SUMMARY PLAN DESCRIPTION

FOR

Krispy Kreme Doughnuts, Inc.

GROUP LIMITED BENEFITS PLAN

Effective: January 1, 2026

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ADMINISTRATIVE INFORMATION

Name of Plan	CareBasic Group Limited Benefit Plan
Employer / Plan Sponsor	Krispy Kreme Doughnuts, Inc. 2626 Glenwood Avenue, Suite 550 Raleigh, NC 27608
Plan Sponsor's Employer Identification Number	56-2169715
Plan Number	510
Group Number	75000
Type of Plan	A welfare benefit plan providing group health benefits. A fixed indemnity medical plan and prescription drug coverage.
Type of Plan Administration	This plan is fully insured. Benefits are provided under group insurance contracts entered into between **Krispy Kreme Doughnuts, Inc.** and BCS Insurance Company.
Plan Administrator/ Named Fiduciary/ Insurance Companies	BCS Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, IL 60181 1(630) 472-7700
Third Party Administrator (TPA):	BCS Insurance Company Attn: Customer Support 2 Mid America Plaza, Suite 200 Oakbrook Terrace, IL 60181 1 (877) 563-2367
Plan Year/Policy Year:	Begins January 1st of each year and continues for 12 consecutive months, ending on December 31st of the same year.

DISCLAIMER

Benefits under the Plan are provided pursuant to insurance contracts between the Employer/Plan Sponsor and the Insurance Companies. If the terms of this Summary Plan Description conflict with the terms of the Plan or the insurance contracts, the terms of the Plan and the insurance contracts will control, unless superseded by applicable law.

CONFORMITY WITH THE LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto. Nothing in this Plan is intended to replace or affect any requirements for coverage by workers compensation insurance.

NOTICES TO EMPLOYEES

NOTICE: Preferred Provider Organizations (PPOs)

- Medical – **First Health Network**

As a selective consumer concerned with health care costs, it would benefit you through added discounts to visit providers who **participate within the First Health Network for medical services.** However, in order to realize these potential discounts, before you receive services or supplies, you should verify whether or not your provider is participating by:

ALWAYS asking the provider the following questions:

For Medical Services:

- **"Do you participate within the First Health Network PPO?"; and**
- **"Will you honor network discounts for Group Limited Benefit Plans?"**

**You can also verify whether or not your provider is participating by:

- Accessing the provider directory online at www.myfirsthealth.com (medical services), or by visiting the BCS Insurance Company (BCS) website at https://bcsgateway.com/
- Calling BCS Toll Free 1(877) 563-2367, Mon – Fri, 7am – 5pm CT.
- Calling First Health Toll Free at 1(800) 226-5116.

****Since there are timing differences between when a provider is approved for enrollment into the network and terminates from the network, the most accurate member information can be obtained by asking your provider directly.**

THIS CERTIFICATE PROVIDES LIMITED ACCIDENT AND SICKNESS COVERAGE

READ IT CAREFULLY

THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS COVERAGE AS DEFINED IN FEDERAL HEALTH LAW. IT IS NOT MEDICARE SUPPLEMENT INSURANCE. INSUREDS ELIGIBLE FOR MEDICARE SHOULD REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US.

INTRODUCTION, LIMITED BENEFITS PLAN

Krispy Kreme Doughnuts, Inc. (the "Employer") is pleased to sponsor a welfare benefit plan (the "Plan") for you and your fellow eligible employees. References to "you", "your", and "the Insured" throughout this document refer to you as the employee who may be entitled to benefits under the Plan.

The Plan provides the following benefits:

Fixed Indemnity Medical (for employees who work in all states EXCEPT HI, NH and PR) and Prescription Drug benefits.

Each of these is summarized in the respective sections within this SPD.

Summary Plan Description

This document is a Summary Plan Description ("SPD"). It provides a summary of the major provisions and benefits of the Plan. It is also intended to inform you of some of the Plan's limitations and exclusions and your rights as a participant. Because this is only a summary, it has not been written with all of the technical words and legal phrases used in the official Plan documents, insurance contracts and other Plan materials. For full details about the Plan and any of the insurance contracts that provide benefits under the Plan, please consult BCS Insurance Company ("BCS").

Employee Welfare Benefit Plan

The Plan is intended to be a program of benefits constituting an "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

Use of Third Party Administration

Your Employer has selected limited benefit coverage underwritten by BCS Insurance Company and administered by BCS - experienced in processing and paying medical claims in connection with the operation of these benefits. Your Third Party Administrator ("TPA"), BCS, is located in Oakbrook Terrace, Illinois. BCS is a TPA who provides record keeping and claims processing services for BCS Insurance Company. As a TPA, BCS has no discretionary powers under the Plan and, in particular, has no discretionary power in the paying or denying of claims.

BCS is committed to helping you understand your coverage and obtain maximum benefits on your claims. If you have questions about your coverage, you may call between Mon – Fri, 7am – 5pm CT, or write to BCS at the following:

BCS Insurance Company
Attn: Customer Support
2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181
1 (877) 563-2367
https://bcsgateway.com/

MAKING CHANGES TO HEALTH INSURANCE BENEFITS

Please read the information below carefully to determine when and how you may make changes to your insurance benefits.

You may cancel coverage or change coverage tiers (such as moving from Family coverage to Employee only) at any time. However, once enrolled in the plan, you may only add coverage during subsequent open enrollment periods or due to a qualifying life event.

The following are considered qualifying life events for changes in coverage:

- Your current health care coverage will no longer be offered;
- You move to a new area that offers you different plans, or isn't covered by your current network;
- You get married, legally separated or divorced;
- You have or adopt a child;
- You lose other health coverage due to job loss, a decrease in work hours, end of COBRA coverage or other reasons;
- You become a U.S. citizen.
- Your income changes, or some other event changes your income or household status; or
- You are no longer covered on a family member's policy because you turned 26 or the policy holder has passed away.

In addition, you may request a special enrollment (for yourself and/or eligible dependents) within sixty (60) days (1) of termination of coverage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance this medical benefit. You are required to provide supporting documentation to your employer for their review and approval for QLEs.

You can make changes by calling **1 (877) 563-2367**.

PLAN ADMINISTRATION

Plan Funding/Administration

All Plan benefits are provided on a fully insured basis through group insurance contracts between BCS Insurance Company and the Plan Sponsor (identified under **Administrative Information**). Participants are responsible for all required premiums. BCS Insurance Company is the insurance underwriter of the Fixed Indemnity Medical and Prescription Drug Plans.

Claims for benefits are sent to BCS Insurance Company in accordance with the Plan's claims procedures. BCS Insurance Company is responsible for paying claims, not the Employer. BCS Insurance Company is responsible for determining eligibility for and the amount of benefits payable under the Plan and for prescribing, implementing and complying with claims procedures established to determine benefits under the Plan.

If you have any questions regarding eligibility or benefits provided under the insurance contracts, please contact BCS Insurance Company.

Contributions to the Plan

If the employer provides an employer contribution, the employee will be responsible for the difference between the employer's contribution and the total premium amount based on the coverage tier selected. If the employer does not contribute, the employee is responsible for 100% of the total premium amount based on the coverage tier selected.

ELIGIBILITY AND PARTICIPATION IN THE PLAN

Active eligible part-time or full-time employees who are 18 years of age or older with a valid Social Security Number (SSN) or an Alien Registration Number (A-Number), are eligible for the fixed indemnity medical and prescription drug benefits. Also eligible to receive benefits are the employee's dependents who have a valid social security number and meet the following descriptions:

a) Lawful Spouse; and

b) Children, who are less than age twenty-six (26).

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures and children for whom coverage has been court-ordered.

Your coverage will become effective after all of the following is complete:

(1) when you become eligible for this plan;

(2) when you have enrolled, no more than 30 days from your date of hire and/or no more than 30 days following your first pay date; and

(3) when the appropriate premiums for benefits are paid.

Once complete, your benefits will begin on the first day of the month after they enroll, provided they satisfy the eligibility requirement and the required premium is paid.

Your spouse's and/or eligible dependents' coverage will become effective after all of the following is complete:

(1) when they become eligible for this plan;

(2) when they are enrolled; and

(3) when the appropriate premiums for benefits are paid.

Once complete, dependent benefits will begin on the first day of the month after they enroll, provided they satisfy the eligibility requirement and the required premium for dependents is paid.

In no case will coverage for your spouse and/or eligible dependents take effect before yours. The insurance company reserves the right to approve or disapprove your late application to cover a spouse and/or eligible dependents.

There are certain exceptions to the annual enrollment requirement. If you declined coverage (for yourself, your spouse and/or eligible dependents) at a time of eligibility due to the fact that you, your spouse and/or eligible dependents were covered under another plan, and that health coverage is terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or Employer contributions towards such coverage were terminated, you can request a special enrollment within 31 days of the loss. In addition, you may request a special enrollment (for yourself, your spouse and/or eligible dependents) within 60 days (1) of termination of coverage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance under this medical benefit. Please consult with BCS if you are interested in obtaining medical benefits and think one of these situations may apply to you.

Newborn Child Coverage

A child of the Insured born while his or her coverage under the Policy is in force is covered for Injury and Sickness for the first 31 days. The child is covered from the moment of birth until the 31st day of age. A notice of birth, together with the additional premium, must be submitted to us within 31 days of the birth to continue coverage for Injury and Sickness beyond the initial 31 day period. If no additional premium is required, we should be notified of the birth in order to facilitate the administration of the child's coverage. Necessary care and treatment of congenital defects, birth abnormality (including care and treatment for cleft lip or cleft palate) and premature birth, as well as routine newborn care, are covered the same as Sickness.

Adopted and Foster Children Coverage

A minor child who comes under the charge, care and control of the Insured while his or her coverage under the Policy is in force is provided coverage from the moment such child is placed in the Insured's home. The coverage of an adopted or foster child will be the same as provided for other members of the Insured's family. Coverage shall begin at the moment of birth for an adopted child if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. Necessary care and treatment of congenital defects, birth abnormality (including care and treatment for cleft lip or cleft palate) and premature birth, as well as routine newborn care, are covered the same as Sickness. If premium is required for coverage of a child, the Insured must pay the required premium within 31 days after placement of the child in the Insured's home to continue coverage for Injury and Sickness beyond the initial 31 day period. If no additional premium is required, we should be notified of the birth or placement in order to facilitate the administration of the child's coverage. Coverage for the minor child continues, unless the petition for adoption is dismissed or denied or such child is removed from the Insured's home.

If you have questions concerning eligibility for benefits, please contact BCS Insurance Company at 1(877) 563-2367.

TERMINATION OF COVERAGE

Your benefits will terminate, except for COBRA continuation coverage, as described below. In addition, benefits will also terminate the date the employee becomes enrolled in a group major medical health benefit program sponsored by the Employer.

Your spouse's and/or eligible dependents' coverage will terminate, except for any COBRA continuation coverage, as described below. In addition, benefits will terminate the date your spouse and/or eligible dependents become enrolled as a covered employee in another group health benefit program.

Except for those benefits that provide COBRA continuation coverage and the Conversion of Benefits Provision referenced within this SPD:

A. Your coverage will terminate:

- on the last day of coverage for which premium payment is made following termination of employment or you otherwise cease to be eligible for coverage;
- on the last day of coverage for which a premium payment was made if you fail to remit, when due, the required premium payment for your coverage;
- on the termination date of the benefit;
- on the date that you enter into an armed service on full-time active duty. For information on continuing benefits after entering into an armed service on active duty, refer to the Uniformed Services Employment and Re-Employment Rights Act (USERRA) on the following page; or
- for any other reason as set forth in the benefit summaries, insurance contracts or other governing documents for each applicable benefit.

B. Coverage for your covered dependents will also terminate on the day:

- on which your coverage is terminated;
- following the last day of coverage for which required premium payments are made;
- that you cease to be in a class eligible for dependent coverage;
- that a covered dependent ceases to meet the definition of a dependent under eligibility;
- coverage for your dependents is discontinued under the Plan; or
- the termination date of the benefit; or
- for any other reason as set forth in the benefit summaries, insurance contracts or other governing documents for each applicable benefit.

In no case will Dependent coverage terminate later than the coverage of the employee.

Certain requirements must be met to continue coverage beyond the age limit for a child. Please consult BCS Insurance Company for more information concerning these requirements.

Extension of Coverage, Other than COBRA

In some limited circumstances, and as governed by state law, you may be entitled to extended coverage if you lose your coverage and do not elect COBRA (or when your COBRA continuation ends). At such time, you should contact the ERISA Plan Administrator to determine what rights, if any, you might have.

Uniformed Services Employment and Re-Employment Rights Act (USERRA)

USERRA requires employers to offer continuation of coverage for Plan participants when called to serve in the military. If you are called to military duty for more than thirty (30) days, you may elect to continue Employer-sponsored health care for yourself and your eligible dependents for up to twenty-four (24) months, but you may be required to pay up to 102% of the applicable premium. The Employer shall be required to provide coverage for you as though you had remained on the job if you are out on military service for less than thirty-one (31) days. In this case, you will be charged only your share of the premium. Upon your return to work, you will be reinstated with no new waiting periods.

Missed Premium Payments

For any given pay period, if you haven't worked enough hours to pay your premium via payroll deduction, you may pay your premium by check or money order after completing a *Missed Premium Direct Payment Form* found at the end of this SPD. You should make a photocopy of the sample form and complete it. Mail the completed form and a check or money order, payable to BCS Insurance Company, to:

BCS Insurance Company
Attn: Customer Support
2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181

If no deduction has ever occurred for an elected coverage or you are no longer eligible, coverage may not be maintained by direct payments. Additionally, manual payments will not be accepted for a period greater than six consecutive weeks and after 6 weeks of missed payment of premiums by payroll deduction your coverage will be terminated.

You must pay the full premium for all consecutive missed premium payment periods. Partial payments will not be accepted. Your check or money order must be mailed within 45 days after the date on the paycheck from which the payroll deduction would have been taken from your pay. If you miss more than one payroll deduction, you must make up all missed premiums within this 45-day period or claim benefits will not be paid.

EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a Participant in the Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act (ERISA) of 1974.

ERISA provides that all Plan participants shall be entitled to:

a) Examine, without charge at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

b) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operations 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, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done. You have the right to obtain copies of documents relating to the decision without charge. You have the right to have the Plan review and reconsider your claim. Certain time schedules apply to these decisions.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a State or Federal court so long as you have exhausted the Plans claims procedures. No such action can be brought against the Employer more than three years after it receives a claim. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

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

You may be eligible to reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan if you have had creditable coverage under a previous plan. A certificate of creditable coverage should be provided to you, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

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

OTHER PROVISIONS

Employment Rights

Under no circumstances does the maintenance of the Plan, the provision of benefits under the Plan or under any insurance contract or agreement, or this SPD constitute a contract of employment or modify, alter or affect the terms of employment of any participant or employee of the Employer. In addition, the provisions of this SPD do not constitute a contractual agreement as to the terms and conditions of your employment.

Plan Amendment or Termination

Although it is the intent of the Employer to continue the Plan indefinitely, the Employer reserves the right to modify, amend or terminate the Plan or any benefit programs or coverage under the Plan, any group insurance contract, and/or any other agreement or contract associated with the Plan at any time.

Misstatement of Age

If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverage or amount of benefits, or both, for which the person is covered shall be adjusted in accordance with the covered individual's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. Contributions and benefits will be adjusted on the contribution due date following the date of the discovery of such misstatement.

Women's Health And Cancer Rights Act Of 1998

The Plan provides, in the case of a participant or covered Dependent who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, coverage for:

A. Reconstruction of the breast on which the mastectomy has been performed;
B. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
C. Prosthesis and treatment for physical complications at all stages of mastectomy, including lymphedemas.

The Plan's Benefit Limitations as outlined in the benefit summaries will apply to these benefits.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health 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, the Plan and the insurance company may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance company for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Order (QMCSO)

The term Medical Child Support Order means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

A. Provides for child support with respect to a child of a participant under the Plan or provides for health benefits coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under the Plan, or
B. Enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

For further information on QMCSOs please contact BCS Insurance Company at 1(877) 563-2367, Mon – Fri, 7am – 5pm CT. A copy of the QMCSO procedures for the Plan is available without charge from the Plan Administrator.

FIXED INDEMNITY MEDICAL SCHEDULE OF BENEFITS, CareBasic

The following does not constitute all Plan benefits information. For the complete benefits provisions please contact BCS Insurance Company at 1(877) 563-2367.

Annual Maximum (Inpatient and Outpatient benefits are subject to the annual maximum)	$5,000
INPATIENT HOSPITAL BENEFIT (Payable benefits require a minimum 24 hour stay)	
Surgical Procedure – Per Day	$1,000
Administration of Anesthesia – Per Day	$250
Hospital Confinement Daily Income – Per Day	$200
Intensive Care Unit Confinement Daily Income – Per Day (Paid in addition to Hospital Confinement Daily Benefit)	$200
OUTPATIENT BENEFITS (All outpatient benefits are subject to the outpatient maximum)	
Annual Maximum	$2,200
Physician Office Visits – Per Day	$125
Diagnostic Lab – Per Day	$75
Diagnostic X-Ray – Per Day	$75
Ambulance Services – Per Day	$500
Emergency Room for Sickness – Per Day	$250
Emergency Room for Accident – Per Day (For off-the-job accidents only)	$250
Surgical Procedure – Per Day	$500
Administration of Anesthesia – Per Day	$100

Benefit Descriptions:

Ambulance Services
This benefit is payable at the reflected fixed dollar amount for the use of ground or air ambulance transportation service, to or from a hospital as a result of an accident or illness.

Diagnostic Lab
This benefit includes all diagnostic lab tests ordered or performed by a licensed practitioner when hospital confinement is not required. It is paid at a preselected fixed dollar amount.

Diagnostic X-ray
This benefit includes all diagnostic x-ray ordered or performed by a licensed practitioner when hospital confinement is not required and is paid at a preselected fixed dollar amount.

Emergency Room
This benefit is payable at a preselected fixed dollar amount for eligible services or supplies received in an emergency room when the visit results from an accident or illness.

Intensive Care Hospital Benefit
This benefit is payable per day for confinement in an intensive care unit. This benefit is paid in addition to the daily standard care hospital benefit, per covered person per policy year at the plan defined daily rate.

Physician Office Visits
This benefit is payable per day for visits to a doctor's office, urgent care or outpatient hospital facility for diagnosis, consultation or treatment for wellness, injury or illness services provided by a licensed practitioner. It is paid at a preselected fixed dollar amount. Diagnostic and X-ray services performed during a physician office visit are payable separately as per the benefit schedule.

Standard Care Hospital Benefit
Payable when a covered person is confined in a hospital as a result of an accident or sickness unrelated to a work injury. This benefit is payable per day to the insured after 24 hours confinement in a hospital.

Surgical and Anesthesia
This benefit pays a preselected fixed dollar amount for surgeries performed by a licensed practitioner and provides for anesthesia administered by an anesthesiologist or anesthetist in connection with a covered surgical procedure. The benefits for surgery and anesthesia are paid at a preselected fixed dollar benefit plan amount.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Preferred Provider Organization (PPO) for the participants with medical benefits under the Plan is:

- **First Health Network**

PPO Providers are hospitals, skilled nursing facilities, home health agencies, hospice, doctors and other providers of medical services and supplies who have a written agreement with the above referenced network.

The PPO Providers will file all claims for covered services or supplies with BCS for you.

You will receive discounted rates when you use PPO Providers for services. **You will pay more if you do not use PPO Providers.** You will receive Non-PPO rates for providers (such as the radiologist, anesthesiologist, etc.) who are not in the preferred network, even if the hospital is a preferred provider. It is in your best interest for you to make sure that all of your providers are participating providers within the appropriate PPO Network. The **NOTICE** on Page 1 has additional information on how to find out if your provider is a PPO Provider.

Non-PPO Providers can bill you their total charge. They may ask you to pay the total amount of their charges at the time you receive services or supplies and you will have to file your own claims.

FIXED INDEMNITY MEDICAL BENEFIT EXCLUSIONS AND LIMITATIONS

A. No benefits will be paid for loss caused by or resulting from:

1. intentionally self-inflicted Injuries, suicide or any attempt at suicide while sane or insane;
2. declared war or any act of war;
3. serving on full-time active duty in the armed forces of any country or international authority;
4. the Covered Person's commission of a felony;
5. flying as a pilot or crew member of any aircraft or travel or flight, including boarding or alighting, in any vehicle or device while being used for any test or experimental purposes or while being operated by, for or under the direction of any military authority other than the Military Airlift Command (MAC) of the United States or similar air transport service of any other country; or
6. the treatment of an occupational Injury or Sickness, which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement under the North Carolina Workers' Compensation Act.

B. In addition to the above exclusions, no benefits will be paid for:

1. eye examinations for glasses, any kind of eye glasses or prescriptions for them;
2. ear examinations or hearing aids;
3. dental care or treatment other than care of sound, natural teeth and gums required on account of Injury to the Covered Person resulting from an Accident that happens while he or she is covered under the Policy and rendered within 6 months of the Accident. Treatment for any type of temporomandibular joint (TMJ) dysfunctions will be covered same as Sickness;
4. reading or interpreting the results of any diagnostic laboratory or X-ray;
5. services rendered in connection with cosmetic surgery, except cosmetic surgery that the Covered Person needs for breast reconstruction following a mastectomy or as a result of an Accident that happens while he or she is covered under the Policy. Cosmetic surgery for an Injury must be performed within 90 days of the Accident causing the Injury and while his or her coverage is in force. This exclusion does not apply to the treatment and/or correction of congenital defects or abnormalities for newborn, adopted, and foster children; or

6. services provided by the Covered Person, a member of the Covered Person's immediate family or the Employer.

PRESCRIPTION DRUG BENEFIT	
Per Covered Person	
Annual Maximum	$300
Generic (Per Day):	$30
Brand (Per Day):	$30

Standard Prescription Drug Plan

For generic and brand prescriptions, the plan pays you $30 per day up to the annual maximum for drugs dispensed by a pharmacist. Prescription drug coverage is not provided for drugs administered during a physician office visit or hospital stay. If you choose a participating pharmacy and present your ID card, you will receive a discount off the retail price of the prescription at the time of purchase. You will then use the Medical Claim Form at the back of this SPD to file your claim for reimbursement with BCS Insurance Company.

CLAIM FILING PROCEDURES

Please follow the instructions below when you have claims for expenses:

- If you receive healthcare services or supplies from a PPO Provider, the Provider will file your claims for you.
- If you receive healthcare services or supplies from a Non-Network Provider, you will have to file your own claims using the Medical Claim Form.
- If you receive prescription drug benefits, please follow the directions outlined in the Prescription Drug Benefit section of this Plan Document.

You can get these forms from the FORMS section at the end of this SPD, or you may print them from the BCS website at https://bcsgateway.com/.

When filing your own claims, here are some things you will need:

1. Limited Benefits Claim Form for each patient.
2. Itemized bills from the providers for each patient. These bills should include:
   A. Provider's name and address and Tax Identification number;
   B. Patient's name and date of birth;
   C. Your ID number;
   D. Description (applicable CPT, dental, vision or NDC drug procedure code) and charge/cost for each service;
   E. Date that each service took place; and
   F. Description of the illness or injury (ICD diagnosis code).

Complete the front of each claim form and attach the itemized bills to it.

Before you submit your claims, we suggest you make copies of all claim forms and itemized bills for your records since we cannot return them to you. Send your Medical and Prescription Drug claims to BCS.

Authorized Representative

Unless expressly permitted under the protection of the ERISA regulations and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your protected health information (PHI) cannot be released to an individual without your consent. There are instances when a family member or representative needs to discuss your protected health information or receive an explanation of benefits to help manage your

care. In order to comply with these regulations and to protect your privacy, a written authorization or a completed Authorized Representative Form is required. Please visit the BCS Insurance Company website at https://bcsgateway.com/ and click FORMS on the left. You can print this form and mail to the BCS address. You can also call 1(877) 563-2367 for a form to complete.

Time Limits to File a Claim

Claims must be filed no later than ninety (90) days from the incurred date of service you or your spouse and/or eligible dependents receive services or supplies. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given within one (1) year after it is due, unless you are legally incapable of doing so.

Denial of Claims

If we deny any part or all of a claim, you will receive an adverse benefit determination notice known as an explanation of benefits (EOB) explaining the reasons for the claim denial.

If you do not understand why we denied your claim, you can:

- Read the information in this SPD. It outlines the terms and conditions of your health coverage; and
- Contact BCS at 1(877) 563-2367, Mon – Fri, 7am – 5pm CT.

Appeal Procedures

If you wish to file a formal appeal, you must write to:

BCS Insurance Company
Attn: Customer Support
2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181

The letter must state that a formal appeal has been requested and all pertinent information regarding the claim in question must also be included in the letter.

Legal Actions

No action at law or in equity can be brought for denial of benefits until sixty (60) days after we receive a claim (proof of loss) and you have exhausted the appeal process. No such action can be brought more than three (3) years after we receive a claim.

PRIVACY NOTICE

This notice describes BCS Insurance Company's privacy practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations that implement HIPAA.

Our Legal Duty
HIPAA requires us to maintain the privacy of information we use and maintain about you (your medical information). We are required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We also must inform you of a breach involving your unsecured medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **July 1, 2013**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time. Any new terms will be effective for all medical information that we maintain, including medical information we create or receive before we make the changes. Before we make a significant change in our privacy practices, we will change this notice and post our new notice on our website. We will provide information about changes to the notice and how to obtain the notice in our next annual mailing to our health plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Medical Information
We use and disclose medical information about you for the following purposes:

Treatment: We may use and disclose your medical information for treatment. For example, we may disclose your medical information to a physician or other health care provider who is providing treatment to you.

Payment: We may use and disclose your medical information to pay for benefits or to obtain premiums. For example, we pay claims to physicians, hospitals and other providers for services delivered to you that are covered by your health plan. We also use and disclose your medical information to establish your eligibility for benefits, to determine medical necessity, and to issue explanations of benefits. We may disclose your medical information to a health care provider or entity subject to HIPAA so they can engage in these type of payment activities.

Health Care Operations: We may use and disclose your medical information in connection with our everyday work activities (health care operations). These operations include, for example, customer service, resolution of grievances, quality assessment and improvement activities, and fraud and abuse detection and compliance. They also include underwriting, enrollment, and other activities related to creating, renewing, or replacing a benefits plan. We may not, however, use or disclose genetic information for underwriting purposes. In limited circumstances, we may disclose your medical information to another entity subject to HIPAA so they can engage in their own health care operations.

Required or Permitted by Law: We may use or disclose your medical information when required by law, such as in response to a court order or for government health oversight activities (*i.e.*, inquiries from a State Department of Insurance). In limited circumstances, we may also give out medical information as permitted by law, such as for public health purposes (*i.e.*, reporting disease outbreaks), law enforcement purposes, research studies, to avoid a serious and imminent threat to health or safety, to create de-identified information, and for emergencies.

To You or Others Involved In Your Care: We may use or disclose your medical information to provide information to you or to a family member, friend or other person to help with your health care or with payment for your health care. Before we disclose your medical information to a family member, friend or other person, we will provide you with an opportunity to object to the use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure is in your best interest.

Plan Sponsors: If you are a participant in a group health plan, we may disclose summary information about the enrollees in your plan to the employer (or other organization that sponsors your plan) to use to obtain

premium bids for the health insurance coverage offered through your plan or to decide whether to modify, amend or terminate your plan. Summary information is partially de-identified information about claims history, claims expenses, or types of claims experienced by plan enrollees. If the employer (or other plan sponsor) takes appropriate steps to comply with HIPAA, we may disclose medical information of individuals enrolled in your plan to the plan sponsor to permit the plan sponsor to perform plan administration functions. If this is the case, your group health plan will publish its own notice describing how it uses and disclosures your medical information.

Situations Other Than Those Above: Except as described in this notice, we may not use or disclose your medical information without your written authorization. You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us written authorization, you may revoke it at any time by notifying us of your revocation in writing. Your revocation will not affect any use or disclosure permitted by the authorization while it was in effect. We need your written authorization to use or disclose psychotherapy notes, except in limited circumstances such as when the disclosure is required by law. We also must obtain your written authorization to sell information about you to a third party or, in most circumstances, to use or disclose your medical information to send you communications about products and services. We do not need your written authorization, however, to send you communications about health related products or services, as long as the products or services are associated with your coverage or are offered by us.

Individual Rights

In most cases, you have the right to look at or get a copy of the medical information that we use to make decisions about you. If you request copies, we may charge you a reasonable, cost-based fee for the copies. You also have the right to receive a list of instances in which we have disclosed health information about you for reasons other than treatment, payment, health care operations, and certain other purposes. If you believe the records we maintain about you are incorrect or are missing important information, you have the right to request that we correct our records.

If you believe that you would be in danger if we send your medical information to the address we have for you in our records, you have the right to request that we communicate with you using alternative means or an alternative location. We will accommodate your request if the request (a) states that our communications could put you in danger, (b) is reasonable, (c) specifies the alternative means or location for communicating with you, and (d) permits us to continue collecting premiums and paying claims under your health plan.

Finally, you may request that we place additional restrictions on how we use or disclose your medical information. We will consider your request but are not legally required to agree to it.

All requests to exercise these rights must be made in writing by you and directed to the contact person named below.

Your California Privacy Rights

If you are a California resident, California law may provide you with additional rights regarding our use of your personal information. To learn more about your California privacy rights, email privacyofficer@bcsigroup.com.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this notice. You may also submit a complaint to the U.S. Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. Privacy Officer at BCS Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, IL 60181 By phone: 833-227-4512, fax: 630-472-7822 or email: privacyofficer@bcsigroup.com.

If you have a question, a general complaint or concern unrelated to your privacy (for example, to request information about your plan or to request an ID card) please contact the BCS Insurance Company Customer Service Team toll-free at (877) 563-2367, by mail to BCS Insurance Company, 2 Mid America Plaza, Suite 200, Oakbrook Terrace, IL 60181, or by e-mail at BCSService@bcsf.com.

COBRA NOTICE

IMPORTANT INFORMATION- PLEASE READ AND KEEP FOR YOUR RECORDS.

COBRA NOTICE **CONTINUATION COVERAGE RIGHTS UNDER COBRA**

This notice describes how/when your coverage can be continued after a coverage loss and also provides additional information about other coverage options available to you. Please read it carefully.

There may be more affordable options available to you through the Health Insurance Marketplace, Medicaid or other group health plan coverage (such as a spouse's employer-sponsored plan). Be sure to compare all your options to COBRA continuation & select what's best for you/your family.

Visit/call the Health Insurance Marketplace at: www.HealthCare.gov **/ 1-800-318-2596.**

COBRA Continuation Introduction

You are receiving this notice because you recently become covered under a Limited Benefit Plan. This notice contains important information about your right to COBRA continuation coverage, a temporary extension of coverage under the Plan. The right to COBRA continuation coverage is created by federal law, called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage becomes available to you & members of your family covered under the Plan when you otherwise lose health coverage.

This notice summarizes COBRA continuation coverage, when it may become available to you, your family, & what to do to protect the rights.

For more information about your rights, obligations under the Plan & under federal law, you should contact BCS Insurance Company (BCS) at: **BCS Insurance Company**
2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181
or call Toll-Free: (877) 563-2367, Mon – Fri, 7am – 5pm CT

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of coverage when coverage otherwise ends because of a life event known as a "qualifying event" (specific qualifying events are listed below). COBRA continuation coverage is offered to each "qualified beneficiary", someone who loses coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, & dependent children of employees may be a qualified beneficiary. Qualified beneficiaries who elect COBRA continuation coverage must pay the premium for it. If you are an employee, you become a qualified beneficiary if you lose coverage under the Plan due to one of the following qualifying events:

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

A spouse of an employee is a qualified beneficiary if they lose coverage under the Plan because of any the following qualifying events:

1) The employee-spouse dies;
2) The spouse's hours of employment are reduced;
3) The spouse's employment ends for any reason other than his or her gross misconduct;
4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5) You become divorced or legally separated from your spouse.

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

1) The parent-employee dies;
2) The parent-employee's hours of employment are reduced;
3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5) The parents become divorced or legally separated; or
6) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes filing a proceeding in bankruptcy under Title 11 of the United States Code is a qualifying event. If a proceeding in bankruptcy is filed, with respect to your employer and bankruptcy results in the loss of coverage

of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, & dependent children are also qualified beneficiaries in this case.

The Plan offers COBRA continuation to qualified beneficiaries only after BCS is notified of the occurrence of a qualifying event. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify BCS of the qualifying event. In addition, if the Plan provides retiree health coverage, then commencement of a proceeding in a bankruptcy with respect to the employer is also a qualifying event where the employer must notify BCS of the qualifying event.

For other qualifying events including divorce, legal separation of employee & spouse or dependent child's loss of eligibility as a dependent, *you* must notify BCS within 60 days after the qualifying event occurs. You must send this notice to:

BCS Insurance Company
Attn: Customer Support
2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181

Upon notice a qualifying event, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or your family member covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage & you notify BCS in a timely fashion, you & your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that BCS is notified of the determination before the end of the 18-month period of COBRA continuation coverage.

This notice should be sent to:

BCS Insurance Company
Attn: Customer Support
2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse & dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse & dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), gets divorced or legally separated.

The extension is also available to a dependent child when the child stops being eligible under the Plan as a dependent**. In all of these cases, you must make sure that BCS is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:**

BCS Insurance Company
Attn: Customer Support
2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181

Trade Act of 2002
If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, then you will be provided with an additional 60-day enrollment period, with continuation coverage beginning on the date of such TAA approval.

If You Have Questions
If you have questions about your COBRA continuation coverage, you should contact BCS's COBRA Unit or you may contact the nearest Regional or District Office of the U.S Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan informed of any family member address changes. You should also keep a copy of any notices you send to the Plan.

HIPAA/COBRA RIGHTS
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes some provisions that may affect decisions you make about your participation in the Group Health Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). These provisions are as follows:

1. Under COBRA, if the qualifying event is a termination or reduction in hours of employment, affected qualified beneficiaries are entitled to continue coverage for up to 18 months after the qualifying event, subject to various requirements. Before HIPAA, this 18-month period could be extended for up to 11 months (for a total COBRA coverage period of up to 29 months from the initial qualifying event) if an individual was determined by the Social Security Administration, under the Social Security Act, to have been disabled at the time of the qualifying event and if the plan administrator was notified of that disability determination within 60 days of the determination and before the end of the original 18-month period.

Under HIPAA, if a qualified beneficiary is determined by the Social Security Administration to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage, the 11-month extension is available to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment. The disabled individual can be a covered employee or any other qualified beneficiary. However, to be eligible for the 11-month extension, affected individuals must still comply with the notification requirements in a timely fashion.

2. A child that is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the employer's group health plan(s) and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.

3. If you were covered by a group health plan(s) prior to your employment with us, your previous employer's insurance carrier should have provided you with a Certificate of Creditable Coverage, a form required by the HIPAA law that describes the health coverage you and your dependents, if any, have or had, and the dates you were covered. IF YOU HAVE NOT RECEIVED A CERTIFICATE OF CREDITABLE COVERAGE AND ARE ENTITLED TO ONE, PLEASE CONTACT YOUR FORMER EMPLOYER. Once you deliver the Certificate of Creditable Coverage to us, you are exempt from any pre-existing condition exclusions in our group health plan(s), provided you had twelve months of creditable coverage (eighteen months if a late enrollment) and have not had more than a sixty-three day gap in coverage.

4. HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations. Under COBRA, your right to continuation coverage terminates if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be immediately terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the employer's group health plan(s) may terminate your COBRA coverage.

CareBasic℠

Medical Claim Form

Send Medical Claims to:
BCS Insurance Company
Attn: Customer Support
2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181

HOW TO FILE A MEDICAL CLAIM

Claim payment may be delayed if information is incomplete or missing.

Please note that HCFA and UB claim forms are available upon request from your provider.

_____Part One – Attach itemized bills.

Itemized bills are not balance due statements or Explanation of Benefits.

Checklist to make sure all information required has been enclosed:

- **_____ Doctor's name and address**
- **_____ Doctor's tax ID number**
- **_____ Patient's name**
- **_____ Diagnosis Code(s) ICD**
- **_____ Date of service**
- **_____ Charges/Cost of each treatment**
- **_____ Procedure Code(s) CPT-4**
- **_____ Place of service code**

_____Part Two (Page 2) – to be complete signed and dated.

To be completed by the Employee. Please note that employee signature, social security number, and authorization are required.

_____Part Three – Keep a copy for your records.

Mail your Medical claim form and itemized bills to:

BCS Insurance Company
2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181

Questions? Call CareBasic toll-free Customer Service Line, 1-877-563-2367, Mon – Fri, 7am – 5pm CT. A language line is available for translation for most languages.

Underwritten and administered by BCS Insurance Company
Oakbrook Terrace, Illinois

Form 1.620.20251008

Medical Claim Form

Send Medical Claims to:
BCS Insurance Company
Attn: Customer Support
2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181

Attach itemized bills providing complete information on:

- Doctor's name and address • Doctor's tax identification number • Patient's name • Diagnosis Code ICD • Date of service
- Charges/Cost of each treatment • Procedure Codes CPT-4 • Place of service code

Note: Itemized bills are not balance due statements or Explanation of Benefits.
Please note: Incomplete forms and the absence of itemized bills may delay the processing of your claim

Section 1: Employee Information

Employee's Name: _____ SSN: _____
Last First Middle

Address: _____
Street City State ZIP

Telephone: _____ Employer Name: _____ Group No. (from ID card): _____

Section 2: Patient Information

Patient's Name: _____
Last First Middle

SSN: _____ Birth Date: _____ Sex ☐ Male ☐ Female

Relationship to Employee: ☐ Self ☐ Spouse ☐ Daughter ☐ Son ☐ Other: (specify): _____

If the patient is your child and over 25, is he or she dependent upon you for support? ☐ Yes ☐ No

Section 3: Claim Information

Is the claim for an ☐ accident ☐ illness Is treatment a result of occupational illness or injury? ☐ Yes ☐ No

When did the accident or illness occur? _____ First date consulted for the diagnosis? _____

Please explain what you were treated for, and if it was an accident, provide details on how, when, and where it happened. (Attach a separate sheet of paper to to this form if necessary.) _____

Section 4: Authorization

Instructions: The authorization should be completed and signed by the insured. If the insured in unable to sign, the authorization should be completed and signed by the legal guardian or next-of-kin.

To healthcare providers:

You are authorized to permit BCS Insurance Company, its Third Party Administrators, and any authorized representative to view and obtain copies of all records related to health care services rendered, health care advice, treatment or supplies provided to the patient including information related to mental illness, drug or alcohol treatment, HIV or AIDS. The information provided will only be used as it relates to the evaluation of claims for benefit payment.

I understand the information obtained will only be used by BCS Insurance Company to determine eligibility for insurance and benefits claimed under the policy. I consent to disclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent. I understand this authorization may be revoked by written notice to BCS Insurance Company but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree that a photographic copy of this authorization shall be as valid as the original.

_____ _____ _____
Signed **Date** **Relationship to insured if signed by other than insured**

(If signed by other than the Insured, please print name and address, and include guardianship papers or other evidence of legal representation.)

_____ _____
Name **Address**

Questions? Call CareBasic toll-free Customer Service Line, 1-877-563-2367, Mon – Fri, 7am – 5pm CT. A language line is available for translation for most languages.

Underwritten and administered by BCS Insurance Company
Oakbrook Terrace, Illinois

Form 1.620.20251008

Send Medical Claims to:
BCS Insurance Company
Attn: Customer Support
2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181

Fraud Notices

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: ALASKA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or receive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection **Arizona** law requires the following statement to appear on this form: Any person who knowingly presents a false or **fraudulent** claim for payment of a loss is subject to criminal and civil penalties. Penalties may include imprisonment, fines, denials of **insurance** and civil damages.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement is state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: **WARNING**: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

All Other States Not Listed Separately: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Questions? Call CareBasic toll-free Customer Service Line, 1-877-563-2367, Mon – Fri, 7am – 5pm CT. A language line is available for translation for most languages.

Underwritten and administered by BCS Insurance Company
Oakbrook Terrace, Illinois

Form 1.620.20251008

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMOs) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
4441 SIX FORKS RD STE 106-153
RALEIGH NC 27609-5729
https://www.nclifega.org/

North Carolina Department of Insurance,
Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.
- They acquired rights to receive payments through a structured settlement factoring transaction

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.

(2) Except as provided in (3) (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.

(3) The guaranty association will pay a maximum of $500,000 with respect to a health benefit plan.

(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.

(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.