether your deductible and out-of-pocket expenses accumulate over the Plan Year, policy year or other 12-month period.

Special Enrollment Rights

You may enroll for coverage outside of the Plan’s initial and annual open enrollment periods if you experience a special enrollment event, as described below. Special enrollment rights apply to the Plan’s medical benefits. These rights, however, may not apply all Benefit Programs (for example, these rights do not apply to Benefit Programs that are “excepted benefits” under HIPAA). You should review your insurance certificate and check with the Plan Administrator if you have questions about enrolling in a Benefit Program.

- If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health coverage is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage). However, you must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).
- If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after coverage ends under Medicaid or a state CHIP.
- 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.
- If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state CHIP with respect to coverage under this Plan, you may be able to enroll yourself and your dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

You will need to provide documentation of your special enrollment event in order to enroll outside of an initial or annual open enrollment period. Contact the Plan Administrator to determine what information you will need to provide.

Code Section 125 Status of Plan

This Plan is designed and administered in accordance with Section 125 of the Internal Revenue Code and underlying regulations. This enables you to pay your share of premiums for certain Benefit Programs on a pre-tax basis, as permitted by the Employer. Review your election and enrollment materials to determine which Benefit Programs permit pre-tax premium payments and are subject to the Section 125 rules. Pre-tax dollars come out of your pay before federal income and Social Security taxes are withheld (and, in most states, before state taxes are withheld). This gives your contributions a special tax advantage and lowers the actual cost of participating in the Plan to you. Neither the Employer nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections for Section 125 benefits. Generally, your elections stay in effect for the Plan Year (or other 12-month period of coverage for an insured benefit, as designated in your enrollment materials and election form) and you can make changes only during an annual open enrollment period. However, depending on the Plan’s rules for mid-year election change events, you may be able to change your elections if a permitted election change event occurs as described below.

Permitted Election Change Events

The elections you make under the Plan are generally irrevocable during the Plan Year (or other 12-month coverage period that applies to a Benefit Program, as indicated in your enrollment

and election materials). This means, for example, that once you have elected how much pre-tax income you will use to pay for the Plan's Benefit Programs, you are locked into that election until the next annual enrollment period. However, there are certain limited situations that allow you to change your Plan elections outside of the annual enrollment period, depending on the Plan's eligibility rules for a Benefit Program. You may change your elections if a "permitted election change event" occurs and you make an election change that is consistent with the event, as determined by the Plan Administrator.

Only the following "permitted election change events" are recognized by the Plan:

- a change in your legal marital status, including marriage, divorce, death of spouse, legal separation or annulment
- a change in the number of dependents, including birth, adoption, placement for adoption or death of a dependent
- a change in employment status for you, a spouse or a dependent that affects eligibility
- a change in a dependent child's eligibility
- a change in residency that would impact eligibility (for example, moving out of a plan's coverage area)
- the cost of a Benefit Program significantly changes
- a new Benefit Program or other coverage option is added or coverage under an existing Benefit Program is significantly improved
- your spouse's or dependent's plan has a different enrollment period and you need to make a change to account for that other coverage
- you, your spouse or your dependent loses group coverage sponsored by a governmental or educational institution
- your change corresponds with a HIPAA special enrollment right (described above)
- you, a spouse or dependent is eligible for COBRA continuation coverage under the Plan (if applicable) and you need to increase your payments for the coverage
- a court order, such as a QMCSO or NMSN, mandates coverage for an eligible dependent child
- you, a spouse or a dependent enrolls in Medicare or Medicaid
- you take an FMLA leave (if applicable)
- a change in your employment status to less than 30 hours of service per week on average even if the reduction does not result in loss of Plan eligibility
- eligibility for a special enrollment period to enroll in a qualified health plan (QHP) through the Marketplace or seeking to enroll in a QHP during the Marketplace's annual open enrollment period

The Plan Administrator may decide to recognize other election change events that are permitted by the IRS. Also, if the cost of a Benefit Program changes by an insignificant amount during a coverage period, the Plan Administrator may automatically make a corresponding change to your election. You should report an election change event to the Plan Administrator as soon as possible, but no later than 30 days after the event occurs. Contact the Plan Administrator if you have questions about when you can change your elections.

When Coverage Ends

Except as otherwise provided in the insurance certificate for an insured Benefit Program, and for self-insured Benefit Programs, your coverage under this Plan ends on the last day of the month in which your employment terminates or upon your death, unless benefits are extended, such as when you take an approved leave of absence.

Coverage for your covered dependents ends on the date your coverage ends, or, if earlier, on the last day of the month in which your dependent is no longer eligible for coverage under the Plan.

Coverage will also end for you and your covered dependents as of the date the Employer terminates this Plan or, if earlier, the effective date you request coverage to be terminated for you and/or your covered dependent.

If your coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Cancellation of Coverage

If you fail to pay any required premium for coverage under a Benefit Program, coverage for you and your covered dependents will be canceled for that Benefit Program and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the Plan's claims and appeals procedures. If your coverage is being rescinded due to fraud or intentional misrepresentation of material fact, you will receive at least 30 days' advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as "excepted benefits" under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentation are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan.

Also, coverage may be retroactively terminated to the date of your divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work

In certain situations, coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you take an unpaid leave of

absence, you will need to make payment arrangements prior to the start of your leave. You should discuss with Human Resources or your supervisor what options are available for paying your share of costs while you are absent from work.

If You Take a Leave of Absence (FMLA)

If you take an approved FMLA leave of absence, your coverage will continue for the duration of your leave, as long as you continue to pay your share of the cost as required under the Employer's FMLA Policy. Coverage for other benefits can be found in the insurance certificates for the respective Benefit Programs in which you have enrolled.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, coverage may continue for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) starting on the date your military service begins.

Coverage for other benefits can be found in the insurance certificates furnished by the Insurer for the respective Benefit Programs in which you have enrolled and will be governed by the provisions of USERRA.

Your Health Care Coverage

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

The following health care Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Medical/Prescription Drug
- Vision

Participation

To become a participant in the above Benefit Program(s), you must meet all eligibility requirements and enroll in coverage. You may also enroll your dependents if they are eligible dependents as defined in the Insurer's benefits booklets.

Benefits Provided

The benefits provided under each Benefit Program are more fully described in the Certificate of Insurance/Coverage and other benefits booklets provided by the Insurer.

Your health care benefits are delivered through a network of participating physicians, hospitals, and other providers who have agreed to provide services at a negotiated cost. You have the flexibility to choose providers inside or outside the network each time you need services.

The following type of medical program is available to you under the Plan:

- a PPO (Preferred Provider Organization).

Generally, when you use network providers, the Plan pays the negotiated amount of covered expenses (after any deductible) to your provider and there are no claim forms to complete. For example, under a PPO or CDHP network, you may receive care from any provider you choose with no referral required. However, if you choose a provider who participates in the Plan's network, your costs will be lower since network providers have agreed to accept a negotiated rate as payment in full. If you receive care outside of the Plan's network, benefits are based on reasonable and customary charges and, in most cases, you must pay your portion of the cost, plus any amount billed over the reasonable and customary limits. You may also be required to file claim forms for reimbursement. Your Certificate of Coverage and other documents provide additional information on how benefits are paid when you access in-network providers and out-of-network providers.

When you enroll in a Plan that uses a network of physicians, you are not required to select a primary care physician to coordinate your care and you do not have to obtain a referral to see a specialist. For a listing of current network health care providers (at no cost to you), contact the Insurer at the telephone number or website shown later in this booklet.

Source of Payments

Benefits for covered services and expenses under the Benefit Program(s) listed above are paid by the Insurer and are guaranteed under the insurance contracts. Any cost-sharing provisions, such as your deductible, co-payment, or coinsurance, are set forth in the materials furnished by the Insurer.

Any required premiums for coverage will be shown in your enrollment materials. Your premiums will be deducted from your pay on a pre-tax basis.

Limitations and Exclusions

The materials for each Benefit Program contain information about limitations on benefits, covered preventive care services, prescription drugs, pre-authorizations required, utilization reviews required, obtaining emergency care, exclusions and expenses not covered, medical tests and procedures covered, any limits or caps on certain coverage, and relative costs for in-network and out-of-network services.

Continuation of Health Care Coverage through COBRA

If your health care coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Health care coverage may continue at your own expense for a specific length of time. See the section entitled "Your HIPAA/COBRA Rights" for additional information. Please note that if your Employer has less than 20 employees, Federal COBRA legislation may not apply to you, but you may instead be eligible for COBRA benefits available through your state. Contact your Insurer for additional information as these provisions vary from state to state.

For More Information

If you have a question about a covered service, or for more information about a specific procedure, coverage of new drugs, tests, or experimental or investigative treatments, you should consult the materials furnished by the Insurer for the coverage in which you are enrolled.

Your Dental Benefits – Self-Insured Benefit

Your dental benefits are delivered through a network of participating doctors, dentists, and other providers who have agreed to provide services at a discounted cost.

To become a participant in a dental option, you must meet all eligibility requirements and enroll in coverage. You may also enroll your eligible dependents. Any required premiums for coverage will be shown on your Election Form.

Network Providers

Dental benefits are self-funded, meaning they are paid by the Employer's general assets rather than through an insurance policy. You should refer to the benefit summary booklet issued by your Claims Administrator, Delta Dental of Kentucky, Inc., for a more detailed summary of what dental benefits are covered under the Plan and how benefits are paid in- and out-of-network. The benefit summary booklet and other materials provided by the Claims Administrator are incorporated by reference as part of this SPD. Those materials contain any deductible, copayments or coinsurance that apply to covered benefits, limitations, preauthorization requirements, waiting periods, maximum benefits payable, exclusions, or discounts that may apply.

If you use in-network providers, the Plan pays covered expenses (after you meet any applicable deductible), based on the negotiated fee schedule. In network providers have agreed to accept the discounted amount, (along with your deductible and coinsurance) as payment in full and you will not be balance billed for discounts. Generally, you will not be required to file a claim form when you receive in-network benefits but in some cases, the provider or Claims Administrator may require you to do so.

If you use out-of-network providers, the Plan pays covered expenses (after you meet any applicable deductible), up to maximum plan allowance (see explanation below). You are responsible for charges in excess of this limit and you may be required to file claim forms.

Refer to the dental benefits summary section for a detailed summary of your dental benefits. To locate a provider or to find out if your provider participates in the network, contact the dental Claims Administrator or visit their website. Contact information is provided below. You may also request a listing of current providers (at no cost to you).

Maximum Allowed Amount

Discounted Fee Schedule

If you use out-of-network providers, the Plan pays covered expenses (after you meet any applicable deductible), based on the same allowance that would have been made for the same services rendered by a network provider. Out of network providers have NOT agreed to accept the discounted amount, (along with your deductible and coinsurance) and you may be responsible for balance billing from the provider for the applied discounts. You may be required to file a claim form when you receive out of -network benefits but in some cases, the provider may file claims on your behalf.

Eligible Expenses

Eligible expenses are those provided for services and supplies that are authorized and approved by your physician or other approved provider. Expenses must be dentally necessary

for the care and treatment of a covered procedure or condition. Refer to the benefits booklets provided by the Claims Administrator for detailed information regarding benefits covered and excluded under the Plan.

Source of Payments

Benefits for self-insured expenses and services are paid from the general assets of the Employer.

Limitations and Exclusions

Limitations on benefits, pre-authorizations required, expenses not covered, and any limits or caps on certain benefits are dependent upon the terms of the dental option that you select, as described in the benefits booklets furnished by the Claims Administrator. In addition, as previously mentioned, your coverage may be subject to deductibles, copayments, coinsurance, or other fees as described in those materials.

Continuation of Coverage through COBRA

If your dental coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan (see "When Coverage Ends" above), you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). You and your covered dependent(s) may continue coverage at your own expense for a specific length of time. See the Section entitled "Your HIPAA/COBRA Rights" for additional information.

For More Information

If you have questions about a covered or excluded service, or for more information about a specific procedure, refer to your benefit booklets or contact the Claims Administrator.

Your Life and Accidental Death & Dismemberment (“AD&D”) Coverage

The following Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Group Term Life Insurance
- Voluntary Life Insurance (supplemental and/or dependent life)
- AD&D Insurance
- Voluntary AD&D Insurance (supplemental and/or dependent AD&D)

Participation

You must meet all eligibility requirements for coverage in order to become a participant. Enrollment in basic coverage is automatic. Any voluntary options available to you and the associated costs are described in the materials provided by the Insurer. Each year during the annual open enrollment period, you will be given an opportunity to elect or change your voluntary coverage, or confirm that your existing coverage is to be maintained for the following year.

Benefits Provided

The benefits and amounts of coverage provided under each Benefit Program are more fully described in the materials provided to you by the Insurer. Life insurance benefits are paid in the event of the death of a covered participant. AD&D benefits are paid if a covered participant becomes dismembered or seriously injured as the result of a covered accident. You will need to designate a beneficiary to receive benefits in the event of your death.

Source of Payment

Group Term Life Insurance and AD&D benefits are paid by the Insurer and are guaranteed under the applicable insurance contracts. The Company pays the full cost of your basic coverage. You are not required to make any contributions. The amounts of voluntary coverage available and, if applicable, any premiums for coverage will be shown on your Election Form when you enroll and will automatically be deducted from your pay.

Plan Limitations and Exclusions

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

Coverage Continuation

If your Group Term Life Insurance coverage ends for any reason other than death, you may have a right to continue your insurance under an individual policy. You should consult your Certificate of Insurance for additional information about continuing your coverage as there may be time limits for making this decision once your coverage under the Plan ends.

For More Information

Consult your Certificate of Insurance or benefits booklets for additional questions about your coverage.

Your Disability Benefits

The following Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Voluntary Short-Term Disability (STD) Benefits – Employee paid
- Voluntary Long-Term Disability (LTD) Benefits – Employee paid

Participation

If you wish to elect voluntary STD coverage, you must enroll in coverage after you meet all eligibility requirements. A description of the coverage available is shown in the materials provided by the Insurer. The associated premium costs for voluntary STD coverage will be shown on your Election Form when you first enroll in the Plan. Coverage becomes effective the first of the month following your date of enrollment. Each year during the annual open enrollment period, you will be given an opportunity to elect or change your coverage, or confirm that your existing coverage is to be maintained for the following year. If you decline STD coverage and later wish to re-enroll, you may need to provide evidence of good health to the Insurer before coverage is approved.

If you wish to elect voluntary LTD coverage, you must enroll in coverage after satisfying all eligibility requirements for coverage. You must also satisfy any required elimination period defined in the Insurer's materials before LTD benefits are payable. A description of the coverage available is shown in the materials provided by the Insurer. The associated premium costs for voluntary LTD coverage will be shown on your Election Form.

The options available to you are shown in the materials provided by the Insurer. Coverage becomes effective the first of the month following your date of enrollment. Each year during the annual open enrollment period, you will be given an opportunity to elect or change your coverage, or confirm that your existing coverage is to be maintained for the following year. If you decline voluntary LTD coverage and later wish to re-enroll, you may need to provide evidence of good health to the Insurer before coverage is approved.

Benefits Provided

Your Certificate of Insurance defines when you are considered disabled. Generally, you are considered disabled when you are unable to perform with reasonable continuity the material duties of your own occupation due to physical disease, injury, or similar disorders.

Your Certificate of Insurance also describes the actual benefit you are eligible to receive when you become disabled and its duration.

You must be under the direct and continuous care of a licensed physician throughout the period for which disability benefits are paid. In order to continue receiving benefits, you are required to submit evidence, as requested, to support your disability claim. You may also be required to apply for Social Security disability benefits during the fifth month of your disability and, if necessary, appeal a denied claim.

Source of Payment

All disability benefits described above are paid by the Insurer and are guaranteed under the applicable insurance contract(s) or policies.

You may elect voluntary STD coverage; you pay the entire cost of this coverage. The premiums for STD coverage will be automatically deducted from your pay.

Voluntary LTD coverage is available for which you pay the full cost. The premiums for voluntary LTD coverage will be automatically deducted from your pay.

Payment of Benefits

Your STD benefit will not be subject to Federal withholding taxes since premiums are paid on an after-tax basis but may be subject to other authorized payroll deductions. Benefit payments will be made for each disability period. A successive period of disability due to the same or related causes will be considered as one continuous period of disability unless it is separated by a return to active employment as described in your Certificate of Insurance.

Your LTD benefit will not be taxable to you as premiums are made on an after-tax basis through a gross-up of your pay.

The Insurer is the Claims Administrator and is authorized to handle the day-to-day administrative tasks and pay claims. The Insurer may obtain the services of a licensed physician who will have the full authority and discretion to determine whether an absence is due to the same or related condition.

Offset of Other Benefits

If you become eligible for any disability benefits under state law or disability fund, Workers' Compensation, the Jones Act or any similar laws, state or Federal government income benefits (excluding military pensions), any self-insured, group, or individual pension plan to which the Employer contributes, or if you become entitled to Social Security disability benefits, your disability benefits may be reduced by the amount of benefits you receive, or are entitled to receive, as the result of your disability.

Limitations and Exclusions

No benefits will be payable for any period in which: 1) you engage in any occupation or perform any work for compensation or profit, except approved rehabilitative employment; 2) you are not under the continuous care of a licensed physician; or 3) you are determined not to be disabled.

You should refer to the materials provided by the Insurer for information concerning any additional limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, taxability of benefits, age reductions, or reductions for other benefits that may apply.

Claims and Appeals

If your claim for disability benefits is denied, you have the right to file an appeal with the Insurer, as described in your Certificate of Insurance and other materials provided by the Insurer. If your claim for benefits is denied, the Insurer will send you written notice of denial which will include the reasons for the decision and other supporting information used to make its decision. Any appeal of a denied claim must be filed within the required time frames specified in the group policy and your Certificate of Insurance.

For More Information

Consult your Certificate of Insurance or benefits booklets for additional questions about your disability coverage.

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Insurer or Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under ERISA and other Federal laws such as COBRA.

IMPORTANT: The Employee Retirement Income Security Act (ERISA) is a Federal law. This Summary Plan Description is issued in accordance with ERISA and may not include language or certain mandated coverage required by state insurance laws. State mandated coverage may be addressed separately in the insurance certificates provided by the Insurer.

Plan Sponsor and Administrator

Pepsi-Cola Bottling Co. of Corbin Kentucky, Inc. is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Plan Administrator
Pepsi-Cola Bottling Co. of Corbin Kentucky, Inc.
1000 Cumberland Falls Highway
Corbin, KY 40701
606-528-1630

As set forth in Section 3(16) under ERISA, the Plan Administrator will administer this Plan and will be the “Named Fiduciary” for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Employer. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Employer, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records; and
- To accept all other responsibilities and duties of the administrator of the Plan as specifically set forth in ERISA.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan.

For fully insured benefits, unless otherwise expressly provided in the insurance policy or contract governing a Benefit Program, the Insurer shall be the Plan Administrator and Named Fiduciary only with respect to the benefits provided through the insurance policy or contract. The Insurer shall be responsible for determining eligibility for and the amount of benefits payable under the Benefit Program, and for prescribing claims procedures to be followed by Participants. The Insurer shall also be responsible for paying claims.

Plan Year

The Plan Year is January 1 through December 31.

Note: An insured benefit may use a policy year that differs from the Plan Year, with deductible and out-of-pocket expenses based on the policy year. Please refer to the insurance certificate and other materials provided by the Insurer to determine how the policy year impacts your benefits.

Type of Plan

This Plan is a called a “welfare plan”, which includes group health plans under ERISA; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 61-0601744 PLAN NUMBER: 501

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	The Plan is administered by the Employer through an arrangement with Insurers and third-party (claims) administrators. Insured benefits will be payable solely by the Insurer.
Funding	The Employer and employees both contribute to the Plan. Premiums are paid to the Insurers for fully insured Benefit Programs and benefits will be paid by the Insurer in accordance with the applicable insurance contract/policy. For self-insured Benefit Programs, benefits are paid by the Employer from its general assets.

Funding for this Plan shall consist of an aggregation of the funding for all Benefit Programs. The Employer shall have the right to insure any benefits under this Plan, to establish any fund or trust for the payment of benefits under this Plan, or to do neither and pay benefits under this Plan from its general assets, either as mandated by law or as the Employer deems advisable. In addition, the Employer shall have the right to alter, modify, or terminate any method or methods

used to fund the payment of benefits under this Plan, including, but not limited to, any trust or insurance policy.

If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the Insurer.

Insurers/Claims Administrators

For fully insured Benefit Programs, the Insurer is responsible for administering benefits and paying claims. They may contract with a separate Claims Administrator to process claims. You may contact the Insurer/Claims Administrator directly, using the information listed below.

For self-insured Benefit Programs, the Employer has contracted with Claims Administrators to administer benefits and pay claims. The Claims Administrator may also handle certain day-to-day administrative functions such as utilization review, provider contracting and prescription benefit management for the Plan.

It is important to understand that if the terms of this SPD conflict with the terms of the insurance certificate regarding substantive rules for an insured Benefit Program (such as benefits and claims procedures), the terms of the insurance certificate will control, unless otherwise required by law.

Medical/Prescription Drug Benefits

Humana Health Plan, Inc.
500 West Main Street
Louisville, KY 40202
800-833-6917
www.humana.com

Dental Administrator – Self-Insured Benefit

Delta Dental
10100 Linn Station Road
Louisville, KY 40223
800-955-2030
www.deltadentalky.com

Vision Benefits

Humana Health Plan, Inc.
500 West Main Street
Louisville, KY 40202
800-833-6917
www.humana.com

Group Term Life Insurance Benefits

MetLife
200 Park Avenue
New York, NY 10166
800-275-4638
www.metlife.com

Accidental Death & Dismemberment Benefits

MetLife
200 Park Avenue
New York, NY 10166
800-275-4638
www.metlife.com

LTD Benefits

UNUM Life Insurance Company of America
PO Box 100158
Columbia, SC 29202
800-858-6843
www.unum.com

Voluntary/Supplemental Life

MetLife
200 Park Avenue
New York, NY 10166
800-275-4638
www.metlife.com

Voluntary Disability

Mutual of Omaha
3300 Mutual of Omaha Plaza
Omaha, NE 68175
800-877-5176
www.mutualofomaha.com

Agent for Service of Legal Process

For disputes arising under any fully insured Benefit Program, Service of Legal Process may be made upon the Insurer listed above. Service of Legal Process may also be served upon:

Chief Financial Officer
Pepsi-Cola Bottling Co. of Corbin Kentucky, Inc.
1000 Cumberland Falls Highway
Corbin, KY 40701
606-528-1630

Service of Legal Process may also be served on the Plan Administrator.

No Obligation to Continue Employment

The Plan does not create an obligation for the Employer to continue your employment or interfere with the Employer's right to terminate your employment, with or without cause.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator

or, where applicable, the Insurer, has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator or Insurer.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits to Others

The Insurer/Claims Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the Company.

Fraud

No payments under the Plan will be made if you or a provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Insurer/Claims Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. If you or a covered dependent attempts or commits fraud upon the Plan, your coverage may be terminated and you may be subject to disciplinary action by the Employer, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the Employer will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative (“Plan Administration Employee”) of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Compliance with State and Federal Mandates

Each Benefit Program will comply to the extent possible with the requirement of all applicable laws, including but not limited to: ERISA, COBRA, USERRA, HIPAA, the Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA), the Women’s Health and Cancer Rights Act of 1998, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle’s Law (if applicable), and Title I of GINA (prohibiting the use of genetic information to discriminate with respect to health insurance premiums, contributions or other restricted purposes).

Refund of Premium Contributions

For fully insured Benefit Programs, the Plan will comply with DOL guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) of insurance premiums. Where any refund is determined to be a plan asset to the extent amounts

are attributable to participant contributions, such assets will be: 1) distributed to current plan participants within 90 days of receipt, 2) used to reduce participants' portion of future premiums under the Plan (e.g., premium holiday); or 3) used to enhance future benefits under the Plan. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

Nondiscrimination

The Plan is intended to be nondiscriminatory under Code Section 125. Code Section 125 prohibits discrimination in favor of highly compensated individuals with respect to eligibility to participate, highly compensated participants with respect to benefits and contributions and key employees with respect to total Plan contributions. If the Plan Administrator determines, at any time, that the Plan may fail to satisfy these nondiscrimination requirements, the Plan Administrator may take such action as it deems appropriate to comply with the nondiscrimination requirements. This action may include, for example, modifying the elections of highly compensated or key employees without their consent.

No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any representation, guarantee or warranty that any amount paid as premiums or distributed as benefits under the Plan will be excludable from your gross income for federal or state income tax purposes (or that any other state or federal tax treatment will apply or be available to you). It is your responsibility to determine whether payments are excludable from your gross income for federal and state income tax purposes.

Future of the Plan

The Employer expects that the Plan will continue indefinitely. However, the Employer has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Employer may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures

This section describes what you must do to file or appeal a claim for services. It also describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Claims and Appeals – Fully Insured Benefits

For fully insured Benefit Programs, the claims procedures, including issues related to payment, preauthorization approval, or utilization review, as well as the time frames for submitting claims, are set forth in the insurance certificates.

If your claim is denied and you disagree and want to pursue the matter, you must file a First Level Appeal with the respective Insurer. A rescission of coverage is also considered an adverse benefit determination that triggers your right to file an appeal. You or your authorized representative may appeal a denied claim within the time frame provided in the insurance certificates for that Benefit Program. Different time frames apply to healthcare claims and disability-related claims. You will have the right to submit for review, written comments, documents, records, and other information related to the claim; and to request, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

The Insurer, acting on behalf of the Plan, has full and exclusive authority and discretion to construe and interpret the provisions of the Program, to determine questions of coverage, and entitlement to and termination of benefits, and to make factual findings. If the Insurer denies your claim (in whole or in part) during a First Level Appeal, you may file a Second Level Appeal. If after such review, the Insurer continues to deny the claim in full or in part, you will be notified of the decision in writing.

The Insurer’s decision will include specific reasons for the decision, written in a manner calculated to be easily understood, with specific references to the Benefit Program’s provision or provisions, including any internal rules, guidelines, protocol, or other similar criterion relied upon, on which the appeal decision is based. It will also include a statement of your right to access and receive copies of all documents, records, and other information relevant to your appeal. You will also be provided a statement advising that you are entitled to bring civil action in Federal court under Section 502(a) of ERISA.

Exhaustion Required

The decision of the Insurer for fully insured Benefit Programs shall be final and conclusive on all persons claiming benefits under the Benefit Program, subject to applicable law. No other actions may be brought by any person until an appeal for denied benefits has been brought and been denied (or deemed denied) as described above under the respective claims procedure. You must exhaust all remedies available to you before bringing legal action. You cannot take any other steps unless and until you have exhausted all appeals. For example, if your claim is denied and you do not use the appeals procedures, the denial of your claim will be conclusive and cannot be challenged, even in court.

Claims and Appeals – Self-Insured Benefits

This section describes what you must do to file or appeal a claim for services received in- and out-of-network.

In-Network Claims — Generally, no claim forms are necessary when you use in-network (participating) providers. Benefits for in-network covered services always are paid to the provider. If you pay the provider for a covered service, you must contact the provider to request a refund.

Out-of-Network Claims — If you use out-of-network (non-participating) providers, you might need to pay them when you receive services, including any coinsurance amount. You must then submit a claim form along with an itemized bill to the appropriate Claims Administrator. In most cases, the Claims Administrator will reimburse you directly. Occasionally, however, the Claims Administrator may reimburse the provider directly for covered expenses. If this happens to you and you already have paid your provider, you must request a refund from your provider.

The steps described below will guide you through the process of submitting your out-of-network claim. To obtain a form, contact your Claims Administrator. Complete a separate claim form for each covered family member who has expenses. If you already paid all or a portion of the fee to the provider, indicate the amount paid on the claim form.

For medical expenses, your Claims Administrator will send you an Explanation of Benefits (EOB) showing what the Plan covered. You may receive a bill from the provider for the remainder of the expense, which will be your responsibility to pay. Send the completed claim form to the appropriate Claims Administrator along with any proof of payment (i.e., a receipt).

To be eligible for reimbursement under the Plan, a claim must be submitted within the time frames established by the Plan Administrator. Claims filed after that time may be reduced or denied. If you are unable to file a claim within the prescribed time frame, the Plan Administrator may elect to approve the claim after reviewing any extenuating circumstances if the claim is filed as soon as possible.

Time Frames for Processing a Claim

Claims are divided into urgent care claims, concurrent care claims, pre-service health claims, and post-service health claims. If you or your representative fail to follow the Plan's procedures for filing a claim or if you file an incomplete claim, the Plan will notify you or your representative of the failure according to the time frames shown in the following chart.

If an initial claim is denied in whole or in part, you or your representative will receive written notice from the Plan Administrator. This notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If your claim for benefits is denied, you or your representative may file a written appeal for review of a denied claim with the Plan Administrator.

The chart below shows the time frames for filing different types of claims with the Plan. If you have any questions about what type of claim you may have or the timing requirements that apply to your claim, please contact your Claims Administrator.

Time Frames for Processing a Claim				
Claim Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
Claims Administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims Administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims Administrator reviews claim and makes determination of:		For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.* For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments.*		
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information		Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information
initial claim	Within 72 hours of receipt of initial claim		Within 15 days of date initial claim is received	Within 30 days of date initial claim is received
Extension period,** if required due to special circumstances beyond control of Claims Administrator	Not applicable	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period

* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the Claims Administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments.

** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

How to Appeal a Claim

To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the Plan. You may also appeal the Plan's decision to rescind your coverage due to fraud or intentional misrepresentation of material fact. The time frames for appealing a claim are shown in the following chart.

If you or your representative submit an appeal, state why you think your claim should be reviewed and include any data, documents, questions, or comments, along with copies of itemized bills and claim forms relating to your claim. You may request, free-of-charge, copies of all documents, records, and other information relevant to your claim. A reviewer who did not make the initial claim determination will be responsible for reviewing your appeal. Also, you will be notified of any expert advice obtained on behalf of the Plan in reviewing the denied claim, regardless of whether such advice was relied upon in reviewing your claim. Such experts will not be individuals who were consulted in making the initial claim determination.

Time Frames for Appealing Denied Claims

Appeal Process	Urgent Care Claim	Concurrent Care Claim	Pre-Service Health Claim	Post-Service Health Claim
You may submit an appeal of denied initial claim to the Claims Administrator	Within 180 days of receiving notice of denied claim	You will be notified of reduction or termination of benefit in time to submit appeal and receive determination before benefit ends	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claims Administrator reviews your first appeal and makes determination	Within 72 hours after appeal is received	Prior to reduction or termination of benefit	Within 15 days of date appeal is received	Within 30 days of date appeal is received
You may submit a second appeal to the Plan Administrator	N/A	N/A	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Plan Administrator reviews your second appeal and makes final determination	N/A	N/A	Within 15 days of date appeal is received	Within 30 days of date appeal is received

You will be notified of the Plan Administrator's decision in writing. If your claim is denied, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that 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, and a statement regarding your right to bring civil action in Federal court under Section 502(a) of ERISA.

The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit in Federal court, as you will not have exhausted your internal administrative appeal rights. Participants or claimants must exhaust all remedies available to them under the Plan before bringing legal action. Additionally,

legal action may not be brought against the Plan more than one year after a final decision on appeal has been reviewed under the Plan.

External Review Rights

If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator, you may be entitled to request an external review of the Claims Administrator’s decision. You will be notified in writing if your claim is eligible for an external review and you will be informed of the timeframes and the steps necessary to request an external review. In most cases, you must complete all levels of the internal claims and appeal procedure before you can request an external review.

External review is only available for adverse benefit determinations that involve medical judgment or a rescission of coverage.

If you decide to seek external review, an independent external review organization (an "IRO") will be assigned your claim. The IRO does not have to give deference to any earlier claims and appeals decisions, but it must observe the written terms of the Plan document. In other words, the IRO is not bound by any previous decision made on your claim. The ultimate decision of the IRO will be binding on you, the Claims Administrator and the Plan.

You or your representative may request a standard external review, or an expedited external review in urgent situations, by following the directions in the determination letter. A request for an external review must be made within four months after the date you received Claims Administrator's decision.

For additional information about the external IRO process, contact the Claims Administrator.

Coordination of Benefits

Non-Duplication of Benefits / Coordination of Benefits – Fully Insured Benefits

If you (or an eligible dependent) are covered by another employer's plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

The Insurer is responsible for ensuring that eligible expenses are coordinated with benefits from:

- other employers' plans;
- certain government plans; and
- motor vehicle plans when required by law.

The Insurer may request information about other coverage you may have. You are required to provide this information to ensure that claims are properly paid.

Health Care Coverage Coordination with Medicare

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will be coordinated with Medicare. Which plan pays first ("primary") is determined by whether your Employer is considered a small or large group employer. Generally, for large group employer plans, Medicare requires the employer's plan to pay first and Medicare pays second ("secondary"). You should check with your Employer if you become eligible for Medicare while employed to determine if your Employer's coverage will be primary or secondary.

The Plan also coordinates with Medicare as follows.

- **End-stage renal disease**—If you or a covered dependent is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.
- **Mandated coverage under another group plan**—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

Non-Duplication of Benefits / Coordination of Benefits – Self-Insured Benefits

If a Plan participant is covered by another employer's plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

Your medical benefits are coordinated with benefits from:

- other employers' plans;
- certain government plans; and
- motor vehicle plans when required by law.

Non-duplication of benefits does not apply to prescription drug benefits.

How Non-Duplication Works

When an expense is covered by two plans, the following apply:

- the primary plan is determined and pays the full amount it normally would pay;
- the secondary plan calculates the amount it normally would pay and then pays any portion of that amount not paid by the primary plan (but not to exceed 100% of charges); and

- you pay any remaining expenses.

If another plan is primary and this plan is secondary, the Plan will calculate the amount it would pay as if there were no other coverage, subtract the amount payable by the primary plan, and then pay any eligible remaining amount.

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows.

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, this Plan normally is primary when you have a covered expense.
- If your covered spouse is the patient, your spouse's company plan (if applicable) is primary. Your spouse should submit expenses to that plan first, wait for the payment, and then submit the claim under this Plan with copies of the expenses and the primary plan's Explanation of Benefits (EOB).
- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply.
    - If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply.
    - If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan).
    - If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary.
    - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
    - When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

Coordination with Auto Insurance Plans

First-party auto insurance coverage is considered primary. This Plan coordinates its benefits with the first-party benefits from an auto insurance plan without regard to fault for the same covered expense. This also applies to the benefit that an auto insurance plan would pay if auto insurance is legally required but not in force.

If you or your covered dependent incurs covered expenses as a result of an automobile accident (either as driver, passenger, or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

- any deductible under the automobile coverage;
- any co-payment under the automobile coverage;
- any expense properly denied by the automobile coverage that is a covered expense; and
- any expense that the Plan is required to pay by law.

For Maximum Benefit

Generally, claims should be filed promptly with all plans to receive the maximum allowable benefits. You must supply the claim information needed to administer coordination of benefits. If you receive more payment than you should when benefits are coordinated, you will be expected to repay any overpayment.

Subrogation and Reimbursement

Subrogation and Reimbursement – Fully Insured Benefits

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Insurer has a right to subrogation and reimbursement. Subrogation applies when the Insurer has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan Administrator has delegated all subrogation rights and third party recovery rights to the Insurer of each fully insured Benefit Program. The Insurer shall undertake reasonable steps to identify claims in which the Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. You are required to cooperate with the Insurer to facilitate enforcement of its rights and interests.

These provisions shall not apply where subrogation is specifically prohibited by enforceable law.

Subrogation and Reimbursement – Self-Insured Benefits

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Company has a right to subrogation and reimbursement, as defined in the following sections.

Right of Recovery

The Plan has the right to recover benefits it has paid on your or your dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period you were meeting the calendar year deductible; or
- advanced during the time period you were meeting the out-of-pocket maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts also are subject to recovery. If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested; or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

Right to Subrogation

The right to subrogation means the Plan is substituted to any legal claims that you may be entitled to pursue for benefits that the Plan has paid. Subrogation applies when the Plan has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan will be subrogated to, and will succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to return to the Plan 100 percent of any benefits you received for that sickness or injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a sickness, injury, or damages, or who is legally responsible for the sickness, injury, or damages; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
    - underinsured or uninsured motorist insurance;
    - medical provisions of no-fault or traditional insurance (auto, homeowners, or otherwise);
    - Workers' Compensation coverage; or
    - any other insurance carrier or third party administrator.

When This Provision Applies To You

If you or any of your covered dependents, or anyone who receives benefits under this plan, becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan will be paid only if you fully cooperate with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, you agree that acceptance of benefits for you and/or your dependents is constructive notice of this provision in its entirety and agree to reimburse the Plan 100 percent of any benefits provided or to be provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. You further agree that the Plan shall have an equitable lien on any funds received by you or your dependents, and/or you or your attorney, if any, from any source for any purpose and shall be held in trust until such time as the obligation under this provision is fully satisfied. If you or your dependent retains an attorney, then you and your dependents agree to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

You or your covered dependent agrees to sign any documents requested by the Plan including but not limited to a reimbursement and/or subrogation agreement, or accident questionnaire, as the Plan or its agent(s) may request. You and your covered dependent also agree to furnish any other information as may be requested by the Plan or its agent(s). Failure to sign and return any requested documentation or information may result in the Plan's denial of claims. However, such failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received, regardless of how characterized, shall first be deemed for reimbursement of expenses paid by the Plan. Any excess after 100 percent reimbursement to the Plan may be

divided between you or your dependent (the covered person) and your attorney if applicable. Any accident-related claims made after satisfaction of this obligation shall be paid by you or your dependent and not the Plan.

You and/or your covered dependents agree to take no action which in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against you or your dependent (the covered person), then you and/or your dependent agree to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary. Furthermore, the Plan may reduce or deny any future benefits by the amount of any recovery received, but not reimbursed, by you or your covered dependent for an accident or injury for which the Plan paid benefits.

If you and/or your covered dependent take no action to recover money from any source, then you and/or your dependent agree to allow the Plan to initiate its own direct action for reimbursement.

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to the following.

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 copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The 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 Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions 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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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 previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If, after you exhaust your appeals, 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. Such suit must be filed

within 180 days from the date of an adverse appeal determination notice. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that 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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.

Your HIPAA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

You will receive a “Notice of Privacy Practices” from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called “ePHI.”

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. “Summary Health Information” means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules. Other than these disclosures, the Plan Sponsor will not create or receive PHI from the HIPAA Plans.

Your COBRA Continuation Coverage Rights

Continuing Health Care Coverage through COBRA

This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Employer is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same healthcare coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

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.

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue healthcare benefits upon the occurrence of a qualifying event that would otherwise result in such person losing healthcare benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Healthcare coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

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

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of COBRA coverage in addition to the 18-month continuation period (for a total of 29 months of coverage from the date of the qualifying event). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled

family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period (including a child born or placed for adoption with you); and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus 11 month extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation, or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Employer within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To

continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage by completing and returning your COBRA enrollment form.

NOTE: If you have a new child during the COBRA continuation period by birth, adoption or placement for adoption, your new child is entitled to the status of a qualified beneficiary. As such, your new child is entitled to receive coverage upon his or her date of birth, date of adoption or date placement for adoption is made and you become legally obligated to provide support for the child, provided you enroll the child within thirty (30) days of the child's birth/adoption/placement.

Cost of COBRA Coverage

You or your eligible dependent pay the full cost for healthcare coverage under COBRA, plus any required administrative fee up to two percent, or up to 102 percent of the full premium cost, except in the case of an 11-month disability extension where you may be required to pay up to 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent COBRA coverage election. You elect coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage.

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or

- on the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare.
- The Employer terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of healthcare coverage in certain circumstances for Employers with 20 or more employees. Small Employers may be subject to individual state COBRA provisions.

Dependent

The definition of a dependent is defined in the insurance certificate and other materials provided by the Insurer. Under the PPACA, your dependent for health insurance coverage includes your child under age 26, regardless of financial dependency, residency with you, marital status, or student status.

Certain states may impose a different definition of dependent that extends coverage beyond age 26. Your employer also may elect a more generous definition of dependent or apply the above definition to other Benefit Programs. For questions regarding dependent eligibility, contact the Plan Administrator.

Employee

A person who is a fulltime employee and who is regularly scheduled to work for the Employer in an employer-employee relationship. The definition of an eligible employee is defined in the Plan Overview.

Election Form

The form used by employees to elect to participate in a Benefit Program and to authorize payment of premiums for such Benefit Program, where applicable.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or
- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Employer for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Employer has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Employer. Various states also have enacted similar legislation for their residents. Covered employers must comply with the Federal or state provision that provides the greater benefit to their employees. If you have

questions regarding your eligibility for FMLA coverage or your state's family medical leave provisions, if applicable, contact your Employer.

GINA

The Genetic Information Nondiscrimination Act of 2008, as amended.

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH

The Health Information Technology for Economic and Clinical Health Act, as amended.

Insurer

Any insurance company that fully insures (or partially insures) any benefit provided by this Plan or any Benefit Program.

Leased Employee

Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Medicare

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

NMHPA

The Newborns' and Mother's Health Protection Act of 1996, as amended. 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Participant

An eligible employee who elects to participate in the Plan by completing the necessary Election Form on a timely basis, as provided by the Plan Administrator.

PPACA

The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994; a Federal law covering the rights of participants who have a qualified uniformed services leave.

WHCRA

The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.

Adoption of the Plan

The Pepsi-Cola Bottling Co. of Corbin Kentucky, Inc. Employee Benefits Plan, effective 08/01/1983, as amended and restated herein, is hereby adopted as of 01/01/2019. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this _____ day of _____, 2019.

BY: _____

TITLE: _____

APPENDIX A

BENEFIT PROGRAM	NAME OF INSURER/ CLAIMS ADMINISTRATOR	POLICY OR CONTRACT NUMBER(S)	START OF POLICY YEAR OR EFFECTIVE DATE OF COVERAGE	ELIGIBILITY	CLAIMS PROCEDURE & BENEFITS
GROUP MEDICAL INSURANCE PPO	HUMANA HEALTH PLAN, INC. INSURER/CLAIMS ADMINISTRATOR	530320	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP DENTAL BENEFITS	DELTA DENTAL OF KENTUCKY, INC. CLAIMS ADMINISTRATOR	679490	January 1	See the corresponding section of the Plan/SPD and contact the Plan Administrator with any questions.	See the corresponding section of the Plan/SPD and contact the Plan Administrator with any questions.
GROUP VISION BENEFITS	HUMANA HEALTH PLAN, INC. INSURER/CLAIMS ADMINISTRATOR	530320	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP TERM LIFE INSURANCE BENEFITS	METLIFE INSURER/CLAIMS ADMINISTRATOR	5913275	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE COVERAGE	METLIFE INSURER/CLAIMS ADMINISTRATOR	5913275	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.

BENEFIT PROGRAM	NAME OF INSURER/ CLAIMS ADMINISTRATOR	POLICY OR CONTRACT NUMBER(S)	START OF POLICY YEAR OR EFFECTIVE DATE OF COVERAGE	ELIGIBILITY	CLAIMS PROCEDURE & BENEFITS
LONG-TERM DISABILITY BENEFITS	UNUM LIFE INSURANCE COMPANY OF AMERICA INSURER/CLAIMS ADMINISTRATOR	113914	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
VOLUNTARY/ SUPPLEMENTAL LIFE	METLIFE INSURER/CLAIMS ADMINISTRATOR	5913275	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
VOLUNTARY DISABILITY	MUTUAL OF OMAHA INSURER/CLAIMS ADMINISTRATOR	G000BBWG	April 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.