PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

GROUP INSURANCE PLAN FOR STORE MANAGERS OF MURPHY USA INC.

(As Amended and Restated Effective as of 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 Store Managers 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.

The Plan believes that it is a "grandfathered" health plan under the Patient Protection and Affordable Care Act ("the Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost-sharing. However, grandfathered health plans must comply with certain other consumer protections under the Affordable Care Act, such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. Individuals may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. Individuals may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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 Store Managers, as so designated in the personnel records of the Covered Employer, who work on a regularly scheduled basis of at least 30 hours per week.

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

Eligibility Requirements for Employee Coverage.

A person is eligible for Employee coverage upon fulfillment of the following:

(1) Is a Full-Time, Active, Store Manager Employee. An Employee 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.

An Employee'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.).

(2) Is in a class eligible for coverage.

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 or dental 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 or dental 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.

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.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins the following January 1.

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. An Employee will be covered under this Plan as of the first day that 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 Periods of Employer-Certified Temporary Layoff, Disability Leave, Disability Termination, Leave of Absence or Reduction in Force. A person may remain eligible for a limited time if Active, Full-Time work ceases due to layoff, disability, leave of absence, or reduction in work force. This continuance will end as follows:

For Disability Leave only: if an Employee is disabled and is absent because of an Illness or Accident, coverage by the Plan may be continued until termination of employment or the end of the one-year period that next follows the date the person last worked as an Active Employee, whichever is earlier.

For Total Disability Termination only: if a covered Employee's employment is terminated due to Total Disability, coverage may be continued under COBRA Continuation, pursuant to procedures adopted by the Plan Administrator and applied on a basis uniformly applicable to all Employees similarly situated.

Important: Where coverage is continued under these provisions, it shall not be in addition to the continuation period required under the Family and Medical Leave Act, but shall run concurrently with FMLA leave.

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 Terminated Employee. A terminated Employee who is rehired will be effective on the date of 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 Dependent coverage is terminated under the Plan.

(3) 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.

(4) 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.

(5) 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, Employees 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.

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/retail 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 70% of In-Network Covered Charges and 50% of Out-of-Network Covered Charges until the following amounts of out-of-pocket payments (including the Calendar Year deductible) are reached, during the Calendar Year, 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 Limit
Per person $4,000
Per Family Unit $12,000

Out-of-Network Out-of-Pocket Limit
Per person $6,500
Per Family Unit $19,500

Out-of-Pocket Accumulation.
In-Network and Out-of-Network Out-of-Pocket Covered Charges are commingled and will accumulate toward both the In-Network and Out-of-Network Out-of-Pocket Limits. 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 Out-of-Pocket Limit:
- Precertification penalties
- Charges in excess of the Allowable Charge
- Charges for services or supplies (including Prescription Drugs) that this Plan does not cover
- 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 $450
Per Family Unit $1,350

Out-of-Network Calendar Year Deductible
Per person $650
Per Family Unit $1,950

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 individual 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 and Out-of-Area Preventive/Routine Well Care

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.

Home Health Care ..... 365 days

Diabetes Self-Management Training ..... one session

Infertility Treatment $10,000
Artificial insemination ..... six cycles*
In-Vitro Fertilization … ..... four completed oocyte retrievals or two live births*
* See the MEDICAL BENEFITS Section for certain exceptions to the maximum number of cycles permitted.
Artificial insemination and in-vitro fertilization coverage is subject to the general $10,000 limit for Infertility treatment, *in addition to* the specific maximums listed above.

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.

Residential Treatment Facility ..... 60 days

Skilled Nursing Facility ..... 60 days

Spinal Manipulation and Chiropractic Services ..... 30 visits

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	Out-of-Area	See Note
Calendar Year deductible Per Individual	$425	$550	$425	
Calendar Year Out-of-Pocket Limit (including deductible) per Individual	$3,500	$6,000	$3,500	
Allergy Testing/Treatment	70% after deductible	50% after deductible	70% after deductible	
Ambulance Service	70% after deductible	50% after deductible	70% after deductible	
Angiogram	70% after deductible	50% after deductible	70% after deductible	
Attention Deficit Disorder	70% after deductible	50% after deductible	70% after deductible	
Bereavement Counseling	70% after deductible	50% after deductible	70% after deductible	
CAT Scan	70% after deductible	50% after deductible	70% after deductible	
Chemotherapy and Radiation Therapy	70% after deductible	50% after deductible	70% after deductible	
Diabetes Self-Management Training	70% after deductible	50% after deductible	70% after deductible	1
Durable Medical Equipment	70% after deductible	50% after deductible	70% after deductible	
Emergency Room Services, Medical Emergency	70% after deductible	70% after deductible	70% after deductible	
Emergency Room Services, non-Medical Emergency	70% after deductible	50% after deductible	70% after deductible	
Growth Hormones	Not Covered	Not Covered	Not Covered	
Hearing Aids	70% after deductible	50% after deductible	70% after deductible	2
Home Health Care	70% after deductible	50% after deductible	70% after deductible	3
Hospice Care	70% after deductible	50% after deductible	70% after deductible	
Hospital Room and Board	70% after deductible	50% after deductible	70% after deductible	4
Hospital Expenses, Other	70% after deductible	50% after deductible	70% after deductible	
Infertility Treatment	70% after deductible	50% after deductible	70% after deductible	5
Inpatient Surgery	70% after deductible	50% after deductible	70% after deductible	
Intensive Care Unit (ICU), CCU, Burn Unit or Immediate Care Unit	70% after deductible	50% after deductible	70% after deductible	6

Jaw Joint/TMJ (Temporomandibular Joint Syndrome) Disorder	70% after deductible	50% after deductible	70% after deductible	7
Mental Illness Treatment	70% after deductible	50% after deductible	70% after deductible	
MRI	70% after deductible	50% after deductible	70% after deductible	
Occupational Therapy	70% after deductible	50% after deductible	70% after deductible	
Organ Transplants	70% after deductible	50% after deductible	70% after deductible	8
Outpatient Surgery	70% after deductible	50% after deductible	70% after deductible	9
Physical Therapy	70% after deductible	50% after deductible	70% after deductible	
Physician Services – Any setting	70% after deductible	50% after deductible	70% after deductible	
Preadmission Testing	70% after deductible	50% after deductible	70% after deductible	
Pregnancy Benefits	70% after deductible	50% after deductible	70% after deductible	10
Preventive/Routine Well Care	100%, no deductible	50% after deductible	100%, no deductible	11
Private Duty Nursing (outpatient only)	70% after deductible	50% after deductible	70% after deductible	
Prosthetics/Medically Necessary Orthotics	70% after deductible	50% after deductible	70% after deductible	
Residential Treatment Facility	70% after deductible	50% after deductible	70% after deductible	12
Routine Newborn Nursery/Physician Care (Inpatient)	70% after deductible	50% after deductible	70% after deductible	
Second/Third Surgical Opinion	70% after deductible	50% after deductible	70% after deductible	
Skilled Nursing Facility/Extended Care	70% after deductible	50% after deductible	70% after deductible	13
Smoking Cessation	70%, no deductible	50%, no deductible	70%, no deductible	14
Speech Therapy	70% after deductible	50% after deductible	70% after deductible	
Spinal Manipulation Services	70% after deductible	50% after deductible	70% after deductible	15
Substance Abuse Treatment	70% after deductible	50% after deductible	70% after deductible	
Telehealth Services by MDLIVE	MDLIVE Providers only: $10 copay, then 100%, deductible waived	Providers not contracted with MDLIVE: Not covered	MDLIVE Providers only: $10 copay, then 100%, deductible waived	16
Urgent Care Services	70%, after deductible	50%, after deductible	70%, after deductible	
Vision Therapy	70% after deductible	50% after deductible	70% after deductible	

Footnotes for Benefits

1 **Diabetes self-management training.** Limited to one training session per Lifetime.

2 **Hearing Aids.** Benefit limit is one per ear every three years.

3 **Home health care.** Lifetime Maximum is 365 days.

4 **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.

5 **Infertility treatment.** Coverage is provided for Allowable Charges for Infertility treatment, including evaluations, diagnostic testing, and procedures performed for the purpose of achieving Pregnancy when a diagnosis of Infertility is established. Prior approval from the Claims Administrator, acting on the Plan's behalf, is required for all Infertility treatment.

Coverage of Infertility treatment is limited to $10,000 per Lifetime. The following limits are in addition to this general $10,000 maximum for Infertility treatment.

- Coverage for artificial insemination is generally provided for no more than six cycles; however, if Pregnancy does not occur in the first six cycles, a Covered Person may request prior approval from the Plan for an additional six cycles, which the Claims Administrator may grant or deny in its discretion.

- Covered Charges for in-vitro fertilization is further limited to four completed oocyte retrievals per Lifetime of the Covered Person or two live births from separate pregnancies. After a first live birth is achieved as a result of a successful in-vitro fertilization cycle, up to two additional complete oocyte retrievals may be covered.

6 **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.

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

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

9 **Outpatient Surgery.** Covered expenses include one night's lodging at a motel or Hospital guest house, limited to a maximum benefit of $50 for the patient, following Outpatient Surgery that is not available at a local facility and the attending Physician certifies that an overnight stay is advisable.

10 **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.

11 **Preventive/routine well care.** This Plan will follow the Patient Protection and Affordable Care Act in the provision of Preventive/Routine Well Care. 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 preventive care services can be accessed at: www.HealthCare.gov/center/regulations/prevention.html. and www.cdc.gov/vaccines.

In addition to the preventive services provision defined by the ACA, the Plan also provides more generous coverage for the following preventive services:

- Routine colonoscopies with related anesthesia and lab work are limited to one per Calendar Year, beginning at age 50.

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

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

14 Smoking cessation. Covers Physician directed services related to smoking cessation, including Prescription Drugs prescribed by a Physician. The Calendar Year deductible is waived.

15 Spinal Manipulation and Chiropractic Services. Limited to 30 visits per Calendar Year.

16 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 Co-payment	Mail Order Co-payment
Generic drugs	20% coinsurance with $20 minimum/ $60 maximum	$40
Preferred Brand Name drugs	25% coinsurance with $40 minimum/ $120 maximum	$80
Non-preferred Brand Name drugs	40% coinsurance with $50 minimum/ $150 maximum	$105
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 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, which the Plan Administrator has adopted for purposes of defining the benefits under this Plan, the Allowable Charge (as defined herein), 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 who the Physician 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. Charges will be payable if and when:
the confinement immediately follows a Hospital confinement of at least five consecutive days;
the attending Physician certifies that the confinement is Medically Necessary. Only the charges incurred in connection with care related to the Injury or Illness for which the Covered Person was confined will be eligible.

(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) **Private Duty Nursing Care.** The outpatient private duty nursing care by a licensed Nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to the extent that care is Medically Necessary or not Custodial in nature.

(7) **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 by a licensed Home Health Care Agency. Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits. A Home Health Care visit will be considered a periodic visit by a member of a Home Health Care Agency or eight hours of home health aide services.

(8) **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 services by a licensed Provider for the patient's immediate family (covered Spouse and/or covered Dependent Children) when rendered by a Hospice Care team.

(9) **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. **Vision therapy** (Non-surgical treatment to the eye muscles) is also covered.

(10) **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.

(11) **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.

(12) **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 care 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.

(13) **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)** 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 onsite 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** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(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.

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(i) **Diabetes Self-Management Training.** Includes diabetic management services provided for the nutritional, educational and psychosocial treatment of the diabetic patient. Such management includes the initial and follow-up instruction concerning:

(i) The physical cause and process of diabetes;

(ii) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;

(iii) Prevention and treatment of special health problems for the diabetic patient;

(iv) Adjustment to lifestyle modifications; and

(v) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

(j) 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.

(k) **Eye exams** are covered when ordered by a Physician during treatment of a medical condition or Injury.

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

(m) **Hypnotherapy** when performed in lieu of anesthesia.

(n) **Infertility Testing, Artificial Insemination and In-vitro Fertilization.** Subject to prior approval from the Claims Administrator, coverage is provided for Allowable Charges for the following services.

(i) **Infertility Diagnostic Testing.** Coverage is provided for certain diagnostic testing, as set out in the Coverage Policy, to establish or confirm a diagnosis of Infertility in a Covered Person after the time period required in the Coverage Policy for unsuccessful attempts to become pregnant.

(ii) **Artificial Insemination.** Coverage is provided for artificial insemination when (1) the Covered Person has a diagnosis of Infertility, as defined, or (2) the Covered Person has unexplained Infertility after at least one year of regular unprotected vaginal sexual intercourse.
Coverage for artificial insemination is generally provided for no more than six cycles; however, if Pregnancy does not occur in the first six cycles, a Covered Person may request prior approval from the Plan for an additional six cycles, which the Claims Administrator may grant or deny in its discretion.

(iii) **In-vitro Fertilization.** Coverage is provided for in-vitro fertilization, as set out in the Coverage Policy, when (1) a Covered Person has a diagnosis of Infertility listed in the Coverage Policy, or (2) the Covered Person has a history of unexplained Infertility of at least two years duration. The in-vitro fertilization procedure must be performed by a Provider acting within the scope of such Provider's license in order to be eligible for benefits. The in-vitro fertilization benefit is limited to four completed oocyte retrievals per Lifetime of the Covered Person or two live births from separate pregnancies as a result of the in-vitro fertilization procedures. After a first live birth is achieved as a result of a successful in-vitro fertilization cycle, up to two additional complete oocyte retrievals may be covered. All viable embryos, fresh or frozen, must be used before undergoing additional oocyte retrieval. Coverage for oocyte retrieval from an oocyte donor will be covered to the same extent as if the donor were the Covered Person.

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

(p) **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.

(q) 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.

(r) **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.

(s) 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.

(t) **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 Employees and their Covered Dependents who are working or assigned outside of the United States, Medically Necessary Prescription Drug coverage is available under Medical Benefits, reimbursed at 70%, after deductible. Covered Charges do not contribute to the out-of-pocket limit nor will they ever be paid at 100%.

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 70%, after deductible. Covered Charges do not contribute to the out-of-pocket limit nor will they ever be paid at 100%.

(u) **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 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.

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

(w) **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.

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.

(x) **Sales tax** on Prescription Drugs or any other covered item.

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

(z) **Smoking cessation** services directed by a Physician, including Prescription Drugs.

(aa) **Spinal Manipulation/Chiropractic services** by a licensed Provider. Covered Charges are limited as shown in the Schedule of Benefits for services billed by a chiropractor.

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

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

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

(ee) 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 newborn child.

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.

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

(gg) 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 the Provider is In-Network	Party Responsible for Notification if the 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 any 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. 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, the 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 BlueAdvantage 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 a 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 Employee. An Employee 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.

An Employee'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.

Infertility means (a) a Covered Person is unable to conceive after at least one year of regular unprotected vaginal sexual intercourse, when the Covered Person is less than 36 years of age, or at least six months of regular unprotected vaginal sexual intercourse when the Covered Person is 36 years of age or older; or (b) a Covered Person has a medically documented inability to conceive due to at least one of the following:

(1) Stage 4, surgically treated endometriosis;

(2) Exposure in utero to Diethylstilbestrol, commonly known as DES;

(3) Blockage or removal of one or both fallopian tubes, not as a result of voluntary sterilization;

(4) Untreatable abnormal male factors contributing to infertility, not as a result of voluntary sterilization;

(5) Cervical factor infertility;

(6) Vaginismus preventing intercourse;

(7) Anovulatory females who have failed to conceive after a six-month trial of ovulation induction with timed intercourse under the supervision and monitoring of a physician; or

(8) Absence or abnormality of uterus that precludes conception with evidence of intact ovarian function.

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 Store Managers 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 on 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

Note: All exclusions related to Dental are shown in the Dental Plan.

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. Charges for abortions performed by pharmaceutical methods are not covered. This Plan does cover treatment of complications that arise after an abortion for a covered Employee or Spouse, 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) **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.

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

(13) **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.

(14) **Cosmetic services.** Cosmetic Surgery, care and treatment provided for cosmetic reasons or complications thereof. This exclusion will not apply if the care and treatment is incurred within twelve months following and as a result of an accidental Injury, for correction of a congenital anomaly or for certain reconstructive and related services following a mastectomy.

(15) **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.

(16) **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.

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

(18) **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.

(19) **Diabetic Supplies.** Charges for diabetic supplies and equipment are covered under the Pharmacy Drug program.

(20) **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.

(21) **Dietitian** services are not covered unless related to Diabetes Self-Management Training.

(22) **Education, training**, bed and board while confined to an institution that is primarily a school or other institution for training, or instruction in alternate life patterns.

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

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

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

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

(27) **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.

(28) **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). Corrective shoes or other orthotic devices or appliances are excluded, except those attached to a brace or prescribed for a diabetic patient.

(29) **Genetic Testing.** Charges for genetic testing, including testing of the products of an amniocentesis to determine the presence of a disease or congenital anomaly in the fetus, or genetic testing of a covered person's tissue to determine if the person has a specific disease.

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

(31) **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 to applied behavioral analysis therapy for treatment of autism.

(32) **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.

(33) **Hearing tests.** Charges for routine hearing tests.

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

(35) **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.

(36) **Hypnotherapy.** Hypnotherapy is not covered for any diagnosis or medical condition, unless it is part of a smoking cessation plan.

(37) **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.

(38) **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.

(39) **Impacted teeth.** Charges related to surgical extraction of impacted teeth unless services are performed in a Hospital Setting.

(40) **Infertility treatment.** Benefits for Infertility diagnostic testing, artificial insemination and in-vitro fertilization are not available if:

(a) the Covered Person has previously had a voluntary sterilization; or

(b) the Infertility is related to natural age-related hormone reduction (i.e. postmenopausal or 45 years of age or older); or

(c) a surrogate is used; or

(d) the Covered Person has previously had three live births by any means.

No benefits are available for post-coital testing of cervical mucus, screening for anti-sperm antibodies, hamster testing, sperm penetration assay, assisted hatching, co-culture of embryos, cryopreservation of ovarian tissue or oocytes, cryopreservation of testicular tissues in prepubertal boys, or for storage or thawing of ovarian tissue, oocytes or testicular tissue.

Infertility treatment benefits are restricted to Covered Employees and the Covered Spouses. There are no Infertility treatment benefits available for a Covered Employee's dependent children.

Coverage is provided in accordance with established Coverage Policies which are available upon request from the Claims Administrator, with the exception that coverage is NOT dependent on the Covered Person's marital status. The Covered Person may call the number on the back of their health insurance identification card for more information.

(41) **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.

(42) **Mouth conditions** due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure or the alveolar process are excluded unless the charges are for the following: (a) treatment or removal of malignant or benign tumors; (b) treatment of an accidental Injury to sound natural teeth or for the setting of a jaw fracture or dislocation. This treatment must be rendered within twelve (12) months from the date of the Accident; or (c) Hospital services, supplies and anesthesia for oral Surgical Procedures for which a doctor (M.D., D.O. or D.D.S.) certifies in advance that hospitalization is Medically Necessary.

(43) **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.

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

(45) **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.

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

(47) **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.

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

(49) **Nuclear Waste/Radiation.** Any loss that is due to, directly or indirectly caused by or contributed to or arising from ionizing, radiation, pollution or contamination by radioactivity from any nuclear waste or

from the combustion of nuclear fuel, the radioactive toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

(50) **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 Plan.

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

(52) **Oral statements.** Charges which are incurred based upon **oral statements** made by anyone involved in the administration of the Plan which are in conflict with the benefits described in this document.

(53) **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.

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

(55) **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.

(56) **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:

For Covered Employees and their Covered Dependents who are working or assigned outside of the United States, Medically Necessary Prescription Drug coverage is available under Medical Benefits, reimbursed at 70%, after deductible. Covered Charges do not contribute to the out-of-pocket limit nor will they ever be paid at 100%.

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 70%, after deductible. Covered Charges do not contribute to the out-of-pocket limit nor will they ever be paid at 100%.

(57) **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.

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

(59) **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.

(60) **Replacement Durable Medical Equipment, prosthetic or orthotic appliances.** Replacement of Durable Medical Equipment, prosthetic or orthotic appliances due to loss or misuse**.** Replacement of Durable Medical Equipment within five years unless Medically Necessary. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person’s physical condition to make the original device no longer functional.

(61) **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.

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

(63) **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.

(64) **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.

(65) **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.

(66) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

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

(68) **Surrogate mother.** Expenses incurred by a surrogate mother.

(69) **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.

(70) **Undefined Provider.** Services or supplies provided by an individual or entity that is not a Provider as defined in this Plan Document are not covered.

(71) **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.

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

(73) Vitamins, minerals, nutritional food supplements (unless it is the sole source of nutrition due to medical necessity), or any over-the-counter items, including, but not limited to, **nicotine gum or patches**, whether or not prescribed by a Physician.

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

(75) **Weekend pass.** Charges for room and board in a facility for days on which the covered person is permitted to leave (a weekend pass, for example).

(76) **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.

(77) **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 co-payment amount shown in the Schedule of Benefits. While each dispensing of a mail order prescription is limited to a 90-day supply, the co-payment 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 for reference numbers.

HOW TO SUBMIT A CLAIM

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

Claim for Benefits. "Claim for benefits" means (1) a request for payment for a service, supply, Prescription Drug, equipment or treatment covered by the Plan or (2) a request for prior approval for a service, supply, Prescription Drug, equipment or treatment covered by the Plan where the Plan conditions receipt of payment for such service, supply, Prescription Drug, equipment or treatment on approval in advance by the Claims Administrator.

Who Can Submit a Claim. A Covered Person, a Provider with an assignment of the claim that is approved by the Claims Administrator or a Covered Person's Authorized Representative may submit a claim. See section concerning the Authorized Representative.

The presentation of a prescription to a pharmacist in accordance with the terms of the Prescription Drug card program administered by the pharmacy benefits manager. However, a Covered Person may submit a claim if, upon such a presentation, the pharmacist informs the Covered Person that, because of the provisions of the Plan, the Plan will not provide benefits for the requested prescription medication.

Classifications of Claims. There are four general types of claims for benefits possible under the Plan. The type of claim involved affects the procedures for filing the claim and the timing of the benefit determination by the Claims Administrator.

(1) **Post-Service Claims.** The most common claim involves post-service benefit determination. Such a claim results when a Covered Person obtains a medical service, Prescription Drug, supply, equipment or other treatment and then, in accordance with the terms of the Plan, the Covered Person or the Covered Person's Authorized Representative submits a claim for benefits to the Claims Administrator. Examples of post-service claims are claims involving Physician office visits, maternity care, Inpatient and Outpatient Services.

The Covered Person, their Provider or Authorized Representative must submit written proof of any service, supply, Prescription Drug, equipment or other treatment within 15 months following the date on which such service, supply, Prescription Drug, equipment or treatment was received. In the case of a claim for Inpatient services for multiple consecutive days, the written proof must be submitted no later than 15 months following the date of discharge for that single admission.

Post-Service Claims may be submitted electronically in accordance with the Claims Administrator's electronic claim filing procedures, or such claims may be mailed to BlueAdvantage Administrators of Arkansas, Post Office Box 1460, Little Rock, Arkansas 72203.

If the Claims Administrator is able to process the post-service claim without requesting additional information, it will notify the Covered Person of its claim determination within 30 days of the Claims Administrator’s receipt of the claim.

If the Claims Administrator requires information reasonably necessary to determine whether or to what extent benefits are covered under the Plan, the Claims Administrator will suspend the claim and request the needed information. A Covered Person or their treating Provider should supply the Claims Administrator with the required information within a reasonable timeframe of the claim suspension. The timeframe will be determined by the Claims Administrator based on Plan timely filing limitations and plan year requirements. Contracted Providers must abide by stipulations within their Provider contract in providing requested information. The Provider will be obligated to write-off their charges if he or she fails to provide the information accordingly.

(2) **Pre-Service Claims.** A pre-service claim results if the terms of the Plan condition receipt of benefits on the Claims Administrator or Plan Administrator giving approval in advance of the Covered Person obtaining a requested medical service, drug, supply, or equipment that such medical service, drug, supply or equipment is Medically Necessary and not Experimental or Investigational. Examples of some

Plan benefits requiring pre-service claims are typically claims involving organ transplants and certain high cost injectable medications. Please note that prior approval does not guarantee payment or assure coverage; it means only that the information furnished to the Claims Administrator at the time indicates that the requested service, supply, Prescription Drug, equipment or treatment is Medically Necessary and not Experimental or Investigational. A pre-service claim receiving prior approval as a pre-service claim must still meet all other coverage terms, conditions and limitations including precertification requirements. Coverage for any such pre-service claim receiving prior approval may still be limited or denied if, when, after the requested service, supply, Prescription Drug, equipment or treatment is completed and the Claims Administrator receives post-service claim(s), 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 Employee contribution, that Out-of-Network limitations apply, or any other basis specified in the Plan applies to limit or exclude the claim.

Pre-Service Claims should be submitted to the BlueAdvantage Administrators of Arkansas Medical Audit and Review Services, FAX (501) 378-6647 or mailed to Post Office Box 3688, Little Rock, Arkansas 72203.

If the Claims Administrator is able to process the pre-service claim without requesting additional information, it will notify the Covered Person of its determination in a time appropriate for the medical exigencies, but in no case later than 15 days from the date it received the pre-service claim.

If the Claims Administrator requires information reasonably necessary to determine whether the requested medical service, drug, supply, or equipment is Medically Necessary and not Experimental or Investigational, the Claims Administrator will suspend the claim and request the needed information. If the Covered Person or their treating Provider supplies the Claims Administrator the required information within 90 days of the claim suspension, the Claims Administrator will notify the Covered Person of its claim determination within 15 days after the Claims Administrator receives such information. If the Claims Administrator does not receive the required information within the 90-day period, the suspended claim will become a denied claim, subject to appeal. See Claim Review Procedure Subsection that follows.

After a Covered Person has received the health intervention that was the subject of an approved pre-service claim, he or she must submit a post-service claim in accordance with Subsection 1, above.

(3) **Claims Involving Urgent Care.** A claim involving urgent care is a pre-service claim (See Subsection 2 above) for which a health care professional with knowledge of the claimant's condition certifies that the processing of the claim in the time period for making a non-urgent claim determination (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to maintain or regain maximum function, or (2) would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A claim involving urgent care must be submitted in writing via mail, facsimile, or e-mail in a format authorized by the Claims Administrator. **A claim involving urgent care must include the medical records pertinent to the urgent condition.**

If the Claims Administrator is able to process the claim involving urgent care without requesting additional information, it will notify the Covered Person of its determination in a time appropriate for the medical exigencies, but in no case later than 72 hours from the date it received the pre-service claim.

If the Claims Administrator requires information reasonably necessary to determine whether the requested medical service, drug, supply, or equipment is Medically Necessary and not Experimental or Investigational, the Claims Administrator will notify the Physician within 24 hours of receiving the claim and request the needed information. If the Covered Person, or their treating Provider supplies the Claims Administrator the required information within 48 hours, the Claims Administrator will notify the Covered Person of its claim determination within 48 hours after the Claims Administrator receives such

information. If the Claims Administrator does not receive the required information within the 48-hour period, the claim will be denied, subject to appeal. See Claim Review Procedure Subsection that follows.

If the urgent care claim is a request to extend previously approved benefits for ongoing treatment the Claims Administrator shall make a determination within 24 hours after receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the previously approved benefit.

Please note that approval of a claim involving urgent care does not guarantee payment or assure coverage; it means only that the information furnished to the Claims Administrator at the time indicates that requested service, supply, Prescription Drug, equipment or treatment is Medically Necessary and not Experimental or Investigational. A requested service, supply, Prescription Drug, equipment or treatment receiving prior approval as a claim involving urgent care, must still meet all other coverage terms, conditions, and limitations. Coverage for any such claim may still be limited or denied if, when the claimed Intervention is completed and the Claims Administrator receives the post-service claim(s), 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 any other basis specified in the Plan applies to limit or exclude the claim.

After receiving the Health Intervention that was the subject of a claim involving urgent care, the Covered Person, their Provider or Authorized Representative must submit a post-service claim in accordance with Subsection 1, above.

(4) **Claims involving Ongoing Care or Concurrent Review.** The Claims Administrator's termination or reduction of a previously granted benefit under the Plan (other than by Plan amendment or termination) results in a claim involving ongoing care or concurrent review. The Claims Administrator shall give an explanation of the reduction or termination of a benefit to the Covered Person (See Explanation of Benefit Determination Subsection that follows.) with sufficient time prior to the termination or reduction to allow for an appeal (See Claim Review Procedure Subsection that follows.) to be completed before the termination or reduction takes place.

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/retail 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 participating 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/retail 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 BENEFIT DETERMINATION

Upon making a determination of a claim, the Claims Administrator will deliver to the Covered Person an Explanation of Benefit Determination containing the following information:

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

(2) Reference to the specific plan provision(s) on which the determination is based;

(3) A description of any additional information necessary for the claim to be perfected and an explanation of why such information is necessary;

(4) A description of the Plan's appeal process, see the Claims Review Procedure Section below. If the claim involves urgent care, a description of the expedited appeals process, see the Expedited Appeal Procedure Subsection below;

(5) If the determination was based in whole or in part on a Claims Administrator Coverage Policy an explanation of how to obtain a copy of the Coverage Policy at no cost; and

(6) A statement of the right to bring a legal action under section 502(a) of the Employee Retirement Income Security Act of 1974.

CLAIMS REVIEW PROCEDURE

The Plan Participant will receive an Explanation of Benefits (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. The Plan Participant also has the right to initiate legal action subsequent to 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. You should provide your name, Plan identification number and reference the specific claim(s) you want to have 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.

The Covered Person and the treating health care professional are required to provide the Claims Administrator, upon request, access to information necessary to make a determination. Such information should be provided not later than five days after the date on which the request for information is received, or, in the case of a claim involving urgent care or concurrent review, at such earlier time as may be necessary to comply with the applicable timelines. Failure to provide access to such information shall not remove the obligation of the Claims Administrator to make a determination, but the determination may be affected if such requested information is not provided.

A determination shall be rendered within 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 receipt.

If the review is in regard to an Urgent Care Pre-Service Claim, response will be provided within 72 hours of receipt.

(2) Appeal.
The Covered Person must submit the appeal to the Plan Administrator in writing and include their name, Plan identification number and reference the specific claim(s) they want to have reviewed. Appeals must be submitted within 180 days after notice is received of the denial or reduction in benefits. However, an appeal related to a claim involving urgent care may be made orally. The Covered Person may submit with their request for review any additional written comments, issues, documents, records and other

information relating to the claim Although the Plan Administrator will immediately commence consideration of an oral appeal, the Plan Administrator requires written confirmation of the appeal.

The Covered Person and the treating health care professional are required to provide the Claims Administrator or the Plan Administrator, upon request, access to information necessary to make a determination. Such information should be provided not later than five days after the date on which the request for information is received, or, in the case of a claim involving urgent care or concurrent review, at such earlier time as may be necessary to comply with the applicable timelines. Failure to provide access to such information shall not remove the obligation of the Plan Administrator to make a determination, but the determination may be affected if such requested information is not provided.

The appeal will be reviewed by the Plan Administrator utilizing personnel with appropriate expertise who is neither the individual who denied the claim that is the subject of the appeal, nor the subordinate of such individual. The Plan Administrator shall conduct a complete review of all information relating to the claim and shall not afford deference to the initial claim determination in conducting the review.

When reviewing a claim in which the determination was based in whole or in part on medical judgment, including determinations with regard to whether a particular treatment is Experimental, Investigational, or not Medically Necessary or appropriate, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual that was consulted in the initial claim determination, nor the subordinate of such individual. The Plan Administrator shall, upon request, provide the identity of the health care professional(s) consulted in conducting the review, without regard to whether the health care professional's advice was relied upon in making the benefit determination.

A determination shall be rendered within 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 receipt.

If the review is in regard to an Urgent Care Pre-Service Claim, the Covered Person or Authorized Representative request an expedited review and a health care professional certifies that determination as a general pre-service claim would seriously jeopardize the Covered Person's life or health or ability to regain maximum function, response will be provided within 72 hours of receipt.

If the review is in regard to a Concurrent Care Claim, response will be provided within the timeframes as noted above, depending upon whether the claim is a post-service claim, a pre-service claim or a claim involving urgent care.

The Plan Administrator shall provide notice in a printed form and written in a manner calculated to be understood by the claimant. The notice shall include:

(a) The specific reason or reasons for the review determination.

(b) Reference to the specific plan provision(s) on which the review determination is based.

(c) 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 claimant's claim for benefits.

Relevant information includes:

(i) Information relied upon in making the benefit determination.

(ii) Information submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination.

(iii) Information that demonstrates compliance with the terms of the Plan.

(iv) Information that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(d) A statement that any internal rule, guideline, protocol or other similar criterion relied upon by the Plan is available upon request and free of charge.

(e) A statement of the right to bring a legal action under Section 502(a) of the Employee Retirement Income Security Act of 1974.

Expedited Appeal Procedure. An appeal of a claim involving urgent care or of a claim involving ongoing care is conducted in accordance with this Plan provision. An expedited appeal may be submitted by telephone, followed by a written confirmation. The Plan Administrator will notify you and your treating health care professional of the determination of your expedited appeal within 72 hours after the Plan Administrator receives the expedited appeal.

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 unfavorable claim 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 "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 your "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 thirty (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 Charges.

Benefit plan. This provision will coordinate the medical and dental 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 or dental coverage, there is a special requirement for working Spouses of Employees. If an Employee's spouse works and has medical or dental 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 or dental 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 or dental charges covered by the Plan.

"Refund" means repayment to the Plan for medical or dental 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 or dental 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 Store Managers 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 group health coverage is lost. For example, an individual may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, he or she may qualify for lower costs on their monthly premiums and lower out-of-pocket costs. Additionally, an individual may qualify for a 30-day special enrollment period for another group health plan for which he or she is 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).

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.

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. An individual may check to see if their 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.

- 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.

- 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/.

- 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 not 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 ***in writing***. Oral notice, including notice by telephone, is not acceptable. The 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 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 Store Managers 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 participate 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 and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by 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 Plan (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 Store Managers of Murphy USA Inc.

PLAN NUMBER: 518

TAX ID NUMBER: 46-2279221

PLAN EFFECTIVE DATE: This Plan, originally effective April 1, 2007, 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 Oil 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.

By: DocuSigned 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 STORE MANAGERS OF MURPHY USA INC.

BY THIS AGREEMENT, the Group Insurance Plan for Store Managers of Murphy USA Inc. (the "Plan"), is hereby amended as follows, effective as of January 1, 2020.

In the SCHEDULE OF MEDICAL BENEFITS Section, the Calendar Year Deductibles Subsection, is AMENDED to read as follows:

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.....$750
Per Family Unit.....$2,250

Out-of-Network Calendar Year Deductible
Per person.....$950
Per Family Unit.....$2,850

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 "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 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 and Out-of-Area Standard Preventive Care
- In-Network and Out-of-Area Primary Care Physician and Specialist office visits
- In-Network and Out-of-Area Urgent Care services
- Services rendered by MDLIVE
- Prescription Drug Program

In the SCHEDULE OF MEDICAL BENEFITS Section, the provision for Mental Illness is DELETED and the following provisions are ADDED, alphabetically:

Benefit Description	In-Network Provider	Out-of-Network Provider	Out-of-Area	See Note
Inpatient Facility/Professional Services	70% after deductible	50% after deductible	70% after deductible	
Office Visit: Mental Health /Substance Abuse Services	$30 copay, per office visit, deductible waived. Other services in the office 70% after deductible	50% after deductible	$30 copay, per office visit, deductible waived. Other services in the office 7% after deductible	
Office Visit: Primary Care Physician	$30 copay, per office visit, deductible waived. Other services in the office 70% after deductible	50% after deductible	$30 copay, per office visit, deductible waived. Other services in the office 70% after deductible	**17**
Office Visit: Specialist	$50 copay, per office visit, deductible waived. Other services in the office 70% after deductible	50% after deductible	$50 copay, per office visit, deductible waived. Other services in the office 70% after deductible	
Outpatient Facility/Professional Services	70% after deductible	50% after deductible	70% after deductible	
Urgent Care Facility	$75 copay, per visit, deductible waived	50% after deductible	$75 copay, per visit, deductible waived	

In the SCHEDULE OF MEDICAL BENEFITS Section, Footnotes for Benefits Subsection, the following footnote is ADDED to read as follows:

17 **Office Visit: Primary Care Physicians.** Includes general practitioners, family practitioners, doctors of internal medicine, pediatricians, geriatricians, and obstetrician/gynecologists.

Covered Charges billed by physician assistants, registered nurse practitioners, certified nurse practitioners, and clinical nurse specialists that work under the direction of a Primary Care Physician will also be paid at the Primary Care Physician reimbursement rate.

IN WITNESS WHEREOF, this Agreement has been approved and executed on behalf of Murphy USA Inc., to be effective as of January 1, 2020.

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 STORE MANAGERS OF MURPHY USA INC.

BY THIS AGREEMENT, the Group Insurance Plan for Store Managers of Murphy USA Inc. (the "Plan"), 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 THREE
To the

GROUP INSURANCE PLAN
FOR
RETAIL STORE MANAGERS OF MURPHY USA INC.

BY THIS AGREEMENT, the Group Insurance Plan for Store Managers 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: _____