PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

GROUP INSURANCE PLAN FOR FIELD HOURLY EMPLOYEES OF MURPHY USA, INC.

(As Amended and Restated Effective as of January 1, 2019)

Group Insurance Plan for
Field Hourly Employees of Murphy USA Inc.
January 1, 2019

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IMPORTANT NOTICE

Benefits are subject to limitations of the Plan including coordination of benefits. This Plan also contains a requirement for certification prior to all hospitalizations to receive full Plan benefits. Emergency admissions must be certified within three days after the emergency admission took place. Non-Emergency admissions must be certified 48 hours prior to the admission.

INTRODUCTION

This document is a description of Group Insurance Plan for Field Hourly Employees of Murphy USA Inc. (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason upon advance notice to all Participants.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

To the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care Provider who is acting within the scope of the Provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of Providers as an In-Network Provider.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies, and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **Please read this part carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees.

All Active, Full-Time Field Hourly Employees, as so designated in the personnel records of the personnel records of the Covered Employer who except as otherwise provided for Cashiers in the section below entitled Eligibility Requirements for Employee Coverage who work on a regularly scheduled basis of at least 30 hours per week.

Specifically excluded are any Part-Time Employees, temporary Employees, Leased Employees, Employees subject to collective bargaining as such agreement(s) do not provide for eligibility in this Plan or Employees enrolled in any other Murphy USA Inc. group insurance plans.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she satisfies the following eligibility requirements:

(1) Is an Active Employee designated as an Assistant Store Manager and is on the regular payroll of the Employer for that work.

(2) Is a Full-Time, Active Employee designated as a Cashier. A Cashier is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

A Cashier's status as a Full-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard look back measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.).

(3) Completes the 90-day employment Waiting Period as an Active employee. The Waiting Period begins on the first day of employment as an Assistant Store Manager or Cashier.

Eligible Class of Totally Disabled Employee

Total Disability (Totally Disabled) means: In the case of an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. Total Disability will be determined by the Employer.

In no event will a Covered Person be considered Totally Disabled for any period of time during which such Covered Person is not under the regular care and attendance of a legally qualified Physician nor for any period of time during which such Covered Person engages in any occupation or performs any work for compensation or profit.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee was married. The Plan Administrator may require documentation proving a marital relationship. "Domestic Partners" are not considered legal Spouses.

Special Requirement Regarding Spouses: There is a special requirement for working Spouses of Employees. If an Employee's Spouse works and has medical coverage available through his or her place of employment, the Spouse must enroll in that coverage to be eligible for benefits under this Plan. If the Spouse elects not to enroll in his or her employer's medical plan, the Spouse will not be eligible for benefits under this Plan.

(2) A covered Employee's child who is less than 26 years old.

(3) A covered Employee's child who reaches age 26 and is Totally Disabled, incapable of self-sustaining employment by reason of mental retardation or physical disability, provided such child is or was under the limiting age of dependency at the time of application for coverage in the Plan and was still covered under the Plan upon reaching age 26. If such Dependent drops coverage under the Plan after reaching age 26, he or she is not permitted to re-enroll.

The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

Except for Dependents considered Totally Disabled, when a child reaches age 26, coverage will end on the last day of the child's birthday month.

The terms "child" or "children" shall include natural children, step-children, Foster Children, adopted children, or children placed with a covered Employee in anticipation of adoption.

If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles, out-of-pocket limits, and all amounts applied to maximums. Additionally, if a person transfers from one Murphy USA benefit plan to another, as a result of a demotion or promotion, credit will be given for deductibles, out-of-pocket limits, and all amounts applied to maximums.

If two Employees are married, their children will be covered as Dependents of one of the parents, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. Murphy USA Inc. shares the cost of Employee coverage under this Plan. The enrollment procedure for coverage includes a payroll deduction authorization form. This authorization form must be signed electronically when enrolling for coverage to start.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions at any time in its discretion.

The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application and paying the required contribution, if any. The covered Employee is required to enroll for Dependent coverage also, including coverage for newborn children.

Enrollment Requirements for Newborn Children.

Charges for covered nursery care and routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the parents will be responsible for all costs.

For coverage of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, the newborn child must be enrolled as a Dependent under this Plan within 31 days of the child's birth in order for non-routine coverage to take effect from the birth.

If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

<u>Important:</u> A newborn child of a covered Employee who has Dependent coverage is <u>not</u> automatically enrolled in this Plan.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two married Employees are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment and coverage begins the following January 1.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Murphy USA Inc., P.O. Box 7300, El Dorado, Arkansas, 71730-7300, (870) 875-7600.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

(1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the day following the loss of coverage.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the day following the loss of coverage.

(e) For purposes of these rules, a loss of eligibility occurs if:

(i) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.

(ii) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (e.g., part-time Employees).

(iii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be

eligible as a Dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(v) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage for other reasons, or as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

(a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of a loss of coverage, the day following the loss of coverage;

(b) in the case of marriage, as of the date of the marriage;

(c) in the case of a Dependent's birth, as of the date of birth; or

(d) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) Medicaid and State Child Health Insurance Programs. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the

Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

CHANGES IN STATUS

Allowable life status changes include:

- Legal marital status changes, such as marriage, divorce, separation, annulment, or death of a spouse;
- Birth, adoption, the placement in anticipation of adoption, or death of a child;
- Any of the following events for a participant, participant's spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- Spouse's gain or loss of coverage;
- A dependent satisfies or ceases to satisfy the requirements for coverage due to change in age or any similar circumstance; or,
- A change in the place of residence of the participant or the participant's spouse that affects eligibility for coverage.

Documentation supporting a change in status will be required. Benefit changes requested as a result of a change in status must be consistent with the change in status as determined by the Plan Administrator.

Changes to coverage, due to one of the above events, will become effective as of the date of the life status change, provided the Plan Participant notifies the Human Resources Department within 31 days of the change in status.

EFFECTIVE DATE

Effective Date of Employee Coverage. Coverage for Assistant Store Managers will become effective on the first day following the date that the Employee satisfies all of the following requirements. Coverage for Cashiers will become effective on the first day of the calendar month following the date of hire, provided the Employee satisfies all of the following:

(1) The Eligibility Requirement;

(2) The Active Employee Requirement; and

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect. If, for reasons not related to a health condition, an Employee is not Actively at Work on the date he or she would otherwise become covered under the Plan, coverage will not begin until the day the Employee returns to Active Work.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the first day that the Dependent Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met. Newborn children enrolled for coverage on a timely basis will be effective from the moment of birth.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate at midnight on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) If an Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

(4) The end of the period for which required contribution has been paid if the charge for the next period is not paid when due.

(5) The date Medicare becomes sole coverage.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Laid Off Employee. An Employee who returns to employment following a layoff will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by the terms of the Plan and applicable law.

Employees on Military Leave. Employees going into or returning from U.S. military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24-month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Murphy USA Inc., P.O. Box 7300, El Dorado, Arkansas, 71730-7300, (870) 875-7600. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason.

(3) The date Dependent coverage is terminated under the Plan.

(4) On the day he or she ceases to be an eligible Dependent as defined by the Plan, except as previously provided for an incapacitated Dependent.

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) The date the Dependent enters active service with the armed forces of any country.

(7) For a dependent Spouse, on the date of divorce or legal separation.

(8) For a dependent child(ren), on the date there is no longer a covered parent under this Plan.

(9) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

OPEN ENROLLMENT

Every year during the annual open enrollment period, Cashiers, Assistant Store Managers and their Dependents who are not currently enrolled (Late Enrollees) will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

SCHEDULE OF MEDICAL BENEFITS
BlueCard PPO Plan

Verification of Benefits

The number to call for eligibility verification, claim inquiries and benefit questions can be found on the Plan Participant's health plan identification card.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the Claims Administrator's established Coverage Policy, Allowable Charge, and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is Medically Necessary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

High Deductible Health Plan
A qualified High Deductible Health Plan (HDHP) with a Health Savings Account provides comprehensive coverage for high cost medical events and a tax-advantaged way to help build savings for future medical expenses. The Plan gives a Covered Person greater control over how health care benefits are used. A HDHP satisfies certain statutory requirements with respect to minimum deductibles and out-of-pocket expenses for both single and family coverage. These minimum deductibles and limits for out-of-pocket expenses' limit are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

PRECERTIFICATION REQUIREMENTS

Note: The Covered Person is responsible for obtaining precertification of an Out-of-Network inpatient admission. Failure to obtain precertification will result in a reduction of $1,000 in benefits paid by the Plan. The Covered Person is responsible for reimbursing the Provider for the penalty amount. Penalty is in addition to any deductible amount and will be applied to charges billed by the facility. See the Cost Management Services section for more information.

The attending Physician does not have to obtain precertification from the Plan for prescribing maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. (Please see the Cost Management section in this booklet for details).

PARTICIPATING PROVIDER ORGANIZATIONS (PPOS).
The Medical Plan provisions work in conjunction with Participating Provider Organizations (PPOs). This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called In-Network Providers. Because these In-Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

A Covered Person is not restricted to using the services of In-Network Providers to receive benefits for covered services. Except for the situations listed below, covered services, treatments and supplies rendered by an Out-of-Network Provider may be subject to a higher deductible and reimbursed at a lower amount, as listed in the Schedule of Benefits. A Covered Person will also be responsible for any amount of an Out-of-Network Provider charge which exceeds the Allowable Charge.

A listing of In-Network Providers will be provided to Plan Participants at no cost and is available upon request or on the web at www.murphyusa.blueadvantagearkansas.com or www.blueadvantagearkansas.com.

The lower Out-of-Network reimbursement rate will not apply if a Covered Person uses an Out-of-Network Provider for the following reasons:

- Non-contracted suppliers and specialists will be reimbursed at the In-Network level of benefits.

- If services are not available from an In-Network Provider, Covered Charges will be reimbursed at the In-Network level of benefits.
- If services from an In-Network Provider are not accessible within 20 miles of the Covered Person's home, Covered Charges will be reimbursed at the In-Network level of benefits.
- Covered Charges for emergency and Accident services will be reimbursed at the In-Network level of benefits.
- Covered Charges for Inpatient or Outpatient Services rendered by an Out-of-Network anesthesiologist, pathologist or radiologist in connection with an In-Network facility will be paid at the In-Network level of benefits.

MAXIMUM OUT-OF-POCKET PAYMENTS, PER CALENDAR YEAR

The Plan will pay 80% of In-Network Covered Charges and 60% of Out-of-Network Covered Charges until the following amounts of out-of-pocket payments (including the Calendar Year deductible) are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise in this document.

In-Network Out-of-Pocket Limits
Per Person $6,350
Per family $12,700

Out-of-Network Out-of-Pocket Limits
Per Person $12,700
Per family $25,400

Out-of-Pocket Accumulation.
In-Network Out-of-Pocket Covered Charges contribute to Out-of-Network Out-of-Pocket limit. Covered Charges incurred under the Prescription Drug card program will also contribute to the Out-of-Pocket Limit.

For single coverage, the Covered Person must meet the "per person" Out-of-Pocket Limit, at which point the Plan will pay Covered Charges at 100% for that Covered Person for the remainder of the Calendar Year. For two-member or family coverage, until the overall Family Unit Out-of-Pocket Limit has been met, each family member who is a Covered Person must meet his or her own "per person" Out-of-Pocket Limit in order for his or her remaining Covered Charges for the Calendar Year to be covered at 100%. Once the overall Family Unit Out-of-Pocket Limit has been met, the Plan will pay Covered Charges at 100% for that Family Unit for the remainder of the Calendar Year (i.e., even for family members who have not reached the "per person" Out-of-Pocket Limit

The charges for the following do not apply to the 100% benefit limit.
- Precertification penalties
- Charges in excess of the Allowable Charge
- Charges for services or supplies (including Prescription Drugs) that this Plan does not cove
- Charges for brand name penalties under the Prescription Drug Program

CALENDAR YEAR DEDUCTIBLES

A deductible is an amount of money that is paid by the Covered Person or Family Unit for Covered Charges during a Calendar Year before any money is paid by the Plan for covered services. The deductible amount must be satisfied by the individual Covered Person or Family Unit, as applicable, each Calendar Year.

In-Network Calendar Year Deductible	
Per person	$5,000
Per family	$10,000

Out-of-Network Calendar Year Deductible	
Per person	$10,000
Per family	$20,000

Deductible accumulation.
In-Network and Out-of-Network Covered Charges are commingled and will accumulate toward both the In-Network and Out-of-Network Deductibles.

For single coverage, the Covered Person must meet the applicable "per person" deductible before any money is paid by the Plan for any Covered Charge.

For two-member or family coverage, until the overall Family Unit Deductible has been met, each family member who is a Covered Person must meet his or her own "per person" Deductible in order for any Covered Charges to be paid by the Plan. Once the applicable overall Family Unit Deductible has been met, the Plan will begin to pay a specified percentage of Covered Charges for that Family Unit (i.e., even for family members who have not reached the "per person" Deductible)

The Calendar Year deductible is waived for the following services:

- In-Network Preventive/Standard Care Benefits

LIFETIME MAXIMUMS

Lifetime Maximums listed below are the limits on what this Plan will pay for each Covered Person's covered expenses during the total time the individual is covered under this Plan.

Diabetes Self-Management Training	one session, with a maximum Allowable Charge of $250

CALENDAR YEAR MAXIMUMS

The Calendar Year maximums listed below are the limits on what this Plan will pay for each Covered Person's covered expenses in a Calendar Year for the corresponding type of benefit.

Chiropractic Services	30 visits
Diabetic Retinopathy Screening	one screening
Home Health Care	50 visits
Occupational Therapy, inpatient	60 days
Physical Therapy, inpatient	60 days
Speech Therapy, inpatient	60 days
Occupational, Physical, and Speech Therapies, outpatient and office	combined 30-visit limit
Residential Treatment Facility	60 days
Skilled Nursing Facility	60 days

MEDICAL SCHEDULE OF BENEFITS

This schedule shows the level of benefits provided under the medical plan. **Please pay close attention to the footnotes that follow the schedule.** These notes further explain the benefit limitations for specific items covered.

Benefit Description	In-Network Provider	Out-of-Network Provider	See Note
Calendar Year deductible-	$5,000 per person $10,000 per family	$10,000 per person $20,000 per family	
Calendar Year Out-of-Pocket Limit (including deductible)	$6,350 per person $12,700 per family	$12,700 per person $25,400 per family	
Allergy Testing/Treatment	80% after deductible	60% after deductible	
Ambulance Service	80% after deductible	60% after deductible	1
Angiogram	80% after deductible	60% after deductible	
Attention Deficit Disorder	80% after deductible	60% after deductible	
Bereavement Counseling	80% after deductible	60% after deductible	
CT Scan	80% after deductible	60% after deductible	
Cardiac and Pulmonary Rehabilitation	80%, after deductible	Not covered	2
Chemotherapy and Radiation Therapy	80% after deductible	60% after deductible	
Chiropractic Services	80% after deductible	60% after deductible	3
Diabetes Self-Management Training	80% after deductible	60% after deductible	4
Diabetic Retinopathy Screening	80%, after deductible	60%, after deductible	5
Durable Medical Equipment	80% after deductible	60% after deductible	
Emergency Room Services	80% after deductible	80% after deductible	6
Growth Hormones	Not covered	Not covered	
Home Health Care	80% after deductible	60% after deductible	7
Hospice Care	80% after deductible	60% after deductible	
Hospital Room and Board	80% after deductible	60% after deductible	8
Hospital Expenses, Other	80% after deductible	60% after deductible	
Inpatient Surgery	80% after deductible	60% after deductible	
Intensive Care Unit (ICU), CCU, Burn Unit or Immediate Care Unit	80% after deductible	60% after deductible	9

Jaw Joint/TMJ (Temporomandibular Joint Syndrome) Disorder	80% after deductible	60% after deductible	10
Mental Illness Treatment	80% after deductible	60% after deductible	
MRI	80% after deductible	60% after deductible	
Occupational Therapy	80% after deductible	Not covered	11
Organ Transplants	80% after deductible	60% after deductible	12
Outpatient Surgery	80% after deductible	60% after deductible	
Physical Therapy	80% after deductible	Not covered	13
Physician Services – Any setting	80% after deductible	60% after deductible	
Preadmission Testing	80% after deductible	60% after deductible	
Pregnancy Benefits	80% after deductible	60% after deductible	14
Preventive/Standard Care benefits	100%, deductible waived	60%, after deductible	15
Private Duty Nursing	80% after deductible	60% after deductible	
Prosthetics/ Orthotics	80% after deductible	60% after deductible	16
Residential Treatment Facility	80% after deductible	60% after deductible	17
Routine Newborn Nursery/Physician Care (Inpatient)	80% after deductible	60% after deductible	18
Second/Third Surgical Opinion	80% after deductible	60% after deductible	
Skilled Nursing Facility/Extended Care	80% after deductible	60% after deductible	19
Smoking Cessation	100%, deductible waived	Not covered.	20
Speech Therapy	80% after deductible	Not covered.	21
Substance Abuse Treatment	80% after deductible	60% after deductible	
Telehealth Services by MDLIVE	MDLIVE Providers only: 80%, after deductible	Providers not contracted with MDLIVE: Not covered	22
Urgent Care Services	80% after deductible	60% after deductible	
Vision Therapy	80% after deductible	60% after deductible	

Footnotes for Benefits

1 **Ambulance services.** Benefits for ground or water ambulance are limited to $1,000 per trip. Benefits for air ambulance are limited to $5,000 per trip.

2 **Cardiac and Pulmonary Rehabilitation.** Out-of-Network services are not covered.

3 **Chiropractic Services.** Charges billed by a chiropractor are limited to 30 visits per Calendar Year.

4 **Diabetes self-management training.** Limited to one training session per Lifetime with a maximum Allowable Charge of $250.

5 **Diabetic Retinopathy Screening.** Limited to one screening per Calendar Year.

6 **Emergency Room Services.** Charges for services rendered in an Emergency Room for treatment of a medical condition that is not a Medical Emergency, as defined by the Plan, are not covered.

7 **Home health care.** Limited to 50 visits per Calendar Year.

8 **Hospital room and board.** Covered Charges for room and board during an Inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan. Precertification is required on all Inpatient confinements.

9 **ICU/CCU.** Covered Charges for room and board during an Inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan.

10 **Jaw joint/TMJ disorder.** Treatment is covered whether surgical or nonsurgical, but not if deemed to be dental or orthodontic in nature.

11 **Occupational Therapy.** Inpatient services are limited to 60 days per Calendar Year. Outpatient and office services for occupational therapy, physical therapy and speech therapy, are subject to a combined limit of 30 visits per Calendar Year. Out-of-Network services are not covered.

12 **Organ transplants.** The Plan covers a Covered Person's charges as a donor only when the recipient is also a Covered Person.

13 **Physical therapy.** Inpatient services are limited to 60 days per Calendar Year. Outpatient and office services for occupational therapy, physical therapy and speech therapy, are subject to a combined limit of 30 visits per Calendar Year. Out-of-Network services are not covered.

14 **Pregnancy benefits.** Charges for Pregnancy or any complication of Pregnancy for a covered Dependent child are not covered under this Plan. Routine obstetrical ultrasounds are limited to one per pregnancy. However, any prenatal, post-natal or maternity care that is required as Standard Preventive Care are covered under the Plan.

15 **Preventive/Standard Preventive Care.** At all times this Plan will comply with the Patient Protection and Affordable Care Act. The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at: www.HealthCare.gov/center/regulations/prevention.html. and www.cdc.gov/vaccines/recs/acip/

This Plan does not cover Out-of-Network Preventive Care.

16 **Prosthetic and Orthotic Appliances.** Replacement prosthetics and orthotics are limited to one every three Calendar Years.

17 **Residential Treatment Facility.** Maximum number of days payable is 60 per Calendar Year.

18 **Routine Newborn Care.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital or Physician makes a charge.

Charges for covered routine nursery care will be applied toward the Plan of the mother. If the mother is not covered under this Plan, charges will be applied toward the Plan of the newborn child.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

If a child is born in an Out-of-Network Hospital because the Employee's Spouse has other coverage, or if such Child is an adopted child born in an Out-of-Network Hospital, nursery charges are covered up to the Allowance or Allowable Charge incurred or $2,000, whichever is less.

19 **Skilled nursing facility/extended care.** Maximum number of days payable is 60 per Calendar Year.

20 **Smoking cessation.** Covers Physician directed services related to smoking cessation as required for compliance with Standard Preventive Care. Related Prescription Drugs are covered under the Pharmacy Drug card program.

21 **Speech therapy.** Inpatient services are limited to 60 days per Calendar Year. Outpatient and office services for occupational therapy, physical therapy and speech therapy, are subject to a combined limit of 30 visits per Calendar Year. Out-of-Network services are not covered.

Telehealth services by MDLIVE- Telephone and Web-Based Video Consultations. In order to obtain this benefit, a Covered Person must complete their medical health history that will serve as an electronic medical record for consulting Physicians. This form can be completed via the MDLIVE website~~,~~ or via the call center. Once enrolled, a Covered Person may phone 1-888-995-1049 or access the MDLIVE website to request a consultation with a Physician.

Telehealth services rendered by Providers that are not contracted with MDLIVE are not covered.

PRESCRIPTION DRUG CARD PROGRAM
SCHEDULE OF BENEFITS

The prescription drug card program is administered by the pharmacy benefits manager.

Type of Drug	Retail Pharmacy Coinsurance	Mail Order Coinsurance
Generic Drugs	20% coinsurance with $10 minimum/$30 maximum	20% coinsurance with $20 minimum/ $60 maximum
Preferred Brand Name Drugs	20% coinsurance with $30 minimum/ $90 maximum	20% coinsurance with $60 minimum/ $180 maximum
Non-preferred Brand Name Drugs	20% coinsurance with $45 minimum/ $135 maximum	20% coinsurance with $90 minimum/ $270 maximum
Dispensing Limits	30-day supply	90-day supply

Important:

1. If a Covered Person chooses to purchase a Preferred or Non-Preferred Brand Name drug when a Generic equivalent is available, the Covered Person will be required to pay the Generic co-payment amount, plus the difference in cost between the Generic drug and the Preferred or Non-Preferred Brand Name drug.

2. If a drug is purchased from a non-participating Pharmacy, the Covered Person will be required to pay 100% of the full prescription cost at the time of dispensing and there will be no reimbursement from the Plan.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits. The deductible is waived for covered In-Network Preventive Care services.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

COVERED CHARGES

All benefits described in this document are subject to the Claims Administrator's established Coverage Policy, Allowable Charge, and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is Medically Necessary; that services, supplies and care are not Experimental and/or Investigational. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. After 23 observation hours, a confinement will be considered an Inpatient confinement.

Covered Charges for room and board during an Inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan.

(2) **Outpatient Surgery** charges for necessary services and supplies for Surgical Procedures performed on an outpatient basis at a Hospital, Ambulatory Surgical Center, or Physician's office, provided that benefits for such charges would be payable if the procedure were performed during a Hospital confinement.

Charges for one night's lodging at a motel, hotel, or Hospital guest house for a patient following Outpatient Surgery (a) if Surgery is not available at a local facility; (b) if certified by attending Physician as to overnight stay being advisable; and (c) with a maximum benefit limited to $50.00 for one-night lodging at a motel, hotel, or Hospital guest house.

(3) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a Covered Employee or Covered Spouse.

The expectant mother is encouraged to enroll in the Special Delivery Program by the 14th week of Pregnancy. Special Delivery can be accessed by calling 1-800-225-1891 ext. 20225. This program is designed to encourage the Covered Person to actively participate in obtaining comprehensive prenatal care. Services that are not normally offered, such as skilled nursing assessments or nursing assistant care in the home for conditions including Pregnancy-induced hypertension, diabetes mellitus, and preterm labor, are covered through the Special Delivery program. The Special Delivery nurse can assist in

coordinating Home Health Care in lieu of hospitalization for those high-risk patients whom the attending Provider feels would benefit from this alternative care.

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

(4) **Skilled Nursing Facility Care.** The Inpatient care in a Skilled Nursing Facility, Extended Nursing Facility or Nursing Home, for patients who no longer need the full range of the acute care hospital's services.

The facility must be approved by the Claims Administrator, the patient must be certified by the attending Physician as needing such care, and the care must be substantially more than seeing to the patient's day-to-day living activities.

Covered services include skilled care ordered by a Physician, room and board, general nursing care, and Prescription Drugs during a covered admission.

(5) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple Surgical Procedures** will be a Covered Charge subject to the following provisions:

(a) Coverage is provided for services of Physicians for Surgery, either as an inpatient or outpatient. If coverage is provided for two or more surgical operations performed during the same surgical encounter or for bilateral procedures, payment for the secondary or subsequent procedure will be made at a reduced rate, which will never exceed 50% of the Allowable Charge.

(b) Payment for a covered assistant surgeon shall be limited to a single Physician, qualified to act as an assistant for the Surgical Procedure. Covered Charges for assistant Surgery services or minimum assistant Surgery services will be paid at a reduced rate which will never exceed 20% of the surgeon's Allowable Charge.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. Covered services must be provided through and billed by a licensed home health agency.

A home health care visit will be considered a periodic visit by either a Nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Bereavement counseling for the patient's immediate family (covered Spouse and/or covered Dependent Children) is covered when rendered by a Hospice Care team.

(8) **Therapy and rehabilitative services.** Coverage is provided for inpatient and outpatient therapy services when performed or prescribed by a Physician. Such therapy services include physical, occupational, and speech therapy. Such therapy services shall include services provided for developmental delay,

developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy services must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate State Licensing Board.

(9) **Mental Illness and Substance Abuse Services (Alcohol and Drug Abuse).** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Plan Document, coverage is provided for Health Interventions to treat Mental Illness and Substance Abuse.

Inpatient, Partial Hospitalization Program and Intensive Outpatient Program Health Interventions

(a) Coverage is provided for Inpatient hospitalization, partial hospitalization programs or intensive outpatient programs (described below) for Mental Illness or Substance Abuse Health Interventions.

(i) Inpatient hospitalization requires a patient to receive covered services 24 hours a day as an inpatient in a Hospital.

(ii) Partial hospitalization programs generally require the patient to receive covered services six to eight hours a day, five to seven days per week in a Hospital outpatient setting.

(iii) Intensive outpatient programs generally require the patient to receive covered services lasting two to four hours a day, three to five days per week in a Hospital outpatient setting.

(b) Precertification is required for Inpatient admissions at a Hospital or a residential treatment facility. The Covered Person may call the MHSA phone number on the back of their health plan identification card to receive precertification.

Non-Hospital Health Interventions

(a) Coverage is provided for a Health Intervention provided during an office visit with a psychiatrist, psychologist or other Provider licensed to provide psychiatric or substance use disorder treatment.

(b) Coverage is provided for a Health Intervention at a licensed psychiatric or substance use disorder treatment facility, accredited by the Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF International).

(c) Coverage for counseling or treatment of marriage, family or child relationship dysfunction is only covered if the dysfunction is due to a condition defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(10) **Advanced practice registered Nurse.** Covered Charges billed by advance practice Nurses, which includes Certified Nurse Practitioners, Certified Registered Nurse Anesthetists, Certified Nurse Midwife, and Clinical Nurse Specialists.

(11) **MDLIVE telehealth services.** This Plan has a special benefit allowing Covered Persons of all ages to receive telephone or web-based video consultations with Physicians for routine primary medical diagnoses. MDLIVE is available 24 hours a day, seven days a week, and 365 days a year, even on holidays. One can use MDLIVE anytime they have a non-emergency medical condition, are unable to see their primary care Provider, or when they simply prefer a convenient, cost effective alternative to the emergency room, urgent care center, or clinic.

MDLIVE may be used:

(a) When immediate medical consultation is needed.

(b) When considering the ER or urgent care center for non-Emergency issues.

(c) When a Covered Person is on vacation or on a business trip.

MDLIVE can provide Physician consultation via electronic conferencing for the following types of conditions:

(a) General medicine, including, but not limited to:
- Sinusitis
- Colds and flu
- Sore throats
- Ear infections
- Allergies

(b) Dermatology, including, but not limited to:

- Poison ivy
- Rashes
- Hives
- Eczema
- Acne

(c) Behavioral health, including, but not limited to:
- Depression
- Anxiety
- Panic disorder

(d) A refill of a recurring Prescription.

(e) Pediatric care.

(f) Non-Emergency medical assistance.

(g) Please note that MDLIVE and the Physicians it makes available are not a service of BlueAdvantage Administrators of Arkansas or of the Plan; neither BlueAdvantage nor the Plan provide any medical services, advice, treatment or consultation in any form. All MDLIVE services are provided by MDLIVE, which is solely responsible for the service and for any advice or consultation of the Physicians working with MDLIVE.

(12) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Treatment of **Acquired Immunodeficiency Syndrome (AIDS)** and routine HIV screening is covered as any other Illness.

(b) **Allergy-related services,** including testing, extracts and injections.

(c) Local Medically Necessary professional land, water, or air **ambulance** service to a Hospital or Skilled Nursing Facility where necessary treatment can be provided. If the Claims Administrator determines that air ambulance was not Medically Necessary, but ground ambulance would have been, the Plan will pay up to the allowed amount for Medically Necessary ground ambulance. Charges for on-site ambulance services which do not result in transport are not covered.

(d) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(e) **Autism Spectrum Disorder.** Coverage is provided for Covered Persons with autism spectrum disorder, including applied behavioral analysis when ordered by a medical doctor or a psychologist and provided by a Board Certified Behavioral Analyst (BCBA). Prior approval is required for applied behavioral analysis. Failure to obtain prior approval may result in denial of reimbursement from the Plan. Please refer to the health plan identification card for the MHSA prior approval phone number.

(f) **Cardiac rehabilitation** services are covered when ordered by a Physician.

(g) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(h) Initial **contact lenses** or glasses required following cataract Surgery.

(i) **Contraceptive** coverage is covered at no charge to the Covered Person as required under the Patient Protection and Affordable Care Act. Coverage under Medical Benefits is limited to services provided in a Physician's office, such as the fitting and placement of contraceptive devices, contraceptive implants and contraceptive drug injections. Contraception that can be purchased from a Pharmacy or is available over the counter is not covered under Medical Benefits, but may be covered under the Prescription Drug Card program administered by the pharmacy benefits manager, also at no charge.

(j) **Diabetes Management Services.** The Plan will pay for one Diabetes Self-Management Training Program per lifetime per Covered Person. Such training program must be in compliance with the national standards for diabetes self-management education programs developed by the American Diabetes Association. If there is significant change in the Covered Person's symptoms or conditions which under Coverage Policy make it necessary to change the Covered Person's diabetic management process, the Plan will pay for an additional Diabetes Self-Management Training Program. This benefit is payable for training in or out of the hospital that has been prescribed by a Physician.

The following services related to Diabetes Management are also covered by the Plan:

(i) Coverage is provided for glucometers, insulin pumps and pump supplies.

(ii) The Plan will cover one eye examination to screen for diabetic retinopathy per calendar year for Covered Persons who are diagnosed with diabetes.

(iii) Coverage of routine foot care, orthopedic shoes and custom foot orthotics is provided when required for prevention of complications associated with diabetes mellitus.

(k) Coverage is provided for **Durable Medical Equipment (DME)** when prescribed by a Physician according to the guidelines specified below.

(i) Durable Medical Equipment is equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an Illness or Injury; and (4) is appropriate for use in the home.

(ii) Coverage for Durable Medical Equipment and Medical Supplies is provided when the Durable Medical Equipment is provided in accordance with Coverage Policy. Examples of Durable Medical Equipment include, but are not limited to, oxygen equipment, wheelchairs and crutches.

(iii) Replacement of DME is covered only when necessitated by normal growth or when it

exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Covered Person.

(iv) When it is more cost effective, the Plan, in its discretion will purchase rather than lease equipment. In making such purchase, the Plan may deduct previous rental payments from its purchase Allowance.

(l) **Eye exams** are covered when ordered by a Physician during treatment of a medical condition or Injury or for children under age six as required by the Patient Protection and Affordable Care Act.

(m) **Genetic** testing is covered in accordance with established Coverage Policy.

(n) Hearing **exams** are covered when ordered by a Physician during treatment of an Illness or Injury.

(o) Treatment of **Temporomandibular Joint (TMJ) Disorder and Cranial Mandibular Disharmony** consistent with established Coverage Policy.

(p) **Laboratory and pathology services.**

(q) **Morbid Obesity** treatment coverage, including gastric bypass Surgery or any other procedure performed for the purpose of weight loss, is subject to prior written approval from the Claims Administrator.

(r) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

(i) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required.

(ii) Emergency repair due to Injury to sound natural teeth. Coverage does not include Injury caused by biting or chewing.

(iii) Dental implants of titanium Osseo integrated fixtures following radiation treatment for cancer of the head or neck or to replace non-diseased teeth following an accidental Injury are covered.

(iv) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

(v) Excision of bony growths of the jaw and hard palate.

(vi) External incision and drainage of cellulitis.

(vii) Incision of sensory sinuses, salivary glands or ducts.

(viii) Surgical extraction of impacted teeth when the attending Dentist or Physician certifies that it is Medically Necessary for services to be performed in a Hospital setting.

Coverage is provided for hospital services, including anesthesia services in connection with treatment for a complex dental condition provided to: (1) a child under seven years of age who is determined by two Dentists (in separate practices) to require the dental treatment without delay; (2) a Covered Person with a diagnosis of serious mental or physical condition; or (3) a Covered Person, certified by his or her Physician to have a significant behavioral problem.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, prosthetic devices, grafts, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(s) **Organ transplant** limits. Coverage is provided for human-to-human organ or tissue transplants in accordance with the following specific conditions:

(i) Not all transplants are covered. There must be a specific Coverage Policy which allows benefits for the transplant in question, and the Covered Person must meet all of the required criteria necessary for coverage set forth in the Coverage Policy and in this Plan Document.

(ii) Except for kidney and cornea transplants, coverage for transplant services requires Prior Approval from the Claims Administrator. A request for approval must be submitted to the Claims Administrator prior to receiving any transplant services, including transplant evaluation.

(iii) Notwithstanding any other provisions, the Allowable Charge for an organ transplant, including any charge for the procurement of the organ, Hospital services, Physician services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) 90% of the billed charges or (b) the global payment determined as payment in full by a Blue Cross and Blue Shield Association Blue Distinction Centers for Transplant participating facility, if the Covered Person chooses to use that facility. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network, but is contracted with a local Blue Cross and/or Blue Shield Plan, the Allowable Charge shall be the price contracted by such Blue Cross and/or Blue Shield Plan. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network and does not contract with the local Blue Cross and/or Blue Shield plan, the Allowable Charge for the transplant services provided in the Transplant Global Period is 80% of the average usual and reasonable charge authorized by participating facilities in the Blue Distinction Centers for Transplant network located in the geographic region where the transplant is performed.

(iv) Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. Benefits under this Plan will be payable only if there is no coverage available under the donor's plan. Donor charges include those for evaluating the organ or tissue, removing the organ or tissue from the donor, and transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

(v) Please note that payments for any transplant (whether performed within the transplant network or by a non-participating facility) are limited to a global payment that applies to all covered transplant services; payment will not be made for any amounts in excess of the global payment for services the facility or any Physician or other Health Care Provider or supplier may bill or attempt to bill separately, because the global payment is deemed to include payment for all related necessary services (other than non-covered services). If a Covered Person uses a facility participating in the Blue Distinction Centers for Transplant network, that facility has agreed to accept the global payment as payment in full, and should not bill for any excess amount above the global payment, except for applicable deductible, coinsurance or non-covered services; however, a non-participating facility may bill the Covered Person for all amounts it may charge above the global payment. These charges above the global payment could amount to thousands of dollars in additional out-of-pocket expenses.

(vi) When the Covered Person is the potential transplant recipient, a living donor's Hospital costs for the removal of the organ are covered with the following limitations:

- Allowable Charges are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less; and
- Donor testing is covered only if the tested donor is found compatible.

(t) The initial purchase, fitting, and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(u) **Podiatry services** are limited to surgical services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or débridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot. Coverage of routine foot care is provided when required for prevention of complications associated with diabetes mellitus

(v) **Prescription Drugs** (as defined) are covered under the Prescription Drug program administered by the pharmacy benefits manager. Coverage under Medical Benefits is available for Prescription Drugs (including injectable drugs) while confined as an Inpatient, or when provided and administered by a Physician in a clinic setting. Injectable drugs prescribed for self-administration require prior approval from the Claims Administrator, acting on behalf of the Plan.

For Covered individuals who are traveling outside of the United States and become Ill or Injured, Medically Necessary Prescription Drug coverage is available under Medical Benefits, reimbursed at 80%, after deductible.

(w) Standard **Preventive Care.** Standard Preventive Care shall be provided as required by applicable law if provided by an In-Network Provider. Standard Preventive Care includes services with an "A" or "B" rating from the United States Preventive Services Task Force.

The list of services included as Standard Preventive Care under the Plan may change from time to time depending upon U.S. federal government guidelines. A current listing of required preventive care can be accessed at: www.HealthCare.gov/center/regulations/prevention.html. and www.cdc.gov/vaccines/.

Examples of Standard Preventive Care for adults include:

(i) Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity;

(ii) Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(iii) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

- Women's contraceptives, sterilization procedures, and counseling;
- Breastfeeding support, supplies, and counseling; and
- Gestational diabetes screening.

Examples of Standard Preventive Care for children include:

Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:

- Diphtheria,
- Pertussis,
- Tetanus,
- Polio,
- Measles,
- Mumps,
- Rubella,
- Hemophilus influenza b (Hib),
- Hepatitis B, and
- Varicella.

Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(x) The initial purchase, fitting and repair, modification or replacement of Medically Necessary **prosthetic devices** which replace a natural eye or limb.

(y) **Reconstructive Surgery.** Correction of abnormal congenital conditions, reconstructive procedures following surgical treatment of an Illness or Accidental Injury, and reconstructive mammoplasties will be considered Covered Charges when provided by an In-Network Provider. Out-of-Network services are not covered.

This mammoplasty coverage will include reimbursement for:

(i) Reconstruction of the breast on which a mastectomy has been performed,

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(z) **Sleep apnea treatment and sleep studies** are covered in accordance with established Coverage Policy.

(aa) **Smoking cessation** services directed by a Physician.

(bb) **Spinal Manipulation/Chiropractic services** by a Provider acting within the scope of his or her license. Coverage is limited as shown in the Schedule of Benefits when performed by a licensed D. C.

(cc) **Sterilization** procedures (tubal ligation and vasectomy) for a Covered Employee and their Covered Spouse.

(dd) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(ee) Treatment of **Temporomandibular Joint (TMJ) Disorder and Cranial Mandibular Disharmony** if not deemed to be dental or orthodontic in nature.

(ff) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Allowable Charges for nursery care for the first five days after birth while the newborn child is Hospital confined as a result of the child's birth or until the mother is discharged, whichever is less.

Charges for covered routine nursery care will be applied toward the Plan of the mother.

If a Child is born in an Out-of-Network Hospital because the Employee's Spouse has other coverage, or if such Child is an adopted child born in an Out-of-Network Hospital, nursery charges are covered up to the Allowance or Allowable Charge incurred or $2,000, whichever is less.

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

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician for routine pediatric care for the first five days after birth while the newborn child is Hospital confined, or until the mother is discharged, whichever is less.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

(gg) The initial purchase of a **wig** following chemotherapy or radiation therapy.

(hh) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES

CERTIFICATION OF MEDICAL SERVICES

The Plan has a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

Please refer to the health plan identification card for the Precertification Services phone number.

The program consists of:

(1) Precertification of the Medical Necessity for the following services before Medical and/or Surgical services are provided:

Inpatient Admissions
Emergency Inpatient Admissions (call must be made within 48 hours of admission);

(2) Retrospective review of the Medical Necessity of the listed services provided;

(3) Concurrent review, in consideration of extended services; and

(4) Discharge planning.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

Precertification requirements are waived for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works:

The responsible party must call the Precertification Services telephone number on the health plan identification card.

Through the precertification process, the number of days of Medical Care Facility confinement authorized for payment will be determined. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the precertification program. The Covered Person's Medical Care Facility stay or use of other medical services will be monitored and either the scheduled release or an extension of the Medical Care Facility stays or extension or cessation of the use of other medical services will be coordinated with the attending Physician, Medical Care Facility and Covered Person.

Responsibility for Obtaining Precertification
The following table identifies services which require precertification and who is responsible for obtaining precertification.

Services requiring precertification	Party Responsible for Notification if Provider is In-Network	Party Responsible for Notification if Provider is Out-of-Network
Inpatient admissions, including emergency admissions	**In-Network Hospital** The In-Network Hospital is responsible for any penalty amounts incurred for failure to obtain precertification.	**Covered Person** Failure to obtain precertification will result in a ***$1,000*** reduction in benefits paid by the Plan. The Covered Person is responsible for reimbursing the Provider for the penalty amount.
Inpatient admissions, concurrent care extension	**In-Network Hospital** The In-Network Hospital is responsible for any penalty amounts incurred for failure to obtain precertification.	**Covered Person** Failure to obtain precertification will result in a ***$1,000*** reduction in benefits paid by the Plan. The Covered Person is responsible for reimbursing the Provider for the penalty amount.

*Some Out-of-Network Providers may have contracts with either the Claims Administrator or the Blue Cross and Blue Shield plan in the state where services were provided, which make them responsible for any penalty amounts incurred for failure to obtain precertification. The Covered Person may contact BlueAdvantage at the customer service telephone number listed on the health plan identification card to determine if a specific Out-of-Network Provider has this type of contract.

PRIOR APPROVAL

Coverage for many Health Interventions are subject to Prior Approval from the Claims Administrator or the Mental Health and Substance Abuse treatment management vendor. To request prior approval, the patient or family member must call the customer service phone number or the MH/SA telephone number on the back of the health plan identification card. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished at the time indicates that the proposed Health Intervention meets the established coverage criteria. All services, including any Health Interventions receiving Prior Approval may be limited or denied if, when the claims for the Health Intervention are received by the Claims Administrator, investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that Out-of-Network limitations apply, or that any other basis for denial of the claim specified in this Plan Document exists.**

SECOND AND/OR THIRD OPINION PROGRAM

Certain Surgical Procedures are performed either inappropriately or unnecessarily. In some cases, Surgery is only one of several treatment options. In other cases, Surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective Surgical Procedure. An elective Surgical Procedure is one that can be scheduled in advance;

that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

CASE MANAGEMENT

Case Management is a program under which Nurses communicate with Plan Participants' Physicians to facilitate access to benefits under the Plan Participants' Medical Benefits Plan, to identify benefit options for outpatient or home treatment settings, and, where appropriate in the Physician's independent professional judgment, to identify and offer Plan Participants a choice of cost-effective alternatives to hospitalization. Case management Nurses are licensed professionals who use their specialized skills to communicate effectively with Physicians; they do not, however, provide any medical services to Plan Participants. All treatment decisions remain exclusively with the Plan Participant and his or her Physicians.

Case management services can provide the following value-added benefits for Plan Participants and the Plan:

(1) Maximize the benefits available under the Medical Benefits Plan;

(2) At the same time, identify cost-effective alternatives to high-cost treatment settings such as hospitalization;

(3) Educate Plan Participants and their Physicians on cost-effective alternatives from which they may choose;

(4) Provide health education to Plan Participants to empower them and their families to self-manage aspects of their care as deemed appropriate by their Physician; and,

(5) Help Plan Participants better understand and deal with the complexities of the health care system and their Medical Benefits Plan.

NOTICE OF PROVIDER INCENTIVES – HOW PAYMENT PROGRAMS FOR NETWORK PROVIDERS MAY AFFECT HEALTH CARE

The Plan has elected to participate in new health care Provider payment initiatives that offer financial incentives – both potential rewards and possible penalties – to Providers based on their ability to meet or exceed certain quality and cost targets or standards.

For example, a Physician may be offered an incentive program in which the Physician's performance of a particular kind of health care service, such as a hip or knee replacement Surgery, is evaluated in terms of the average cost of the surgery when performed by the Physician, as well as whether or how often the Physician meets certain defined quality standards when performing such Surgery. Under such an incentive program, the Physician may be told that the incentive program target for average Physician cost is, for example, $5,000. The Physician also may be informed of five or six quality indicators that the incentive program will require be confirmed in all or a high percentage of the Physician's hip/knee surgical cases, in order to qualify for incentive payments.

Under such an incentive program, if the average cost for all hip and knee replacement Surgeries performed by the Physician during a defined review period (for example, 12 months) exceeds the program target average cost of $5,000, the Physician would be responsible for refunding a portion of such excess costs to insurers or self-funded health benefit plans (such as this Plan). Such refunds for excess average costs might be recovered from the Physician through what are known as "withholds," whereby the insurer or self-funded health benefit plan would withhold a certain percentage from future claims payments otherwise due to the Physician, until the excess cost amount is fully recovered. On the other hand, if the average costs for all hip and knee replacement Surgeries performed by the Physician during a defined review period was less than the program target average cost of $5,000, the Physician would qualify to receive additional incentive payments (sometimes called "bonus" payments) from the insurer or self-funded health benefit plan (including this Plan) as a reward for reducing the Physician's average cost for such Surgeries.

The preceding is simply one example of a possible incentive program; there are very likely to be numerous other types of incentive programs focusing on different kinds of surgeries, medical treatments, or "episodes of care." While the precise working or content of each incentive program may vary, the goal of all such incentive programs is the same: to give the Provider financial incentives to control costs of services, as well as financial incentives to maintain certain quality standards. "Episodes of Care" is a term that refers to the grouping of certain sets of medical services that may be provided over an extended period of time into one "episode" for purposes of quality and cost evaluation. Hip and knee replacement surgeries are one such type of "episode of care," but there are likely to be many others, which could focus on virtually any aspect of health care services, procedures, surgeries or treatments. Please note as well that although the example above refers to Physician services and charges, the provider incentive programs in which the Plan has elected to participate may include other categories of Providers, not just Physicians. Also, Covered Persons should be aware that any deductibles and coinsurance, or other Plan Participant cost-sharing provisions of the Plan shall not apply in any manner to any incentive payments or withholds that result from participation in the incentive programs.

If an individual has concerns about whether their Provider is participating in a Provider incentive program, or how the potential for reward or penalty in that program might affect the Provider's provision of health care services, they should ask the treating Provider or their administrative staff about such incentive program participation prior to receiving any health care services. Additional details on incentive programs in which the Plan participates as of a certain date can be obtained from the Claims Administrator at 1-800-370-5725. Please note that the types of Provider incentive programs, or the specifics of such programs, including payment methods or methods of calculating potential rewards or penalties, may change from time to time, and could be changed quickly, as conditions in the health care or financing marketplace change. Accordingly, a Covered Person may request updated information from the treating Provider, or request it from the Plan, prior to undergoing a specific course of treatment.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Accident is an unintentional, unforeseeable and undesirable happening that results in bodily Injury for which medical treatment is required.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a Full-Time basis. (See definition for Full Time Employee.)

Actively at Work and **Active Work** means actually performing the regular duties of the Employee's occupation at an Employer-designated work site. For a vacation, holiday or scheduled non-working day (e.g., weekend, etc.), Actively at Work and Active Work mean the capacity to perform the regular duties of the Employee's occupation at an Employer-designated work site.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient Surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Claims Administrator means Blue Advantage Administrators, or its successor in interest. Blue Advantage Administrators of Arkansas is an independent licensee of the Blue Cross and Blue Shield Association.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Surgery means any Surgical Procedure, including corrective plastic or reconstructive plastic Surgical Procedures, having the primary purpose of improving physical appearance. Cosmetic Surgery also includes any procedure required in order to correct complications caused by or arising from prior Cosmetic Surgery. However, Cosmetic Surgery does not include in connection with a mastectomy, (a) reconstruction of the breast on which the mastectomy has been performed, and (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance.

Coverage Policy - With respect to certain drugs, treatments, services, tests, equipment or supplies, the Claims Administrator has developed specific Coverage Policies, which have been put into writing, and are available upon request from the Claims Administrator. If the Claims Administrator has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment or supply that the Covered Person received or seeks to have covered under the Plan, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service, test, equipment or supply meets the coverage criteria; however, the absence of a specific Coverage Policy with respect to any particular drug, treatment, service, test, equipment or supply shall not be construed to mean that such drug, treatment, service, test, equipment or supply meets the coverage criteria.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Murphy USA Inc., and any of, its affiliates and subsidiaries that is an employer of any Employees covered under the Plan.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational. The Plan shall have full discretion to determine whether a drug, device or medical treatment is experimental or investigational. Any drug, device or medical treatment may be deemed experimental or investigational, in the Plan's discretion, if:

(1) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and final regulatory approval for marketing has not been announced to the public at the time the drug or device is furnished; or

(2) the drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval;

(3) Reliable Evidence (as defined below) shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II or III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;

(4) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

(5) Reliable Evidence (as defined below) shows that a majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure neither supports nor denies its use for a particular condition or disease.

(6) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that it should not be used as a first line therapy for a particular condition or disease.

"Reliable Evidence" shall mean only the following sources:

(a) the patient's medical records or other information from the treating Physician(s) or from a consultant(s) regarding the patient's medical history, treatment or condition;

(b) the written protocol(s) under which the drug, device, treatment or procedure is provided to the patient;

(c) any consent document the patient has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;

(d) published reports and articles in the authoritative medical and scientific literature, signed by or published in the name of a recognized medical expert, regarding the drug, device, treatment or procedure at issue as applied to the injury, illness or condition at issue; or

(e) the written protocol(s) used by another facility studying substantially the same drug, device, medical treatment or procedure.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Foster Child means a child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Full-Time employment. A Cashier is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

A Cashier's status as a Full-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard look back measurement period, as applicable, as established by the Plan Administrator in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.).

Generic Drug means a prescription drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Health Intervention or Intervention means an item or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body.

HIPAA is the Health Insurance Portability and Accountability Act of 1996 as amended.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of a Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital means an acute general care Hospital, a psychiatric Hospital and a rehabilitation Hospital licensed as such by the appropriate state agency. It does not include any of the following, unless required by applicable law: Hospitals owned or operated by state or federal agencies, convalescent homes or Hospitals, homes for the aged, sanitariums, long term care facilities, infirmaries, or any institution operated mainly for treatment of long-term chronic diseases.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

In-Network Provider means a health care Provider who has entered into a network participation contract with either the Claims Administrator or, outside the state of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided ("Host Plan").

In-Network Transplant Center means a health care facility that provides organ and/or tissue transplants, and which has entered into a network participation contract with either the Claims Administrator, or outside the state of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided ("Host Plan"), or with the national Blue Cross and Blue Shield Association.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Inpatient means confined in a Hospital or other eligible facility as a registered bed patient and incurring charges for at least one day's room and board.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

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

Medical Emergency means medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that a condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically or Dentally Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Illness means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include only illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)

Morbid Obesity is a diagnosed condition in which the patient has a BMI of 40 or greater, or a BMI of 36-39 with the presence of other high-risk co-morbid conditions.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Nurse is a licensed Registered Nurse (R.N.) or licensed Practical Nurse (L.P.N.) or licensed Vocational Nurse (L.V.N.) who does not usually live with the patient and is not a member of his or her family.

Occupational Therapy is the therapeutic use of self-care, work or other therapy activities for the sole purpose of reducing disability and restoring function and motor skills following an Injury or Illness.

Out-of-Network Provider means a health care Provider who does not have a network participation contract with either the Claims Administrator or, outside the state of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided ("Host Plan").

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) duly licensed and qualified to practice medicine and perform Surgery at the time and place a claimed intervention is rendered. Physician also means a Doctor of Podiatry (D.P.M.), a Chiropractor (D.C.), a Psychologist (Ph.D.), an Oral Surgeon (D.D.S.) or an Optometrist (O.D.) duly licensed and qualified to perform the claimed health intervention at the time and place such intervention is rendered. A Physician may not be a person who ordinarily resides in the Covered Person's home or a

person who is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Plan means Group Insurance Plan for Field Hourly Employees of Murphy USA Inc., which is a self-funded group health plan for certain Employees .and is described in this document.

Plan Administrator is the person responsible for the functions and management of the Plan, as described herein, including, but not limited to, decisions on Plan policy, interpretations, and practices and procedures. The Plan Administrator may employ persons or firms to process claims and perform other services for the Plan.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Sponsor means Murphy USA Inc. or its successor in interest.

Plan Year is the 12-month period beginning on January 1 and ending December 31.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician.

Provider means a Hospital or a Physician. Provider also means a certified registered Nurse anesthetist; a licensed audiologist; a chiropractor; a dentist; a licensed certified social worker; a licensed durable medical equipment Provider; an optometrist; a pharmacist; a physical therapist; a podiatrist; a psychologist; a respiratory therapist; a speech pathologist and any other type of health care Provider which the Plan Administrator, in its sole discretion, approves for reimbursement for services rendered.

Routine Physical Exam is an exam by a Physician not required because of Illness or Injury.

Second/Third Surgical Opinion is a written report from a qualified Physician, who is not financially or professionally associated with the first Physician, as to the Medical Necessity of a future Surgical Procedure that was recommended by another Physician. This will include all outpatient tests and diagnostic procedures Medically Necessary to render such an opinion.

Sickness is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered Nurse (R.N.) or by a licensed practical Nurse (L.P.N.) under the direction of a registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed Nurses, under the direction of a full-time registered Nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

Surgery or Surgical Procedure is the performance of a generally accepted and Medically Necessary operative procedure, including, but not limited to:

- a cutting operation;
- suturing of a wound;
- treatment of a fracture;
- reduction of a dislocation;
- laser surgery or lithotripsy;
- radiotherapy, if used in lieu of a cutting operation for removal of a tumor;
- electrocauterization;
- diagnostic and therapeutic endoscopic procedures; or
- nerve blocks, placement of an epidural catheter or injection for the treatment of pain.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. Total Disability will be determined by the Employer.

In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

In no event will a Covered Person be considered Totally Disabled for any period of time during which such Covered Person is not under the regular care and attendance of a legally qualified Physician nor for any period of time during which such Covered Person engages in any occupation or performs any work for compensation or profit.

Transplant Global Period means a period of time that begins on or prior to the day of the transplant procedure and extends for a number of days after the transplant procedure. The length of the Transplant Global Period varies, depending upon the type of transplant involved.

Urgent Care Services means care and treatment for an illness, Injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

MEDICAL PLAN EXCLUSIONS

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest. Services must be performed in a Hospital or Outpatient Hospital setting. Charges for abortions performed by pharmaceutical methods are not covered. This Plan does cover treatment of complications that arise after an abortion, whether or not the abortion was a covered procedure.

(2) **Active Duty.** Charges for an Injury sustained or an Illness contracted while on active duty or military service, unless payment is legally required.

(3) **Acupuncture.** Services, supplies, care or treatment in connection with acupuncture.

(4) **Administrative Fees.** Fees incurred for acquiring or copying medical records, sales tax, preparation of records for other insurance carriers or insurance agencies, medical evaluation for life, disability or any type of insurance coverage are not covered.

(5) **Alcohol**. Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol. The following must be present for there to be sufficient evidence for the purpose of this exclusion: (1) the results of a valid blood, breath or urine test performed by a qualified Provider indicating the Covered Person's alcohol level exceeds the legal limit in the state where the Injury or Sickness occurred or (2) a written citation from a law enforcement officer, in attendance where the Injury or Sickness occurred, indicating the Covered Person was under the influence of alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(6) **Appointments.** Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider are not covered.

(7) **Autism Spectrum Disorder.** For treatment of Autism Spectrum Disorder, this Plan does not cover early intensive behavioral intervention (EIBI)—including but not limited to Lovaas therapy, Treatment and Education of Autistic and Related Communication-handicapped Children (TEACCH), and Early Start Denver Model (ESDM). Additionally, the following modalities do not meet primary coverage criteria that there is scientific evidence of effectiveness in improving health outcomes and are therefore not covered:

- Secretin therapy
- Facilitated communication
- Nutritional or dietary supplements
- Music therapy
- Squeeze machine therapy
- Craniosacral therapy

(8) **Bereavement services.** Medical social services and outpatient family counseling and/or therapy for bereavement, except if provided as Hospice Care, are not covered.

(9) **Biofeedback.** Biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered for any diagnosis or medical condition.

(10) **Blood typing.** Blood typing for paternity testing.

(11) **Cardiac or pulmonary rehabilitation therapy in Freestanding Facilities**. Cardiac or pulmonary rehabilitation in Freestanding Facilities are not covered.

(12) **Chemical Ecology**. Diagnostic studies and treatment of multiple chemical sensitivities, environmental Illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology is not covered.

(13) **Clinical Trials.** Services or supplies provided in connection with a phase I, II, III or IV clinical trial or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. This exclusion will not apply to routine items and services that (a) would have been Covered Expenses had they not be incurred during an approved clinical trial, and (b) are provided during an approved clinical trial, as required and defined under PHSA Section 2709.

(14) **Cochlear implants.** Charges related to cochlear implants.

(15) **Cognitive Rehabilitation**. Services or supplies provided as or in conjunction with, Cognitive Rehabilitation are not covered. However, subject to all terms, conditions, exclusions and limitation of the Plan as set forth in this Benefit Certificate, coverage is provided for Neurologic Rehabilitation Facility Services for Covered Persons with Severe Traumatic Brain Injury.

(16) **Cold Therapy**. Cold Therapy devices are used in place of ice packs. The use of active or passive, intermittent or continuous, with or without pneumatic compression, cold therapy is not covered. Examples of cold therapy devices include, but are not limited to, the Cryocuff device, the Polar Care Cub device, the Autochill device, and the Game Ready device.

(17) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan, except complications from an abortion for a covered Employee or Spouse are covered.

(18) **Cord Blood**. The collection and/or storage of cord or placental blood cells for an unspecified future use as an autologous stem-cell transplant in the original donor or for some other unspecified future use as an allogeneic stem-cell in a related or unrelated donor is not covered.

(19) **Cosmetic services.** Cosmetic Surgery, care and treatment provided for cosmetic reasons. This exclusion will not apply if services are for reconstructive procedures following surgical treatment of an Illness or Accidental Injury, or correction of an abnormal congenital condition. Reconstructive mammoplasty will be covered after Medically Necessary surgery.

(20) **Court ordered or third party recommended treatment**. Services required or recommended by third parties, including physicals and/or vaccines/immunizations for employment, overseas travel, camp, marriage licensing, insurance, and services ordered by a court or arranged by law enforcement officials, unless otherwise covered by the Plan, are not covered.

(21) **Custodial care.** Services or supplies for custodial, convalescent, domiciliary or support care and non-medical services to assist a Covered Person with activities of daily living are not covered.

(22) **Custodial Care Facility.** Services or supplies furnished by an institution which is primarily a place of rest or a place for the aged are not covered. Youth homes, schools, therapeutic camps, or any similar institution are not covered.

(23) **Dental Care or orthodontic services**. Dental Care and orthodontic services are not covered.

(24) **Dental Implants**. Dental implants of titanium Osseo integrated fixtures or of any other material, are not covered regardless of the diagnosis, medical condition, accident or Injury.

(25) **Delivery Charges.** Charges for shipping, packaging, handling or delivering Medications are not separately covered.

(26) **Detoxification.** Treatment solely for detoxification or maintenance care is not considered effective treatment and is not covered under this provision. "Detoxification" means care is aimed primarily at overcoming the after-effects of a specific drinking or drug episode and "maintenance care" means providing an environment free of alcohol or drugs.

(27) **Diabetic Supplies.** Charges for diabetic testing supplies, insulin, and syringes are covered under the Prescription Drug program.

(28) **Dietary and nutritional services.** Services or supplies provided for dietary and nutritional services, unless such services are for the sole source of nutrition for a Covered Person.

(29) **Dietitian** services are not covered unless related to a covered medical condition.

(30) **Education Programs**. Education programs, including but not limited to physical education programs in a group setting, health club memberships, athletic training, back schools, Work Hardening and Work Integration (Community) training, are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Diabetes Self-Management Training.

(31) **Environmental change.** Charges for environmental change including Hospital or Physician charges connected with prescribing an environmental change.

(32) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.

(33) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(34) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(35) **Eye care.** Radial keratotomy or other eye Surgery to correct refractive disorders. Also, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages, nor does it apply to the first pair of eyeglasses or contact lenses following cataract Surgery.

(36) **Family Planning**. The following family planning services are not covered: a) reversal of sterilization, b) preimplantation, c) surrogate mothers providing services for a Covered Person.

(37) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease.

(38) **Foreign travel.** Care, treatment or supplies out of the United States if travel is for the sole purpose of obtaining medical services. Services received outside of the United States must be Medically Necessary to be considered eligible for coverage.

(39) **Fraud or Material Misrepresentation**. Health Interventions, including but not limited to Medications, obtained by unauthorized or fraudulent use of the Covered Person's health plan identification card or by material misrepresentation are not covered.

(40) **Free Health Interventions**. Health Interventions, including but not limited to Medications, provided or dispensed without charge to the Covered Person or for which, normally (in professional practice), there is no charge, are not covered.

(41) **Freestanding Cardiac Care Facility**. Treatment received at a Freestanding Cardiac Care Facility is not covered.

(42) **Growth hormones.** Charges related to growth hormones, including administration, are not covered.

(43) **Habilitative Services.** Services provided in order for a person to attain and maintain a skill or function that was never learned or acquired are not covered; however, limited coverage is available for applied behavioral analysis therapy for treatment of autism.

(44) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician. However, the Plan will allow charges associated with the initial purchase of one wig following chemotherapy.

(45) **Hearing tests and hearing aids.** Charges for routine hearing tests, services or supplies in connection with hearing aids or exams for their fitting.

(46) **High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation**. High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation are not covered except in accordance with specific Coverage Policies.

(47) **Hippotherapy.** Charges associated with hippotherapy.

(48) **Home delivery**. Services and supplies received in connection with child birth in the home are not covered regardless of the Provider.

(49) **Hospital employees.** Professional services billed by a Physician or Nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(50) **Hypnotherapy.** Hypnotherapy is not covered for any diagnosis or medical condition.

(51) **Illegal Acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(52) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness resulting from that Covered Person's voluntary taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person illegally using the controlled substances. A written citation from a law enforcement officer, in attendance where the Injury or Sickness occurred, indicating the Covered Person was under the influence of a controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician must be present for there to be sufficient evidence for the purpose of this exclusion.

(53) **Impacted teeth.** Charges related to surgical extraction of impacted teeth.

(54) **Impotence.** Care treatment, services, supplies or medication in connection with treatment for impotence.

(55) **Infertility treatment.** Care, supplies, services and treatment for infertility, related diagnostic testing, artificial insemination and in vitro fertilization or any other procedure performed for the purpose of achieving pregnancy is not covered.

(56) **Learning Disabilities.** Services or supplies provided for learning disabilities, i.e. reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty, and other learning difficulties, are not covered.

(57) **Medical Supplies**. Medical Supplies that can be purchased without a prescription or over the counter, whether or not a prescription was obtained, are not covered; for example, medication coated dressings, tape and gauze are not covered even with a Physician Prescription. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, Medical Supplies necessary for the management of diabetes mellitus or for home health services are covered. Medical Supplies, Diabetes Management Services and Home Health Services. Expenses for Medical Supplies provided in a Physician's office are included in the reimbursement for the procedure or service for which the supplies are used.

(58) **Naturopath/Homeopath Treatment**. Naturopathic or Homeopathic treatments of any condition are not covered.

(59) **Nicotine replacement products.** Charges for nicotine replacement products, including lozenges, nasal sprays, inhalers, nicotine gum and transdermal nicotine patches purchased over the counter or with a prescription, are not covered under Medical Benefits.

(60) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(61) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(62) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(63) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if Surgery is performed within 24 hours of admission.

(64) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(65) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. All treatment for Morbid Obesity is subject to prior approval by the Claims Administrator, acting on behalf of the Plan Administrator.

(66) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(67) **Orthoptic, Pleoptic or Vision Therapy**. Orthoptic, pleoptic or vision therapy services are generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set out in this Benefit Certificate, coverage is provided for office-based orthoptic training in the treatment of convergence insufficiency when supported by the Coverage Policy on Orthoptic Training for the Treatment of Vision and Learning Disabilities.

(68) **Orthopedic shoes**. Charges for orthopedic shoes (except when they are an integral part of the leg brace and the cost is included in the orthotist's charge) or shoe inserts, or the purchase of orthotic services or

appliances. This exclusion does not apply to orthopedic shoes prescribed during the treatment of a metabolic or peripheral-vascular disease.

(69) **Out-of-Network Reconstructive Surgery**. Services rendered for any Reconstructive Surgery, including reduction mammoplasty, are not covered when rendered by an Out-of-Network Provider.

(70) **Out-of-Network Therapy**. Services rendered Out-of-Network for physical, occupational, speech therapy, and cardiac rehabilitation therapy are not covered.

(71) **Pain Pump, Disposable**. Disposable pain pumps following surgery are not covered.

(72) **Peripheral Vascular Disease Rehabilitation Therapy**. Peripheral vascular disease rehabilitation therapy is not covered.

(73) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(74) **Physical Therapy Aide**. Services or supplies provided by a physical therapy aide are not covered.

(75) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(76) **Pregnancy of dependent other than the Covered Spouse.** Care and treatment of Pregnancy and Complications of Pregnancy for a dependent other than the Covered Spouse unless such services are classified as Standard Preventive Care.

(77) **Prescription Drugs** are not covered under Medical Benefits, but are covered under the Prescription Drug Card program administered by the pharmacy benefits manager. This exclusion does not apply in the following situations:

(78) **Private duty nursing.** Charges for private duty nursing are not covered unless services are rendered as part of a pre-approved Home Health treatment plan.

(79) **Provider Not Defined.** Services or supplies provided by an individual or entity that is not a Provider as defined in this SPD are not covered.

(80) **Recreational therapy.** Services or supplies provided by a recreational therapist.

(81) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(82) **Replacement prosthetics and orthotic devices.** Replacement of a prosthetic or orthotic device is covered no more frequently than once per three-year period except when necessitated by normal growth or when the age of the prosthetic or orthotic device exceeds the useful life. Maintenance and repair resulting from misuse or abuse of a prosthetic device, orthotic device, or Durable Medical Equipment are the responsibility of the Covered Person.

(83) **Residents, interns, students or fellows**. Services performed or provided by a Hospital resident, intern, student or fellow of any medical related discipline are not covered.

(84) **Residential expenses.** Electrical power, water supply, sanitary waste disposal systems, saunas, hot tubs or swimming pools or their installation, or any similar expense(s) associated with a residence.

(85) **Respite care**. Charges for temporary relief to family members or friends for the duties of caring for the Covered Person are not covered.

(86) **Rest cures**. Services or supplies for rest cures are not covered.

(87) **Seasonal Affective Disorder (SAD).** Use of photo therapy or light therapy to treat seasonal affective disorder or depression is not covered.

(88) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(89) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(90) **Sex changes/sex therapy.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, Surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including Prescription Medications and sex therapy.

(91) **Short stature syndrome**. Any services related to the treatment of short stature syndrome, except for laboratory documented growth hormone deficiency, are not covered.

(92) **Smoking cessation/Caffeine addiction.** Treatment of caffeine or nicotine addiction, smoking cessation Prescription Medication products, including, but not limited to, nicotine gum and nicotine patches are not covered under the Medical Plan.

(93) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(94) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense, or a single-night's lodging expenses associated with an Outpatient Surgery, as described in the Medical Benefits Section.

(95) **Ultrasounds**. More than one basic level obstetrical ultrasound during Routine Prenatal Care is not covered.

(96) **Unlicensed Provider.** Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not include within its scope the treatment, procedure or service provided.

(97) **Vertical dimension.** Any charges related to alteration of vertical dimension, including but not limited to dental implants, Surgical Procedures, or appliances.

(98) **War.** Any loss that is due to a declared or undeclared act of war.

(99) **Weight Control.** Medications prescribed, dispensed or used for the treatment of obesity, or for use in any program of weight control, weight reduction, weight loss or dietary control are not covered.

(100) **Workers' Compensation.** Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Worker's Compensation law, Employer's liability law, or occupational disease law, even though the covered person fails to claim rights to such benefits or fails to enroll or purchase such coverage.

PRESCRIPTION DRUG PROGRAM

Prescription Drug Card Program

Murphy USA Inc. offers a discount Prescription Drug program through a pharmacy benefits manager. For the Covered Person's prescription needs, this program enables the Covered Person to receive a 30-day supply of covered medication filled at any of the network Pharmacies. Most major retail Pharmacies participate in this Plan. Many smaller, local Pharmacies also participate in the Plan. A Covered Person can check with a local pharmacist to see if the pharmacist participates in the Plan.

When purchasing prescription medications, a Covered Person should present his or her insurance card at a participating Pharmacy and pay the appropriate co-payment amount. The co-payment is the Covered Person's partial responsibility for the prescription purchased. It is applied to each covered retail prescription charge and is shown in the Schedule of Benefits. Again, each dispensing at a participating retail Pharmacy is limited to a 30-day supply.

Important: If a drug is purchased from a non-participating Pharmacy, the Covered Person will be required to pay 100% of the full prescription cost at the time of dispensing and there will be no reimbursement from the Plan.

Mail Order Drug Benefit Option

If the Covered Person is currently taking a maintenance prescription, the Covered Person can take advantage of the Mail Order Pharmacy and receive, at his or her home, up to a 90-day supply of covered medications after paying the applicable coinsurance amount shown in the Schedule of Benefits. While each dispensing of a mail order prescription is limited to a 90-day supply, the coinsurance will only be equivalent to that of a sixty-day supply.

Maintenance Medications

Maintenance medications are those taken on a regular or long-term basis (for more than 30 days). Some examples of conditions often treated with maintenance medications are high blood pressure, high cholesterol, ulcers, arthritis, heart or thyroid conditions, emphysema and diabetes.

In order to use the mail order Pharmacy, a Covered Person must obtain a prescription for a 90-day supply of the medication they need. A Covered Person may ask his or her doctor to provide this prescription for a 90-day supply with three refills to cover an entire year of medication.

Important Phone Numbers

If the Covered Person has any problems getting a prescription filled while using their pharmacy health plan identification card at a local participating Pharmacy, ask the pharmacist to call the Pharmacy Help Desk. Refer to the Covered Person's identification card reference numbers.

If the Covered Person has any questions concerning the Prescription Drug card program, the Covered Person may call the Customer Service Department. Refer to the Covered Person's identification card reference numbers.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only in the accordance with the terms and conditions of the Plan.

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described later in this section.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If the Covered Person has any questions regarding these procedures, they should contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Claims Administrator must decide whether to approve or deny the Claim. The Claims Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Claims Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Claims Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Claims Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of Claim determination .....72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing .....24 hours

Response by claimant, orally or in writing .....48 hours

Benefit determination, orally or in writing .....48 hours

Notification of Adverse Benefit Determination on Appeal .....72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction.....Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal

Notification to claimant of rescission.....30 days

Notification of determination on Appeal of
Urgent Care Claims ..... 24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)

Notification of Adverse Benefit Determination
on Appeal for non-Urgent Claims ..... 15 days

Notification of Adverse Benefit Determination
on Appeal for Rescission Claims ..... 30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits, pre-certification or mandatory second opinions. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination ..... 15 days

Extension due to matters beyond the control of the Plan ..... 15 days

Insufficient information on the Claim:
Notification of ..... 15 days
Response by claimant ..... 45 days

Notification, orally or in writing, of failure to follow
the Plan's procedures for filing a Claim ..... 5 days

Notification of Adverse Benefit Determination on Appeal ..... 30 days:

Reduction or termination before the end of the treatment ..... 15 days

Request to extend course of treatment ..... 15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination ..... 30 days

Extension due to matters beyond the control of the Plan ..... 15 days

Extension due to insufficient information on the Claim ..... 15 days

Response by claimant following notice
of insufficient information ..... 45 days

Notification of Adverse Benefit Determination on Appeal.....60 days

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Claims Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the health care Provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures, incorporating any voluntary appeal procedures offered by the Plan. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

PREFERRED PAYMENT PLAN AND HOSPITAL REIMBURSEMENT PROGRAM PARTICIPATING PROVIDERS

The Plan participates in the Preferred Payment Plan (PPP) and the Hospital Reimbursement Program (HRP) with BlueAdvantage Administrators of Arkansas. Participating Providers agree to accept the Allowances of BlueAdvantage Administrators of Arkansas and not charge the Covered Person more than that amount. No Assignment of Benefits by the Covered Person shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to the Covered Person.

A listing of Providers participating in the PPP or HRP is available on the web at www.murphyusa.blueadvantagearkansas.com or www.blueadvantagearkansas.com or by phone at 1-800-370-5725.

The Claim Process

This Plan uses a direct claims administration system. Under this approach, the PPP or HRP Provider submits the claims directly to the Claims Administrator.

Any payment due for eligible services rendered by PPP or HRP Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by non-participating Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person

PREFERRED PROVIDER ORGANIZATION (PPO)

The Plan participates in a Preferred Provider Organization (PPO). In-Network Providers agree to accept the PPO allowances and not charge the Covered Person more than that amount.

No Assignment of Benefits by the Covered Person shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to the Covered Person.

A listing of In-Network Providers is available on the web at www.murphyusa.blueadvantagearkansas.com or www.blueadvantagearkansas.com or by phone at 1-800-370-5725.

The Claims Process

The Plan uses a direct claims administration system. Under this approach, the In-Network Provider submits the claims directly to the Claims Administrator.

Any payment due for eligible services rendered by In-Network Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Out-of-Network Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

BLUECARD® PROGRAM

Out-of-Arkansas Services. The Health Plan participates in a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever a Covered Person obtains health care services outside of the State of Arkansas ("the service area"), the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Health Plan and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the service area, a Covered Person will obtain care from health care Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, a Covered Person may obtain care from nonparticipating health care Providers. The Health Plan's practices for consideration of payment in both instances are described below.

(1) BlueCard® Program.

(a) Under the BlueCard® Program, when a Covered Person accesses covered health care services within the geographic area served by a Host Blue, the Health Plan will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers. Whenever a Covered Person accesses covered health care services outside the service area and the claim is processed through the BlueCard Program, the amount a Covered Person pays for covered health care services is calculated based on the lower of:

- The billed Covered Charges for the covered services; or
- The negotiated price that the Host Blue makes available to the Health Plan.

(b) Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with the health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

(c) Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price used for a Covered Person's claim because the adjustments will not be applied retroactively to claims already paid.

(d) Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Health Plan would then calculate the Covered Person's liability for any covered health care services according to applicable law.

(2) Non-Participating Health Care Providers Outside the Service Area

(a) When covered health care services are provided outside of the service area by non-participating health care Providers, the amount a Covered Person pays for such services will generally be based on either the Host Blue's nonparticipating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, a Covered Person may be liable for the difference between the amount that the non-participating health care Provider bills and any payment made for the covered services as set forth in this paragraph.

(b) In certain situations, the Health Plan may use other payment bases, such as billed Covered Charges, the payment the Health Plan would make if the health care services had been obtained within the service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Health Plan will pay for services rendered by nonparticipating health care Providers. In these situations, a Covered Person may be liable for the difference between the amount that the non-participating health care Provider bills and the payment the Health Plan will make for the covered services as set forth in this paragraph

BLUE CROSS BLUE SHIELD GLOBAL CORE

If the Covered Person is outside the United States (hereinafter "BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Plan Participants with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when a Covered Person receives care from Providers outside the BlueCard service area, they will typically have to pay the Provider directly. If a Covered Person needs medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, they may contact customer service at the number on the back of their health plan identification card or additional information can be found at www.bcbsglobalcore.com.

(1) **Inpatient Services.** In most cases, if the Covered Person contacts Blue Cross Blue Shield Global Core for assistance, Hospitals will not require a Covered Person to pay for covered Inpatient services, except for applicable cost-share amounts (deductibles, coinsurance, etc.). In such cases, the Hospital will submit claims to the service center to begin claims processing. However, if the Covered Person paid in full at the time of service, they must submit a claim to receive a benefit determination. Contact the Claims Administrator to obtain prior approval for non-emergency Inpatient services.

(2) **Outpatient Services.** Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require the Covered Person to pay in full at the time of service. A claim must be submitted to receive a benefit determination.

(3) **Submitting a Blue Cross Blue Shield Global Core Claim.** When the Covered Person pays for services outside the BlueCard service area, claim must be submitted to receive a benefit determination. For institutional and professional claims, a Blue Cross Blue Shield Global Core claim form should be completed and submitted with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from the service center or online at www.bcbsglobalcore.com.

ALL OTHER PROVIDERS

When a Covered Person has a Claim to submit for payment that person must:

- Obtain a Claim form from the Claims Administrator.
- Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- Have the Physician complete the Provider's portion of the form. For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

  Name of Plan
  Employee's name
  Name of patient
  Name, address, telephone number of the Provider of care
  Diagnosis
  Type of services rendered, with diagnosis and/or procedure codes
  Date of services
  Charges

Send the above to the Claims Administrator at this address:

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas
72203

WHEN CLAIMS SHOULD BE FILED

The Plan has established and will enforce a one-year timely filing deadline for all claims for benefits under the Plan, meaning that the Covered Person, the treating Provider, or Authorized Representative acting on the Covered Person's behalf, must submit the claim to the Claims Administrator within one year from the date of service. However, In-Network Providers must submit claims within the time limits provided in their applicable Provider contract, if shorter than one year. Claims are not payable if they are not submitted to the Claims Administrator within the applicable time limit.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to require a Covered Person to seek a second medical opinion before making a determination that a particular service or supply will be covered under the Plan.

EXPLANATION OF BENEFITS (EOB)

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied. Upon making a determination of a claim, the Claims Administrator will deliver to the Covered Person an Explanation of Benefit Determination (EOB) containing the following information:

(1) the specific reason or reasons for the determination;

(2) specific reference to those Plan provisions on which the denial is based;

(3) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

(4) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

CLAIMS REVIEW PROCEDURE

The Plan Participant will receive an EOB explaining the claim determination, and if applicable, the reason or reasons for any denial or reduction of benefits. In cases where a claim for benefits payment is denied or reduced in whole or in part, the Plan Participant or the Authorized Representative may request an informal claim review.

In a situation where the determination, after informal review, remains adverse, the Plan Participant or the Authorized Representative may request an appeal of the denial. This appeal provision will allow the Plan Participant to:

(1) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

(2) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within 180 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60-day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits. If a lawsuit is brought, it must be filed within two years after the final determination of an appeal.

The following describes the informal review and appeals processes:

(1) Informal Claim Review.

Requests for review may be submitted in writing, email, or by telephone to the Claims Administrator. The request should provide the patient's name, Plan identification number and the specific claim(s) to be reviewed. Additional relevant documentation may also be provided to the Claims Administrator to assist in the review. A request for an informal claim review must be submitted within 180 days after notice is received of the denial or reduction in benefits.

A determination shall be rendered with a reasonable period of time, but notification of the determination will be provided not later than 60 days after received.

If the review is in regard to a Pre-Service Claim, response will be provided within 30 days of received.

If the review is in regard to an Urgent Care Pre-Service Claim, response will be provided within 24 hours of receipt.

(2) Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(a) was relied upon in making the benefit determination;

(b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a manner calculated to be understood by the claimant:

(a) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the health care Provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(b) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(c) Reference to the specific Plan provisions on which the determination was based.

(d) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(e) A description of the Plan's internal and external review procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(f) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(g) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be

provided free of charge to the claimant upon request.

(h) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(i) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. This request must be filed in writing within four months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the four-month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating Provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Appeals Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the plan.

AUTHORIZED REPRESENTATIVE

One Authorized Representative. A Covered Person may have one representative, and only one representative at a time, to assist in submitting a claim or appealing an Adverse Benefit Determination.

Authority of Authorized Representative. An Authorized Representative shall have the authority to represent the Covered Person in all matters concerning the Covered Person's claim or appeal of a claim determination. If the Covered Person has an Authorized Representative, references to or "Covered Person" in the provision of this document entitled "How to Submit a Claim" refer to the Authorized Representative.

Designation of Authorized Representative. Except to the extent mandated by the U.S. Department of Labor claims rules in the case of a treating health care professionals and urgent care claims, the Plan does not permit appeals on your behalf by any other person or entity not properly designated as an "authorized representative" in the manner specified in this section.

One of the following persons may act as a Covered Person's Authorized Representative:

(1) An individual designated by the Covered Person in writing in a form approved by the Claims Administrator. A "Designation of Authorized Appeal Representative" form is available from the Claims Administrator or the Plan Administrator;

(2) The treating Provider, if the claim is a claim involving urgent care, or if the Covered Person has designated the Provider in writing in a form approved by the Claims Administrator. A "Designation of Authorized Appeal Representative" form is available from the Claims Administrator;

(3) A person holding the Covered Person's durable power of attorney;

(4) If the Covered Person is incapacitated due to Illness or Injury, a person appointed as guardian to have care and custody of the Covered Person by a court of competent jurisdiction; or

(5) If the Covered Person is a minor, the Covered Person's parent or Legal Guardian, unless the Claims Administrator is notified that the Covered Person's claim involves health care services where the consent of the Covered Person's parent or Legal Guardian is or was not required by law and the Covered Person shall represent himself or herself with respect to the claim.

Term of the Authorized Representative. The authority of an Authorized Representative shall continue for the period specified in the Covered Person's appointment of the Authorized Representative or until the Covered Person is legally competent to represent him or herself and notifies the Claims Administrator in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative.

(1) If the Authorized Representative represents the Covered Person because the Authorized Representative is the Covered Person's parent or Legal Guardian or attorney in fact under a durable power of attorney, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

(2) If the Authorized Representative represents the Covered Person in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

(3) If the Authorized Representative represents the Covered Person in connection with the submission of a post-service claim, the Claims Administrator will send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Covered Person, but the Claims

Administrator will provide copies of such correspondence to the Authorized Representative upon request.

(4) The Covered Person understands that it will take the Claims Administrator at least 30 days to notify all its personnel about the termination of the Covered Person's Authorized Representative and it is possible that the Claims Administrator may communicate information about the Covered Person to the Authorized Representative during this 30-day period.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Eligible Charge. For a charge to be eligible it must be an Allowable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which

covers a person as a Dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare to the extent required by federal law.

Spouse Coverage. To ensure that the Plan does not pay more than its fair share for Employee medical coverage, there is a special requirement for working Spouses of Employees. If an Employee's spouse works and has medical coverage available through his or her place of employment, the Spouse must enroll in that coverage to be eligible for benefits under this Plan. If the Spouse elects not to enroll in his or her employer's medical plan, the Spouse will not be eligible for benefits under this Plan.

Coordination with Medicare. For terminated Employees and Dependents, the Plan will coordinate with the benefits from Medicare on an "exclusion" basis as follows: first the Plan determines what expenses are eligible for payment, and subtracts or "excludes" the benefits received from Medicare. Then, the Plan calculates what benefits the Plan will pay on the remaining amount. This includes consideration of the Covered Person's deductible, coinsurance and out-of-pocket maximum.

For example, assume a Covered Person has covered expenses totaling $4,000 and Medicare pays $2,500. The Plan will consider the remaining $1,500 of covered expense to calculate the benefits payable under the Plan. After applying the $350 deductible, the Plan will pay 70% of the remaining $1,150 or $805. In all Medicare and the Plan together pay $3,305 and the Covered Person pays $695.

Medicare. If a Covered Person is an Active Employee age 65 or over, the person must elect either:

(1) The Plan as the primary medical coverage and Medicare as the secondary medical coverage, or

(2) Medicare for the primary medical coverage.

A Dependent Spouse, age 65 or over, of any active Employee, must also make an election.

If a Covered Person elects Medicare as primary coverage, the Spouse, if age 65 or over, will also have Medicare as primary medical coverage. If a Covered Person elects the Plan as primary medical coverage, the Spouse may elect Medicare as his or her medical coverage or may continue coverage under the Plan. Unless an election is made to choose Medicare as primary, coverage will automatically continue under the Plan and this Plan's benefits will be primary. **IF MEDICARE IS ELECTED, ALL COVERAGE UNDER THIS PLAN WILL TERMINATE.**

When Medicare is primary, and the Plan is secondary, Medicare (Parts A and B) will be considered a Plan for the purposes of coordination of benefits. The Plan will coordinate benefits with Medicare with the required enrollment in Medicare Parts A and B by the Covered Person and his or her Spouse.

The Plan will coordinate benefits with Medicare whether or not the Covered Person or the Spouse is actually receiving Medicare benefits.

Medicare for Disabled Beneficiaries Under Age 65. The Plan is primary and Medicare will be secondary for an Active Employee, Spouse or Dependent child who is under age 65 and eligible for Medicare by reason of disability.

If a Covered Person is not an Active Employee, Medicare is primary, and the Plan will be secondary for the Covered Person and the Spouse or Dependent child who is under age 65 and eligible for Medicare by reason of disability. Medicare will be considered a plan for purposes of coordination of benefits. The Plan will coordinate benefits with Medicare whether or not the Covered Person or the Spouse or Dependent child is actually receiving Medicare benefits.

Medicare for Persons with Permanent Kidney Failure. The Plan is primary, and Medicare will be secondary for an active Covered Person and the Spouse or Dependent child during the first 30 months in which the active Covered Person or the Spouse or Dependent child is eligible for Medicare solely because of permanent kidney failure. After the first 30- months, Medicare is primary, and the Plan will be secondary. Medicare will be considered a Plan for purposes of coordination of benefits. The Plan will coordinate benefits with Medicare whether or not the active Covered Person is actually receiving Medicare benefits.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Claims Administrator or Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

Reimbursement

This section applies when a Covered Person, or the legal representative, estate or heirs of the Covered Person (sometimes collectively referred to as the "Covered Person") recovers damages, by settlement, verdict or otherwise, for an Injury, Sickness or other condition. If the Covered Person has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an Injury or Illness or the treatment of such an Injury or Illness. These benefits are specifically excluded.

However, if the Plan does advance moneys or provide care for such an Injury, Sickness or other condition, the Covered Person shall promptly convey moneys or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by the Covered Person (or by the legal representative, estate or heirs of the Covered Person), to the Plan for the reasonable value of the medical benefits advanced or provided by the Plan to the Covered Person, regardless of whether or not [1] the Covered Person has been fully compensated, or "made-whole" for his/her loss; [2] liability for payment is admitted by the Covered Person or any other party; or [3] the recovery by the Covered Person is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over the Covered Person, or any other party, to receive reimbursement of the benefits advanced on the Covered Person's behalf. This reimbursement shall be from any recovery made by the Covered Person, and includes, but is not limited to, uninsured and underinsured motorist coverage, any No-Fault Auto Insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties.

In order to secure the rights of the Plan under this section, and because of the Plan's advancement of benefits, the Covered Person hereby [1] acknowledges that the Plan shall have first priority against proceeds of any such settlement, arbitration award, verdict, or any other amounts received by the Covered Person; and [2] assigns the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. The Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, the Covered Person acknowledges that any proceeds of settlement of judgment, including a Covered Person's claim to such proceeds held by another person, held by the Covered Person or by another, are being held for the benefit of the Plan under these provisions.

The Covered Person shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided. The Covered Person shall not take any action that prejudices the Plan's rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this section, and/or to set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of Covered Person, whether under comparative negligence or otherwise.

Subrogation

This section applies when another party is, or may be considered, liable for a Covered Person's Injury, Sickness or other condition (including insurance carriers who are so financially liable) and the Plan has advanced benefits.

In consideration for the advancement of benefits, the Plan is subrogated to all of the rights of the Covered Person against any party liable for the Covered Person's Injury or Illness, or is or may be liable for the payment for the medical treatment of such Injury or occupational Illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person. This right includes, but is not limited to, the Covered Person's rights under uninsured and underinsured motorist coverage, any No-Fault Auto Insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Covered Person's rights under the Plan to bring an action to clarify his or her rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on behalf of the Covered Person, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that the Covered Person fails to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Covered Person shall be borne solely by the Covered Person.

Defined terms: "Recovery" means any monies paid (full recovery or partial recovery) to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical charges covered by the Plan.

"Refund" means repayment to the Plan for medical benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue the Covered Person's claims for medical charges against the other person.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Group Insurance Plan for Field Hourly Employees of Murphy USA Inc. (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Murphy USA Inc. c/o Employee Benefits Committee, P.O. Box 7300, El Dorado, Arkansas, 71730-7300, (870) 875-7600. The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

There may be other options available 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.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" means an Employee who has met the eligibility requirements of this Plan and whose coverage has become effective.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the day after the leave ends, if the Employee does not return to work in an Eligible Class.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care Provider. You may want to check to see if your current health care Providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Medicare Eligibility:** Individuals should be aware of how COBRA coverage coordinates with Medicare eligibility. If an individual is eligible for Medicare at the time of the Qualifying Event, or if he or she will become eligible soon after the Qualifying Event, he or she has eight months to enroll in Medicare after employment -related health coverage ends. Electing COBRA coverage does not extend this eight-month period. For more information, see https://www.medicare.gov/sign-up-change-plans/.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. More information about these options is available at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002,

and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If an individual has questions about these new tax provisions, he or she may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), the Covered Person or someone on their behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. This notice must be sent to the Murphy USA Inc. Employee Benefits Committee.

NOTICE PROCEDURES:

Any notice must be provided ***in writing***. Oral notice, including notice by telephone, is not acceptable. This notice must be mailed, faxed, or hand-delivered to the person, department or firm listed below, at the following address:

Murphy USA Inc.
Employee Benefits Department
P.O. Box 7300
El Dorado, Arkansas 71730-7300

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice provided must state:

- the **name of the plan or plans** under which coverage has been lost or will be lost,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, the notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If an individual does not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage may terminate if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

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

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

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a

Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is

provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

For More Information

If an individual has questions about COBRA continuation coverage, they should contact the Plan Sponsor. For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, 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 The Plan Administrator Informed Of Address Changes

In order for an individual to protect his or her family's rights, they should keep the Plan Administrator informed of any changes in the addresses of family members. The individual should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Group Insurance Plan for Field Hourly Employees of Murphy USA Inc. is the benefit plan of Murphy USA Inc., also called the Plan Sponsor. The Plan is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or a committee may be appointed by Murphy USA Inc. to be Plan Administrator and serve at the convenience of the Plan Sponsor.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility to participated and eligibility for benefits including, without limitation, factual determinations, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. For purposes of clarity and not limitation, the Plan Administrator has the maximum legal discretionary authority to reconcile any inconsistency, supply any omission and remedy any defect affecting the terms and provisions of the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A “fiduciary” under ERISA exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding for employee coverage is derived from the funds of the Employer and contributions made by the covered Employees.

For Dependent Coverage: Funding for dependent coverage is derived from the funds of the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

ASSIGNMENT OF BENEFITS

Any payment due for eligible services rendered by Providers participating in the Preferred Payment Program (PPP) or Hospital Reimbursement Program (HRP) will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by non-participating Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

Any payment due for eligible services rendered by In-Network Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Out-of-Network Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

The Plan Sponsor intends to maintain this Plan indefinitely; however, it reserves the unilateral right to amend, suspend or terminate the Plan, in whole or in part, at any time in its discretion This includes, without limitation, amending the eligibility rules for participation in the Plan or the benefits under the Plan.

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

DISCRETIONARY AUTHORITY

This Plan Document and Summary Plan Description describes in specific terms and provisions those items and services which are covered under the Plan and those items and services which are not covered under the Plan. Due to the ever-changing environments in health care and generally accepted norms for group health care plan administration, this Plan Document is unable to address every conceivable situation wherein a claim for benefit eligibility may arise. As such, the Plan Administrator possesses explicit discretionary authority to determine eligibility for, or the amount of any benefits available under the Plan, and/or construe the terms and provisions of the Plan.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

> Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including 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 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.
>
> Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.
>
> Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a

duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

AMERICANS WITH DISABILITIES ACT

The Plan has not been created to violate the Americans with Disabilities Act (ADA). Should it be determined that a provision could be in violation, the Plan shall be amended. The ADA was effective July 26, 1992, for all employers with 25 or more Employees. On July 26, 1994, the ADA will affect all employers with 15 or more Employees.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan and the administration is provided through the third-party Claims Administrator. The Plan is not insured. Also, no trust is maintained in connection with the Plan.

PLAN COST: The Plan is financed by contributions from the Employer and the Employees. The amount of Employee contributions is determined annually by the Plan Sponsor.

PLAN NAME: Group Insurance Plan for Field Hourly Employees of Murphy USA, Inc.

PLAN NUMBER: 521

TAX ID NUMBER: 46-2279221

PLAN EFFECTIVE DATE: January 1, 2015 and is amended and restated effective January 1, 2019.

PLAN YEAR: January 1 through December 31

PLAN SPONSOR INFORMATION
Murphy USA, Inc.
P.O. Box 7300
El Dorado, Arkansas 71730-7300
(870) 875-7600

EMPLOYER AFFILIATES/SUBSIDIARIES
Murphy USA, Inc.

PLAN ADMINISTRATOR
Murphy USA, Inc. – Employee Benefits Committee
P.O. Box 7300
El Dorado, AR 71730-7300
(870) 875-7600

NAMED FIDUCIARY
Murphy USA, Inc.
P.O. Box 7300
El Dorado, AR 71730-7300

AGENT FOR SERVICE OF LEGAL PROCESS
Murphy USA, Inc. – Employee Benefits Committee
P.O. Box 7300
El Dorado, AR 71730-7300

CLAIMS ADMINISTRATOR
BlueAdvantage Administrators
P.O. Box 1460
Little Rock, Arkansas 72011
888-872-2531

BlueAdvantage Administrators of Arkansas is an independent licensee of the BlueCross and Blue Shield Association. BlueAdvantage Administrators does not underwrite or assume any financial risk with respect to the claims liability of the Plan.

IN WITNESS WHEREOF, this amended and restated Plan is hereby approved and adopted by a duly authorized officer of Murphy USA, Inc. on behalf of the Plan Sponsor, to be effective as of January 1, 2019.

DocuSigned by:

By: Terry Hatten
D44A3283E28646A...

Name: Terry Hatten

Title: Senior Vice President, Human Resources

Date: 6/16/2020

AMENDMENT ONE

To the

GROUP INSURANCE PLAN
FOR
RETAIL FIELD HOURLY EMPLOYEES OF MURPHY USA INC.

BY THIS AGREEMENT, the Group Insurance Plan for Retail Field Hourly Employees of Murphy USA Inc. is hereby amended as follows, effective as of November 1, 2019.

In the CONTINUATION COVERAGE RIGHTS UNDER COBRA Section, under "What is a Qualifying Event Subsection" provision, item (2) is AMENDED to read as follows:

(2) The termination, or reduction of hours, of a covered Employee's employment.

IN WITNESS WHEREOF, this Agreement has been approved and executed on behalf of Murphy USA Inc., to be effective as of November 1, 2019.

ON BEHALF OF MURPHY USA INC.
(in its capacity as sponsor of the Plan)

By: _____
Signature

Terry Hatten
Name

Senior Vice President, Human Resources
Title

11/19/19
Date

_____
Witness Signature

_____
Name

_____
Title

_____
Date

AMENDMENT TWO
To the

GROUP INSURANCE PLAN
FOR
RETAIL FIELD HOURLY EMPLOYEES OF MURPHY USA INC.

BY THIS AGREEMENT, the Group Insurance Plan for Retail Field Hourly Employees of Murphy USA Inc. (the "Plan"), is hereby amended as follows, effective as of March 18, 2020.

After the SCHEDULE OF BENEFITS Section, the following Section is ADDED:

CORONAVIRUS PANDEMIC, TEMPORARY BENEFITS

During the coronavirus (COVID-19) pandemic, the Plan will provide temporary benefits as specified below. These benefit enhancements apply solely and exclusively during the temporary period specified herein and will not be available at the conclusion of the federally-declared public health emergency period. All other terms, conditions, exclusions or limitations in the Plan Document continue to apply and must be satisfied in order for any benefits to be paid.

Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act

Effective March 18, 2020, in accordance with the FFCRA and CARES Act, the Plan shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during the federally-declared public health emergency period. Benefits are available for services rendered by an In-Network or Out-of-Network Provider.

(1) Diagnostic testing products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 and the administration of such diagnostic test that:

- **(a)** Is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act;
- **(b)** The developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until the emergency use authorization request has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;
- **(c)** Is developed in and authorized by a State that has notified the Secretary of Health and Human Services (the "Secretary") of its intention to review tests intended to diagnose COVID-19; or
- **(d)** Another test that the Secretary determines appropriate in guidance.

(2) Items and services furnished to an individual during health care provider office visits (including in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of a diagnostic test, or an evaluation to determine if a diagnostic test is necessary.

In the event that any new federal laws or regulations are enacted, the Plan will comply with any applicable law or regulation as determined by the Plan Administrator.

Additional benefits

In addition to the services mandated by the FFCRA and CARES Act, the Plan will also provide the following additional benefits in an effort to help mitigate the spread of the coronavirus. Coverage will begin on the date cited below and will continue for the duration of the federally-declared public health emergency period.

(1) Effective March 20, 2020, waiver of prescription drug refill limitations that would apply for 30-day prescription maintenance medications for the treatment of COVID-19.

(2) Effective March 27, 2020, MDLIVE telemedicine consultations are subject to a $10 copay, per consultation; deductible and coinsurance are waived.

(3) Effective March 27, 2020 telehealth services, for treatment of eligible diagnoses, including phone-based consultations and audio-visual telemedicine visits rendered by an In-Network Provider are subject to a $10 copay, per consultation; deductible and coinsurance are waived.

IN WITNESS WHEREOF, this Amendment has been approved, ratified and adopted by and on behalf of Murphy USA Inc., by its duly authorized officer, to be effective as of March 18, 2020.

Murphy USA Inc.	Witness:
By: DocuSigned by: Terry Hatten D44A3283E28646A...	By: _____
Name: Terry Hatten	Name: _____
Title: Senior Vice President, HR	Title: _____
Date: 5/19/2020	Date: _____