7-Eleven, Inc.

Employee Welfare Benefits

Summary Plan Description

Effective January 1, 2017

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BENEFITS ADMINISTRATOR DIRECTORY

BENEFIT PROGRAM	WHO TO CONTACT	HOURS
BLUECROSS BLUESHIELD MEDICAL PLANS	BlueCross BlueShield of Texas 1-888-588-2896 Website: www.bcbstx.com/7eleven	Monday–Friday, except holidays, from 9:00 a.m. to 7:00 p.m. ET Benefits Value Advisor: 9:00 a.m. to 9:00 p.m. ET
AETNA DENTAL	Aetna Life Insurance Company P.O. Box 14094 Lexington, KY 40512 1-877-238-6200 Website: www.aetna.com	Monday–Friday, except holidays, from 8:00 a.m. to 6:00 p.m. ET
EXPRESS SCRIPTS	1-877-782-8699 Website: www.express-scripts.com	24 hours/7 days a week
VISION	VSP 3333 Quality Drive Rancho Cordova, CA 95670 1-800-877-7195 Website: www.vsp.com	Monday–Friday, except holidays, from 8:00 a.m. to 11:00 p.m. ET Saturday from 10:00 a.m. to 11:00 p.m. ET Sunday from 10:00 a.m. to 10:00 p.m.ET
HEALTH SAVINGS ACCOUNT	BenefitWallet P.O. Box 1584 Secaucus, NJ 07094 1-877-472-4200 Website: www.mybenefitwallet.com/	Monday–Friday, 8:00 a.m. to 11:00 p.m. ET Saturday–Sunday, 9:00 a.m. to 6:00 p.m. ET
DEPENDENT CARE SPENDING ACCOUNT	PayFlex Flex Dept. P.O. Box 981158 El Paso, TX 79998-1158 1-800-284-4885 Website: www.payflex.com	Monday–Friday, except holidays, from 8:00 a.m. to 8:00 p.m. ET Saturday from 10:00 a.m. to 3:00 p.m. ET
SHORT-TERM AND LONG-TERM DISABILITY	Unum P.O. Box 9793 Portland, ME 04104-5093 1-855-502-4711 Website: www.unum.com	Monday–Friday, except holidays, from 8:00 a.m. to 8:00 p.m. ET
LIFE AND AD&D INSURANCE	Sun Life 1-800-247-6875 Website: www.sunlife.com	Monday–Friday, except holidays, from 8:00 a.m. to 8:00 p.m. ET
TRAVEL ASSISTANCE PROGRAM	Assist America 1-800-872-1414 (U.S.) 1-609-986-1234 (collect, non-U.S.)	24 hours/7 days a week
CRITICAL ILLNESS INSURANCE	Voya Financial 230 Park Avenue New York, NY 10169 1-877-236-7564 Website: www.voya.com	Monday–Friday, except holidays, from 9:00 a.m. to 6:30 p.m. ET

BENEFIT PROGRAM	WHO TO CONTACT	HOURS
GROUP LEGAL SERVICES	Hyatt Legal Plans, a MetLife company 1111 Superior Avenue E. Cleveland, OH 44114-2407 1-800-821-6400 Website: www.legalplans.com	Monday–Friday, except holidays, from 8:00 a.m. to 7:00 p.m. ET
COBRA ADMINISTRATION	PayFlex 1-800-284-4885 Website: www.payflex.com	Monday–Friday, except holidays, from 8:00 a.m. to 9:00 p.m. ET
ALL PROGRAMS	7-Eleven Benefit Service Center P.O. Box 199407 Dallas, TX 75219 1-800-601-0711 Website: www.ebenefitscenter.com/7-Eleven	Monday–Friday, except holidays, from 8:00 a.m. to 6:00 p.m. ET

INTRODUCTION

This document is a Summary Plan Description ("**Summary**") summarizing many of the employee benefit programs covering you as an employee of 7-Eleven, Inc. ("**7-Eleven**" or "**Company**"). In addition to your paycheck, 7-Eleven offers a comprehensive benefits package that includes medical, disability, and life insurance protection, plus other benefits described in this Summary.

Your benefit coverage depends on your employment status — full-time, part-time, or variable-hour. Some benefits cover you immediately after you're hired, while others have a waiting period before coverage begins. Please read this Summary carefully to understand your benefits and when you are covered.

This Summary describes 7-Eleven's benefits programs (referred to as "**Programs**" throughout this Summary). Most of these benefits are governed by plan documents and insurance contracts, which are available from the Plan Administrator upon request. If there is a conflict between the official plan document or insurance contract and this Summary, the plan document or insurance contract controls.

However, this Summary and the official plan documents will control over insurance contracts as to the eligibility criteria of the underlying Program.

If this Summary contains information that is not included in the official plan document, the material in this Summary is considered incorporated by reference into the plan document. The official names of the benefit Programs and other relevant information can be found in the "Plan Administration" section at the end of this Summary.

Terms that are capitalized in this Summary have specific definitions, which can be found either in the text or in the Glossary at the end of this Summary.

If you have questions about this Summary, the Programs, or any of the benefit options, you can call the 7-Eleven Benefit Service Center toll-free at 1-800-601-0711, or you can find information online at www.ebenefitscenter.com/7-Eleven.

If you are employed by a subsidiary or affiliated company of 7-Eleven, you may be eligible to participate in the benefits described in this Summary if your employer adopts the benefits with 7-Eleven's consent. Your employer will tell you which sections of this Summary apply to you.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY CHARTS

The benefits available to you depend on whether you are classified as a:

- Full-time employee: scheduled to work at least 30 hours per week on average.
- Part-time employee: scheduled to work fewer than 30 hours per week on average.
- Variable-hour employee: scheduled to work a variable number of hours such that 7-Eleven measures your average hours worked over a 12-month period to determine if you will be eligible for full-time or part-time benefits for the following year. All Sales Associates are variable-hour employees.

Employee classifications are re-evaluated each year prior to Open Enrollment, based on average weekly hours worked. This chart shows what's available and when based on your employment classification. The benefits are described in detail in the sections that follow in this Summary.

	When Hired (No Enrollment Required)	1st of Month	1st of Month after 90 Days of Employment§§	1st of Month after 12 Months
Full-Time Exempt Employees/ Full-Time Hourly Non-Store Employees	Basic Life Occupational AD&D (Store Employees only) BenefitHub	BlueCross BlueShield Medical Plans Health Savings Account*** Aetna Dental Plans Vision Optional Life Optional AD&D Dependent Care Spending Account* Critical Illness MetLaw Group Legal Adoption Asssistance (no enrollment required) Transit and Parking Spending Accounts§	Short-Term Disability (STD) Long-Term Disability (LTD)† Profit Sharing/ 401(k) Plan	Profit Sharing/401(k) Plan discretionary match Separation Pay†† Educational Assistance††

	When Hired (No Enrollment Required)	1st of Month	1st of Month after 90 Days of Employment§§	1st of Month after 12 Months	
Variable-Hour Employees (All Sales Associates)	Basic Life Occupational AD&D BenefitHub	Transit and Parking Spending Accounts§	Profit Sharing/401(k) Plan	**If 30+ Hours/Week** BlueCross BlueShield Medical Plans Health Savings Account*** Aetna Dental Plans Vision Optional Life Optional AD&D Dependent Care Spending Account* Short-Term Disability Adoption Assistance (no enrollment required) Critical Illness MetLaw Group Legal Profit Sharing/401(k) Plan discretionary match Separation Pay††	**If Fewer than 30 Hours/Week** Profit Sharing/ 401(k) Plan discretionary match
Part-Time Employees	Basic Life Occupational AD&D (Store Employees only) BenefitHub	Transit and Parking Spending Accounts§	Profit Sharing/401(k) Plan	Profit Sharing/401(k) Plan discretionary match Educational Assistance†††	

*Employee in pay grades 24 and higher are not eligible for the Dependent Care Spending Account.

**Salaried exempt employees only.

***Option if enrolled in the Health (1500 – HSA Option) Plan.

†Excludes Assistant Managers.

††Requires at least 32 hours per week instead of 30.

†††Requires at least 24 hours per week.

§Transit not available in all locations.

§§ The later of date of transfer to full time or 90 days of continuous employment

GENERAL ELIGIBILITY

Each benefit Program covers specific groups of employees, based on employment status. If you are eligible for a benefit, your dependents may be eligible as well. The following applies in all cases:

Employees

The benefits available to you depend on whether you are classified as a full-time, part-time, or variable-hour employee. Full-time employees are scheduled to work at least 30 hours per week on average. Part-time employees are scheduled to work fewer than 30 hours per week on average. Variable-hour employees have variable work schedules. All Sales Associates are variable-hour employees. 7-Eleven measures the average hours worked by variable-hour employees over a 12-month period ending prior to Open Enrollment to determine if they will be eligible for full-time or part-time benefits for the following calendar year. If they averaged 30 hours or more per week during the measurement period, they are eligible for full-time benefits, and if they averaged less than 30 hours per week, they are eligible for part-time benefits, for the following calendar year.

For newly hired or newly classified variable-hour employees, an initial measurement period of 12 months beginning on the date of hire or classification will determine eligibility for full-time or part-time benefits for the following 12 months.

Employees do **not** include any individual:

- Whose terms and conditions of employment are governed by a collective bargaining agreement unless the agreement provides for his or her coverage under a particular Program,
- Who is a temporary employee (A "**temporary employee**" is an individual employed for a limited period of time and classified by the Company as a temporary employee),
- Who is a nonresident alien with no United States source income, or
- Who is a leased employee within the meaning of section 414(n) of the Code or is determined by the Company to be an independent contractor (even if such leased employee or independent contractor is subsequently determined by the Internal Revenue Service, the Department of Labor, a court of competent jurisdiction, or the Company to be a common law employee of the Company).

Dependents

Generally, dependents eligible for the Programs ("**dependents**") include:

- Your legal spouse by marriage (defined as the individual lawfully married to you under a marriage which is recognized by the state, possession, or territory of the United States in which the marriage is entered into, without regard to domicile or gender),
- Your children under age 26, unless otherwise defined under the Program description or required by applicable law,
- Your children who become physically or mentally disabled before age 26 and remain disabled, regardless of their current age, and

Your "**children**" include children for whom you have legal custody, including your children by birth, your stepchildren (including children of your legally married same-gender spouse), your legally adopted children or children lawfully placed for adoption with you, foster children placed with you by an authorized agency or court, and children for whom your coverage has been court-ordered.

If you are claiming a legal spouse by common law marriage, you must supply documentation of that common law marriage acceptable to the Plan Administrator.

For benefits purposes, your spouse is defined only according to legal marriage and does not include a civil union, domestic partnership, or other relationship that the state of celebration does not denominate as marriage. The Plan Administrator may require documentary proof, acceptable to it, of spousal status. Some benefit Programs have different definitions of who qualifies as a dependent. See the sections for each Program for more information.

The definition of who qualifies as a dependent for income tax purposes may differ from the definitions provided under the Programs.

You will be required to provide proof of eligible dependent status for anyone you wish to cover as a dependent, even if he or she currently has dependent coverage. This includes coverage for spouses (same sex and opposite sex) and children. Failure to provide proof by the stated deadline will result in termination of dependent coverage for that person. If you provide proof of eligibility after the deadline, you may not re-add the dependent until the next Open Enrollment period, so long as the person is still eligible at Open Enrollment. Coverage elected at Open Enrollment begins January 1 of the following year.

Rehired Employees

If an employee is eligible for health and welfare benefits upon separation and is re-hired within four months of separation, there is no waiting period upon re-hire and the employee is eligible immediately. Health and welfare benefits will not be automatically reinstated. The employee must re-elect health and welfare benefits within the time frame provided in his or her benefits enrollment package.

ELECTING BENEFIT COVERAGE

Initial Enrollment/Open Enrollment

You will be given the opportunity to enroll in each Program at the time you first become eligible to participate in that Program. If you do not enroll in a Program when you first become eligible, you must generally wait until the next Open Enrollment period, which usually begins during the fall for coverage that will be effective the following January, to enroll in that Program.

These enrollment-timing restrictions do not apply to Basic Term Life coverage and Occupational AD&D coverage (store employees only). You are immediately eligible for and automatically enrolled in Basic Term Life coverage and Occupational AD&D coverage (store employees only) upon your hire date. Also, if you are a full-time employee or variable-hour employee determined to be eligible for full-time benefits, you do not have to enroll in the 7-Eleven, Inc. Adoption Assistance Program ("**Adoption Assistance Program**") and you can use it any time when you meet the eligibility requirements for that Program.

MID-YEAR CHANGES

Other than during the annual Open Enrollment period, you may request changes to the benefit options you have elected or declined only (i) during a special enrollment period (as described in the "Special Enrollment in the Medical Programs" section), (ii) if you experience a Qualifying Life Event and you change your coverage to be consistent with that Qualifying Life Event, or (iii) in the case of other events, such as a cost or coverage change, as described below.

Qualifying Life Events

You may make a Mid-Year Change in your benefit option elections if you have a Qualifying Life Event. **A request for a change in your benefit elections must be made within 31 days of the date of the Qualifying Life Event**.

The following events are "**Qualifying Life Events**":

- Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment
- Events that change your number of dependents, including birth, death, adoption, and placement for adoption, or that cause the loss of dependency status of your dependents, such as attainment of maximum age
- Events that change your employment status or your dependent's employment status including: (i) termination of employment or commencement of employment; (ii) a strike or lockout; (iii) a commencement of, or return from, an unpaid leave of absence; (iv) a change in work site; and (v) any other change in your employment status or your dependent's employment status that causes a change in eligibility for any or all of such individuals regarding benefits under the Programs or similar employee benefit plans of another employer

- A significant increase in the cost of a benefit because of a significant reduction in your pay due to demotion, transfer from full-time to part-time status, or a reduction in hours at the store level
- A change in the place of your residence or the residence of your dependents

Eligibility or coverage changes under a health insurance marketplace or exchange policy are not considered Qualifying Life Events.

Consistency Rule for Qualifying Life Events

You may make a Mid-Year Change in your benefit option elections as a result of a Qualifying Life Event occurring during a Plan Year only if the election is on account of the Qualifying Life Event, the new election corresponds with the Qualifying Life Event, and the Qualifying Life Event affects eligibility for coverage under the applicable Program ("**Consistency Rule**"). The Plan Administrator will determine whether your Qualifying Life Event and subsequent election satisfy the Consistency Rule in accordance with the Code and other guidance issued by the IRS. Only those individuals affected by the change are eligible for a new election.

Special Enrollment Rights Under HIPAA

If you decline health insurance coverage for yourself or your dependents (including your spouse) because you already have other health insurance coverage, in the future you may be able to enroll yourself or your dependents in health insurance coverage provided by 7-Eleven **if you request enrollment within 31 days after your other health coverage ends (or within 60 days for certain government health coverage)**. The "Special Enrollment in the Medical Programs" section of this Summary discusses these rights in more detail.

Judgment, Decree, or Order

You may change your benefit option election during the year if the change is on account of and consistent with a judgment, decree, or order pursuant to a divorce, legal separation, annulment, or change in legal custody requiring health coverage for your child. You may cancel your election for coverage for the child only if health coverage is actually provided to the child by an individual as required by the judgment, decree, or order.

Entitlement to Medicare or Medicaid

You may change your benefit option election to cancel, reduce, or begin coverage if you become entitled to, or lose, coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). The same rule applies to dependents.

Cost or Coverage Changes

You may be allowed to change your benefit option election because of the cost or coverage changes described in this section.

- ***Cost Change.*** If the cost under any of your benefit option elections increases or decreases, your paycheck deductions will automatically be changed to correspond to the cost change if the Plan Administrator determines that such an election change is permitted by the applicable benefit option and the law.
- ***Significant Cost Decrease.*** If the cost for a benefit option significantly decreases, the Plan Administrator **may** allow all eligible employees, including employees who have elected another benefit option and those who have not previously participated in the applicable Program, to elect the benefit option that had a significant decrease in cost.
- ***Significant Cost Increase.*** If the cost under any of your benefit option elections significantly increases, the Plan Administrator **may** allow you to make a corresponding change to your benefit option election, including revoking your election for the benefit option that significantly increased in cost. In such case, you may either elect to receive, on a prospective basis, a new benefit option providing similar coverage, or you may drop coverage if no other benefit option providing similar coverage is available.

An election change is not permitted under the Dependent Care Spending Account because of a significant cost increase if the cost change is imposed by a dependent care provider who is your relative.

- ***Reduction in Coverage.*** If your elected benefit option has a significant reduction in coverage (other than a loss of coverage described in the paragraph below), such as a significant increase in the deductible, the copay, or the out-of-pocket maximum, the Plan Administrator **may** allow you to revoke that benefit option election and elect, on a prospective basis, to receive coverage under another benefit option providing similar coverage.
- ***Loss of Coverage.*** If you have a loss of coverage under any of your benefit option elections, the Plan Administrator **may** allow you to revoke that election and to elect another benefit option providing similar coverage in its place or drop coverage if no other benefit option providing similar coverage is available. A "**loss of coverage**" means a complete loss of coverage under the benefit option, including the elimination of a benefit option, or your losing all benefits under the option by reason of an overall lifetime or annual limitation. In addition, the Plan Administrator **may** treat the following as a loss of coverage: (i) a substantial decrease in the health care providers available under a benefit option; (ii) a reduction in the benefits for a specific type of health condition or treatment with respect to which you or your dependents (including your spouse) are currently in a course of treatment; or (iii) any other similar, fundamental loss of coverage.
- ***New or Improved Coverage.*** If a benefit option is added during a Plan Year, or if an existing benefit option is significantly improved, the Plan Administrator **may** allow eligible employees (whether or not they previously made an election under the applicable Program or have previously elected the benefit option) to revoke their existing benefit option election and make an election, prospectively, for coverage under the new or improved benefit option.
- ***Another Employer's Plan.*** A prospective election change under one of these Programs that is made on account of (and corresponds with) a change made under the section 125 plan of another employer **may** be permitted if (i) the other employer plan allows its participants to make election changes as provided by law; or (ii) the other employer plan allows its participants to make elections for a period of coverage different from the period of coverage under the applicable Program.
- ***Government or Educational Plan.*** An election to add coverage, prospectively, may be permitted if you or your dependent loses group health coverage sponsored by a governmental or educational institution, including (i) The Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act; (ii) a medical care program of an Indian tribal government, the Indian Health Service, or a tribal organization; (iii) a state health benefits risk pool; or (iv) a foreign government group health plan.

SPECIAL ENROLLMENT IN THE MEDICAL PROGRAMS

Special Enrollment Because of Losing Other Coverage

An employee (or dependent) who was eligible but not enrolled in a BCBS plan ("**Medical Program**") may later enroll in the Medical Program if the following conditions are met:

- The employee (or dependent) was covered under another group health plan (or had other health insurance coverage) at the time coverage under the Medical Program was previously offered to the individual and the individual lost the other coverage as a result of either (i) losing eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment), (ii) losing employer contributions toward the other coverage, or (iii) exhausting COBRA coverage of the employee (or dependent) who has lost coverage;
- The employee declined coverage under the Medical Program when it was initially offered because he or she had the other health coverage; and
- The employee requests enrollment in the Medical Program within 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, as described above.

If the employee (or dependent) lost the other coverage as a result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim), that individual does not have a special enrollment right.

Dependent Special Enrollment

If an employee is a participant under the Medical Program (or has met the waiting period applicable to becoming a participant under the Medical Program) and 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 the Medical Program as a covered dependent of the covered employee. In the case of the birth or adoption or placement for adoption of a child, the spouse of the covered employee may be also enrolled as a dependent of the covered employee during the dependent special enrollment period if the spouse is otherwise eligible for coverage under the Medical Program.

The dependent special enrollment period is a period of 31 days that begins on the date of the marriage, birth, adoption, or placement for adoption of the new dependent. The coverage of the new dependents, the employee, and the spouse, if applicable, enrolled during this special enrollment period will become effective:

- In the case of marriage, the date of marriage,
- In the case of a dependent's birth, the date of birth, or
- In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Special Enrollment Rights with Medicaid, CHIP, and State Subsidies

The Medical Program will permit special enrollment in two additional circumstances. The first is if you or a dependent loses eligibility for Medicaid or for coverage under the Children's Health Insurance Program (CHIP). The second is if you or a dependent becomes eligible for a state premium assistance subsidy under a Medical Program through Medicaid or CHIP. (States may offer subsidies to eligible low-income children and families.) Special enrollment under these two circumstances must be requested within 60 days after the loss of coverage or the determination of eligibility for a state premium assistance subsidy, as applicable. Note that this is longer than the 31-day period for other special enrollment rights, as explained above.

BLUECROSS BLUESHIELD MEDICAL BENEFITS

7-Eleven provides eligible employees with medical benefits administered by BlueCross BlueShield of Texas (BCBS).

ELIGIBILITY

Who Is Eligible for Coverage?

You are eligible to receive medical benefits from the BCBS plans if you are:

- Classified as a full-time employee
- Classified as a variable-hour employee and you work an average of 30 hours or more during your 12-month measurement period.

Full-time employees are eligible for medical benefits beginning on the first of the month following the date of hire. Variable-hour employees who work an average of 30 hours or more during their 12-month measurement period are eligible for medical benefits for the 12 months following completion of the measurement period. The initial measurement period for a newly hired or newly classified variable-hour employee begins on the date of hire or classification, and if eligible, participation in medical benefits begins on the first of the month following the initial measurement period. After the initial measurement period, the subsequent measurement period is a 12-month period ending prior to Open Enrollment, and if eligible, participation in medical benefits begins on the January 1 following Open Enrollment.

Part-time employees are not eligible for the BCBS plans. All dependents (as defined in the "General Eligibility" section above) of employees eligible to participate in the BCBS plans are also eligible to participate in the BCBS plans.

Your dependents will also become eligible for coverage on your date of eligibility. **If you do not elect coverage for your dependent within 31 days of his or her initial eligibility date or during Open Enrollment, you will not be eligible to elect coverage for your dependent until the next Open Enrollment** unless your dependent becomes eligible for enrollment in accordance with the special enrollment or Mid-Year Change rules explained near the beginning of this Summary. A newborn child is not automatically covered; you must elect coverage for a newborn within 31 days of birth or else you will have to wait until the next Open Enrollment to elect coverage for that child.

WHEN COVERAGE BECOMES EFFECTIVE

If you elect coverage under the BCBS plans, your coverage will become effective as described in the "Who is Eligible for Coverage?" section above and after you complete your enrollment in the BCBS plans through the 7-Eleven Benefit Service Center. Coverage for any dependents that you enroll at the same time as you enroll yourself will be effective on the same day as your coverage.

Once you initially elect (or decline to elect) coverage under one of the BCBS plans, you may make changes to that elected coverage only during the next Open Enrollment, or in accordance with the Special Enrollment or Mid-Year Change rules discussed earlier in this Summary.

Coverage elected during Open Enrollment becomes effective on the following January 1.

PAYING FOR COVERAGE

You and 7-Eleven share the cost of the BCBS plans. You generally pay your share of your medical premiums through payroll deductions before most taxes are withheld. The cost of the coverage will depend upon the coverage option you select and whether you elect to cover your dependents.

TOBACCO-FREE WELLNESS PROGRAM

Your share of the medical premium for 2017 will be reduced if you complete tobacco-free wellness steps by the required deadlines. See your Enrollment Guide for details.

Your health plan is committed to helping you achieve your best health. Rewards for participating in the tobacco-free wellness program are available to all employees who are eligible for the health plan. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact BCBS at 1-888-588-2896 and they will work with you (and, if you wish, your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

WHEN COVERAGE ENDS

Your and your dependents' coverage under the BCBS plans will terminate effective at 11:59 p.m. on the date that any one of the following events occurs:

- Your employment with 7-Eleven terminates
- You stop making premium payments
- You begin any leave of absence, except if you continue to make premium payments while on a disability, unpaid medical, or FMLA leave of absence
- You no longer qualify for disability income benefits, for an unpaid medical leave of absence, or for an FMLA leave of absence, unless you return to Active Employment or retire, if eligible
- You or any covered dependent submits (or attempts to submit) a false, altered, forged, or fraudulent claim or document requesting benefits under any 7-Eleven benefit plan
- You are no longer eligible under the BCBS plans
- The BCBS plans are terminated
- 7-Eleven no longer offers any medical coverage

Your dependents' coverage under the BCBS plans will also terminate effective at 11:59 p.m. on the date that they are no longer eligible dependents under the BCBS plans and/or on the date they are no longer enrolled as dependents under the BCBS plans. Dependent children who reach the limiting age of 26 will lose coverage at the end of the month in which they turn age 26.

If you or any of your dependents lose coverage under the BCBS plans, you or your dependents may be entitled to continue group health care coverage as provided in the "COBRA — Continuation of Group Health Program Coverage" section later in this Summary.

BCBS MEDICAL PLAN OPTIONS

You may choose from two medical plan options, as follows:

- The Health Select (1500 – HSA Option) Plan
- The Health Choice (3000 – CoPay Option) Plan

The Health Select (1500 – HSA Option) Plan has high deductibles, but comes with the option to open a Health Savings Account (HSA) to pay for eligible expenses with pre-tax savings. (Any HSA is separate and not part of the Health Select (1500 – HSA Option) Plan.) The Health Choice (3000 – CoPay Option) Plan offers copays for some services, has significantly higher deductibles and does not have the option to open an HSA.

Both plans permit you to choose coverage from in-network or out-of-network providers. You can obtain the most up-to-date list of in-network providers by going online to www.bcbstx.com/7eleven and clicking on the "Find a Doctor" box. For both plans, choose the "BlueChoice PPO Plan" from the drop-down menu. You can also obtain a printed list at no charge by calling BCBS at 1-888-588-2896. Be aware that paper directories are updated less frequently.

HEALTH SELECT (1500 – HSA OPTION) PLAN

If you elect the Health Select (1500 – HSA Option) Plan, a calendar-year deductible must be satisfied before any medical benefits are paid, except for eligible in-network preventive care, which is covered at 100%. Once the deductible is met, the Plan starts to pay a portion of the cost of covered expenses, which is also referred to as coinsurance, until you reach the out-of-pocket maximum. You will pay 20% for in-network expenses, and the Plan will pay 80%. After your out-of-pocket maximum is met, the Health Select (1500 – HSA Option) Plan pays 100% of eligible in-network charges for the calendar year. The following chart shows the calendar-year deductibles and out-of-pocket maximums for the Health Select (1500 – HSA Option) Plan:

	Annual Deductibles	
	In-Network	**Out-of-Network**
Individual	$1,500	$3,000
Family	$3,000	$6,000
	Annual Out-of-Pocket Maximums	
Individual	$5,000	$10,000
Family	$10,000	$20,000

If you cover at least one family member, the Plan doesn't begin paying for covered health care expenses for anyone in the family until the entire family deductible is met. This is also true for the out-of-pocket maximum; however, no individual will pay more than $7,150 in in-network expenses per calendar year.

Example: Joe has Individual coverage under the BCBS Health Select (1500 – HSA Option) Plan. His individual deductible is $1,500. He has in-network covered expenses of $3,700 for an appendectomy. First, Joe can use the funds in his Health Savings Account, if he contributes to one, to pay toward the deductible. He is responsible for paying the full deductible ($1,500) out of pocket. The remaining amount of $2,200 is paid 80% by the BCBS Health Select (1500 – HSA Option) Plan ($1,760) and 20% by Joe ($440).

When covered expenses, including the calendar year deductible, reach the out-of-pocket maximum for the calendar year, the BCBS Health Select (1500 – HSA Option) Plan will pay 100% of in-network covered expenses for the remainder of the calendar year, subject to the Allowable Amount requirements described below.

The deductibles and out-of-pocket maximums are entirely separate for in-network and out-of-network charges. In other words, in-network charges do not reduce the out-of-network deductible, and out-of-network charges do not reduce the in-network deductible. Likewise, in-network charges do not apply toward the out-of-network out-of-pocket maximum, and out-of-network charges do not apply toward the in-network out-of-pocket maximum. However, any specific benefit maximums apply to both in-network and out-of-network charges in combination.

If an employee covers at least one family member, one or more member's in-network expenses must reach the family deductible of $3,000 before the Plan will begin paying in-network benefits for any member. When the family deductible is met, the Health Select (1500 – HSA Option) Plan will begin paying benefits for the entire family. The out-of-pocket maximum works the same way. Once at least two family member's expenses reach $10,000, the Health Select (1500 – HSA Option) Plan will pay the entire family's covered medical expenses for the remainder of the year.

Example: Steve has Family coverage under the BCBS Health Select (1500 – HSA Option) Plan and covers his wife, Nancy, and son, Matt. Steve has in-network covered expenses of $2,000 for a minor procedure. First, he can use the funds in his Health Savings Account, if he contributes to one, to pay toward the deductible. Because his expenses don't meet the family deductible, he is responsible for 100% of the cost. Later in the year, Matt comes down with pneumonia and has to be hospitalized. His expenses are $4,000. He is responsible for paying $1,000 to meet the family deductible. The remaining amount of $3,000 is paid 80%

by the Plan ($2,400) and 20% by Steve ($600).

Only in-network covered expenses and the Allowable Amount for out-of-network covered expenses incurred during a calendar year will count toward the calendar year deductibles and the out-of-pocket maximums for that calendar year.

HEALTH CHOICE (3000 – COPAY OPTION) PLAN

With the Health Choice (3000 – CoPay Option) Plan, you pay a pre-determined copay for some services, such as in-network office visits. For other services, you pay 100% of charges until a calendar-year deductible is met. After you meet your deductible, you pay coinsurance until you reach the out-of-pocket maximum. You will pay 20% for in-network expenses, and the Plan will pay 80%. When you reach your out-of-pocket maximum, the plan pays 100% of covered expenses for the remainder of the calendar year. The amount of the calendar-year deductible will depend upon the coverage option you choose. The following chart shows the calendar-year deductibles and out-of-pocket maximums for the Health Choice (3000 – CoPay Option) Plan:

	Annual Deductibles	
	In-Network	**Out-of-Network**
Individual	$3,000	$6,000
Family	$6,000	$12,000
	Annual Out-of-Pocket Maximums	
Individual	$5,000	$10,000
Family	$10,000	$20,000

When covered expenses reach the calendar-year deductible, the BCBS Health Choice (3000 – CoPay Option) Plan will pay 80% of all in-network covered expenses and 50% of the Allowable Amount for out-of-network covered expenses until covered expenses reach the out-of-pocket maximum for the calendar year.

Example: Irene has Family coverage under the BCBS Health Choice (3000 – CoPay Option) Plan for herself and her two children, Linda and Sam. At the beginning of the year:

- Each family member's individual deductible is $3,000
- Their family deductible is $6,000
- Each family member's individual out-of-pocket maximum is $5,000
- Their family out-of-pocket maximum is $10,000

If an employee covers at least one family member, each covered individual will have a calendar-year individual deductible, and the family group will have a calendar-year family deductible. When the family deductible is met, any remaining individual deductible amounts are reduced to zero. Once an individual family member meets his or her calendar-year individual deductible, the BCBS Health Choice (3000 – CoPay Option) Plan will pay his or her covered claims at 80% even if the calendar-year family deductible has not been met. An individual family member cannot contribute more toward the calendar-year family deductible than the individual deductible.

Similarly, if an employee covers at least one family member, each covered individual will have an individual out-of-pocket maximum and the family group will have a family out-of-pocket maximum. When the family out-of-pocket maximum is met for the year, any remaining individual out-of-pocket maximums are reduced to zero for the remainder of the year. Once an individual family member meets his or her individual out-of-pocket maximum, the BCBS Health Choice (3000 – CoPay Option) Plan will pay his or her claims at 100% even if the family out-of-pocket maximum has not been met. An individual family member cannot contribute more toward the family out-of-pocket maximum than the individual out-of-pocket maximum.

The example below provides a more detailed illustration of how various expenses incurred by family members during a calendar year are paid under the Family coverage option of the BCBS Health Select (1500 – HSA Option) Plan and Health Choice (3000 – CoPay Option) Plan, assuming that all providers are in-network.

Example: The deductible is the amount you pay for covered expenses before the plan begins to pay. Once you meet the deductible, the plan starts to pay a portion of the cost of covered expenses, which is referred to as coinsurance. You will continue to pay the coinsurance amounts until you meet the out-of-pocket maximum. At that time, the plan will then pay 100% of covered expenses.

It is important to note that if you have dependent coverage, the deductibles and out-of-pocket maximums work differently for the Health Select (1500 – HSA Option) Plan option vs. the Health Choice (3000 – CoPay Option) Plan option.

If you enroll yourself and dependent(s) in the **Health Select (1500 – HSA Option) Plan option**, you must **meet the family deductible** before the plan begins to pay a portion of covered expenses. You must also meet the **family out-of-pocket maximum** before the plan will pay 100% of covered expenses. For example, the family deductible is $3,000. Covered expenses for any one person, or collectively for all covered dependents, must reach $3,000 before the plan will begin to pay. The same applies with respect to the out-of-pocket maximum; however, no individual will pay more than $7,150 in in-network expenses per calendar year.

If you enroll yourself and dependent(s) in the **Health Choice (3000 – CoPay Option) Plan option**, you pay a $35 copay for a primary care doctor visit or a $50 copay for a specialist visit, but for other covered expenses, the plan does not begin paying a portion of covered expenses for an individual until he/she meets the individual deductible, which is $3,000. Please note that your copays do not apply to the deductible. For example, the family deductible of $6,000 must be met by the combined expenses of at least two individuals. The same applies for the family out-of-pocket maximum. For example, in the Jones family:

Dave incurs $1,500 in covered expenses — He has not met the individual deductible, so the Plan will not yet pay for additional covered expenses for him.

Mary incurs $2,000 in covered expenses — She has not met the individual deductible, so the Plan will not yet pay for additional covered expenses for her.

Jane incurs $3,000 in covered expenses — Because Jane has met the individual deductible, the plan will begin paying 80% of additional covered expenses for her. In addition, Jane's expenses, along with Dave and Mary's expenses also satisfy the family deductible of $6,000. Now, the plan will start paying a portion of the covered expenses (coinsurance) for Dave, Mary, and Jane.

Your share of the cost of prescription drugs is outlined under the Prescription Drug section; however, the costs for those drugs will also count towards meeting the deductibles and out-of-pocket maximums under both the Health Select (1500 – HSA Option) Plan and Health Choice (3000 – CoPay Option) Plan options.

OUT-OF-NETWORK BENEFITS

If you choose Out-of-Network Providers, only Out-of-Network Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out-of-Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided.

You will be responsible for paying:

- Billed charges above the Allowable Amount as determined by the Claims Administrator,
- Co-Share and Deductibles,
- Limited or non-covered services, and
- Failure to preauthorize penalty.

For more detailed information about the Allowable Amount, please refer to the Glossary.

PRECERTIFICATION

Certain services require precertification by BCBS. Precertification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the plan. It also allows BCBS to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called "discharge planning"), and to register you for specialized programs or case management when appropriate.

In-network and out-of-network providers may precertify services for you, but it is your responsibility to ensure that any precertification requirements are satisfied. If you do not precertify, your benefits may be reduced or the plan may not pay any benefits.

The Precertification Process

Prior to being hospitalized or receiving certain other medical services or supplies, certain precertification procedures must be followed.

You or a member of your family, a hospital staff member, or the attending physician must notify BCBS to precertify any of the out-of-network admissions or medical services and expenses shown in the chart below, prior to receiving any of the services or supplies, within the time frames specified below. To obtain precertification, call BCBS at the telephone number listed on your ID card. This call must be made in the following circumstances:

Services Requiring Precertification	Time Period for Precertification
Non-emergency inpatient admission (including inpatient mental health care and treatment of serious mental illness and chemical dependency)	You, your physician, or the facility must call and request precertification at least two working days before the date you are scheduled to be admitted (not applicable to minimum hospital stay for maternity or breast cancer treatment).
Emergency inpatient admission (including inpatient mental health care and treatment of serious mental illness and chemical dependency)	You, your physician, or the facility must call within two working days after admission, or as soon as reasonably possible, after you have been admitted.
Transfer to another facility or to or from a specialty unit within the facility	Prior to transfer.
The following outpatient treatment of mental health care and treatment of serious mental illness and chemical dependency: - Psychological testing - Neuropsychological testing - Electroconvulsive therapy - Intensive Outpatient Program	At least two working days prior to beginning treatment.
Extended care expenses	Prior to initiating extended care, when an extension of the initial precertified service is required, and when the treatment plan is altered.
Home infusion therapy	Prior to initiating home infusion therapy, when an extension of the initial precertified service is required, and when the treatment plan is altered.
Extension of minimum length of stay for inpatient maternity care and treatment of breast cancer	As soon as possible after the need for the extension is determined.

To precertify a medical admission, you, your physician or provider of services, or a family member should call one of the Customer Service toll-free numbers listed on the back of your ID card, on business days between 7:30 a.m. and 6:00 p.m. Central Time. After working hours or on weekends, call the Medical

Preauthorization Helpline toll-free number listed on the back of your ID card, and your call will be recorded and returned the next working day. A benefits management nurse will follow up with your provider's office.

To precertify a mental health or chemical dependency treatment, call the Mental Health/Chemical Dependency Preauthorization Helpline toll-free number on your ID card. This helpline is available 24 hours a day, seven days a week.

When you have an inpatient admission to a facility, BCBS will notify you, your physician, and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days will need to be certified. You, your physician, or the facility will need to call BCBS at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. BCBS will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If precertification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how BCBS's decision can be appealed. You or your provider may request a review of the precertification decision pursuant to the "Claims and Review Procedures" section later in this Summary.

If you request precertification prior to admission and BCBS determines that care is not available from in-network providers, BCBS may authorize your visit to an out-of-network provider at the in-network level of benefits.

Minimum Stay for Maternity Care and Treatment of Breast Cancer

The Plan provides a minimum length of stay in a hospital as follows:

Maternity care:

- 48 hours after an uncomplicated vaginal delivery
- 96 hours after an uncomplicated delivery by caesarean section

Treatment of breast cancer:

- 48 hours following a mastectomy
- 24 hours following a lymph node dissection

Precertification is not required for a length of stay equal to or less than the minimum. If you require a longer stay, you or your provider must seek precertification for an extension.

How Failure to Precertify Affects Your Benefits

A precertification benefit reduction will be applied to the benefits paid if you fail to obtain a required precertification prior to incurring medical expenses. This means BCBS will reduce the amount paid toward your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary precertification from BCBS prior to receiving services from an out-of-network provider. Your provider may precertify your treatment for you; however, you should verify with BCBS prior to the procedure that the provider has obtained precertification from BCBS. If your treatment is not precertified by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered.

The chart below illustrates the effect on your benefits if necessary precertification for outpatient or inpatient services, procedures, and treatments is not obtained.

If precertification is:	Then the expenses are:
Requested and approved by BCBS	Covered
Requested and denied	Not covered, but may be appealed
Not requested, but would have been covered if requested	Covered after precertification benefit reduction of $500 is applied
Not requested and would not have been covered if requested	Not covered, but may be appealed

Any additional out-of-pocket expenses incurred because your precertification requirement was not met will not count toward your deductible, payment percentage, or payment limit.

HEALTH SAVINGS ACCOUNT (HSA)

ELIGIBILITY

If you enroll in the Health Select (1500 – HSA Option) Plan, you may open a Health Savings Account (HSA) if you:

- Do not have any other health care coverage that reimburses expenses for covered services (other than preventive services) before reaching an annual deductible (as defined by federal rules).
- Are not covered by your spouse's health plan, unless that health plan is a qualified high deductible health plan, or reimbursement account. Reimbursement accounts include health care reimbursement accounts or health care flexible spending accounts that reimburse expenses for covered services before meeting the Medical Plan's annual deductible (other than a limited scope health care flexible spending account).
- Are not eligible to be claimed as a dependent on someone else's federal income tax return.
- Are not enrolled in Medicare, Medicaid or TRICARE. This includes Medicare Part A, which is typically provided at no cost to people who are Medicare eligible.
- Do not receive Veterans Administration Benefits, have not used a Veterans Administration hospital and have not received Veterans Administration Benefits for three months prior to opening an HSA. However, if your Veterans Administration medical or hospital benefits are provided in connection with a service-connected disability, you are eligible to open and contribute to an HSA as long as you are enrolled in a qualified high-deductible health plan (regardless of when your last Veterans Administration benefit was received).

You may enroll in the Health Select (1500 – HSA Option) Plan without opening an HSA. Whether to open an HSA, and any HSA contributions you make, are completely voluntary. Although enrolling in the Health Select (1500 – HSA Option) Plan may make you eligible to open an HSA, any HSA you choose to open is separate from, and not a part of, the Health Select (1500 – HSA Option) Plan.

OPENING AN HSA

7-Eleven has made opening and contributing to an HSA convenient by selecting BenefitWallet for HSA management. If you qualify for an HSA, you may open your HSA with any financial institution. But if you choose BenefitWallet for your HSA, you may make contributions through convenient payroll deductions, and you will not have to pay a monthly administration fee. You may move your HSA contributions from BenefitWallet to another HSA provider of your choosing, if you wish.

Individually Owned HSA

You own and administer your HSA. You determine how much you will contribute to your HSA, subject to IRS annual limits, and when and for what to use the money. Your HSA is an individual trust or custodial account separately established and maintained by BenefitWallet or another financial institution. 7-Eleven will maintain records to keep track of HSA contributions an employee makes to BenefitWallet through its payroll deductions, but 7-Eleven will not create a separate fund or otherwise segregate assets for this purpose. 7-Eleven has no authority or control over the funds deposited in an HSA. The HSA is not an employer-sponsored employee benefits plan and is not covered by ERISA.

You keep your HSA and any money in it, even if later you are no longer enrolled in the Health Select (1500 – HSA Option) Plan or your employment with 7-Eleven ends. The HSA grows tax-free for federal income tax purposes, including any interest. BenefitWallet offers individual investment options for you if your account reaches $1,000 or above.

Because your HSA is an individual bank account, you must take action when you first open the HSA. Due to the Patriot Act, additional information may be requested from the HSA administrator before your HSA is opened.

When your 7-Eleven employment terminates, you may keep your HSA with the same HSA Administrator or transfer it to another financial institution.

CONTRIBUTIONS

Employee Contributions

When you choose BenefitWallet for your HSA, you may elect to contribute to your HSA through federal pre-tax payroll deductions. You may start or stop your payroll deductions at any time. You may also make lump-sum contributions by check. Lump-sum contributions that meet IRS rules are deductible on your federal income tax return. Lump-sum contributions cannot be made by payroll deduction, but must be made directly to the HSA Administrator.

The amount you choose to contribute by payroll deduction is expressed as an annual figure and is withheld in equal amounts from each of your future paychecks for the balance of the year. Elections to begin, decrease or increase payroll deductions are effective as of the first of the month following the date the change is requested. If you stop contributions, they will end on the last day of the month for which the change is effective.

If you become ineligible to contribute to your HSA because you enroll in Medicare or TRICARE, you receive VA benefits, or you become covered by a non-high-deductible medical plan or full scope Health Care Flexible Spending Account (Health FSA) or Health Reimbursement Account (HRA), you must call the 7-Eleven Benefits Service Center immediately to cease your payroll deduction HSA contributions.

Contribution Limits

Your contribution cannot exceed the annual IRS maximum as shown below for 2017.

HSA Funding Limits	
You Only	$3,400
You + Dependent(s)	$6,750

If you change between "You Only" and "You + Dependent(s)" coverage during the year due to a Qualifying Life Event, the new limit will become effective for you on the first of the month following the effective date of the Qualifying Life Event, unless the effective date is the first of a month, in which case the new limit will become effective on that day.

If you become ineligible to contribute to an HSA during the year, the amount of contributions you can make to the HSA during that year will be reduced. Any excess contributions will be subject to ordinary federal income tax plus an additional 6% federal excise tax.

Catch-up Contributions

If you are age 55 or older during 2017, you may contribute an additional "catch-up contribution" of up to $1,000 during 2017. Your eligibility to make additional contributions ends when you enroll in Medicare, typically at age 65. These additional contributions can be made to your account by you or anyone else, provided the contributions do not exceed the federal maximums. The IRS limits may be adjusted each year.

HOW THE HSA WORKS

You can use your debit card to pay for qualified medical expenses. You must have a balance to use your debit card. Receipts are not required for reimbursement, but it is recommended you retain the receipts in case the IRS ever requires substantiation.

HSA Fees

The Company pays BenefitWallet's monthly maintenance fee while you are an active employee and participating in the Health Select (1500 – HSA Option) Plan. All other fees are your responsibility and will be deducted from your HSA. You will receive a schedule of fees from the HSA Administrator when you enroll in the HSA.

It is important for you to know the amount in your HSA prior to withdrawing funds. If you withdraw funds that exceed the available balance, you will be responsible for overdraft plus bank fees.

Eligible Expenses

If you use your HSA for qualified medical expenses, the money will not be taxable for federal tax purposes when withdrawn. Qualified medical expenses include those of your spouse and dependents you can claim on your federal income tax return, even if they are not covered by the Health Select (1500 – HSA Option) Plan. Note that expenses for adult children age 19 or older cannot be reimbursed from your HSA unless they are your tax dependents, even if they are enrolled in the Health Select (1500 – HSA Option) Plan. An adult child age 19 or older is considered your federal income tax dependent if he or she is a full-time student under age 24, or a "qualifying relative" as provided in Internal Revenue Code Section 152 (basically, a relative for whom you provide more than half the support).

Qualified medical expenses include any expense considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended. A complete list of these expenses is found in IRS Publication 502. In addition to medical, dental and vision expenses, qualified expenses include premiums for long-term care insurance, COBRA continuation coverage and Medicare (but not Medigap policies).

HSA funds used for expenses that are not qualified medical expenses are generally subject to:

- Federal income tax, and
- A 20% additional federal tax (unless an exception applies, such as your death or disability, or your attainment of age 65)

HSA FEDERAL TAX ADVANTAGES

Contributions to an HSA are tax-free for federal tax purposes (they will be made through payroll deductions on a pre-tax basis if you elect to contribute through BenefitWallet). The money in this account (including interest and investment earnings) grows tax-free. As long as the funds are used to pay for qualified medical expenses, they are reimbursed tax-free. If you use your HSA funds for an expense that is not a qualified medical expense, the money is taxable and subject to a 20% tax penalty if you are under age 65. Discuss any state or local tax issues with your personal tax advisor before taking any action regarding an HSA.

Tax Reporting

Each year that you have money in your HSA, you must file a Form 8889 with your federal income tax return. This assures the pre-tax treatment of money (for federal income tax purposes) withdrawn from your HSA and calculates the deduction for any contributions you make by check to your HSA. If you spend HSA money for non-qualified medical purposes, taxes due on the non-medical payments are calculated on the Form 8889. Tax documents for your HSA will be provided by your HSA Administrator.

This Summary discusses federal tax treatment but does not address any state or local tax issues. You should discuss all those issues (federal, state, and local) with your personal tax advisor before taking any action regarding an HSA.

PRESCRIPTION DRUGS

Both BCBS plans include benefits for prescription medications through Express Scripts. You can fill your prescriptions at participating in-network retail pharmacies or use the Express Scripts mail order program for medications you take regularly. To find a participating retail pharmacy, visit www.express-scripts.com. After you register with the site, click on "**Find a Pharmacy**" on the homepage. You can also download a mobile app for finding a network pharmacy. **The plans do not cover prescriptions filled at an out-of-network pharmacy or an out-of-network mail order service.**

The prescription drug program also covers injectable vaccines. This means you can receive your covered flu shot and other preventive vaccines at an in-network pharmacy through the prescription drug program, as well as at your physician's office through the medical program.

If you elect the Health Select (1500 – HSA Option) Plan, you pay the full cost for your prescription drugs — except those defined as preventive under the Affordable Care Act, which are covered with no deductible — until your deductible is met, and after that you pay coinsurance, as follows:

Type of Prescription Drug	Retail (30-Day Supply)	Mail Order (90-Day Supply)
Generic	20% after deductible ($10 minimum/$30 maximum)	20% after deductible ($25 minimum/$75 maximum)
Brand — Formulary	20% after deductible ($20 minimum/$100 maximum)	30% after deductible ($50 minimum/$250 maximum)
Brand — Non-Formulary	50% after deductible ($40 minimum/$250 maximum)	50% after deductible ($100 minimum/$625 maximum)
Specialty	Same as brand	Same as brand

If you elect the BCBS Health Choice (3000 – CoPay Option) Plan, you pay copays for generic, formulary brand, and specialty prescription drugs. If the cost of the drug is less than the copay, you pay the drug's cost. You pay the full cost for non-formulary brand-name drugs until your deductible is met, then you pay coinsurance, as follows.

Type of Prescription Drug	Retail (30-Day Supply)	Mail Order (90-Day Supply)
Generic	$15	$37.50
Brand — Formulary	$40	$100
Brand — Non-Formulary	50% after deductible ($40 minimum/ $250 maximum)	50% after deductible ($100 minimum/$625 maximum)
Specialty	$300	$300

"**Formulary**" means a drug is on Express Scripts' Preferred Drug List of brand-name drugs that have been chosen based on quality, effectiveness, and cost. If your brand-name drug is not on the formulary list, talk to your physician to see if a generic drug or one that is on the formulary list might work just as well for you. The Express Scripts formulary can be found online by following these instructions:

- Go to www.express-scripts.com.
- After you register with the site, click on "Drugs Preferred by Your Plan" on the homepage.
- You can also call Express Scripts at 1-877-782-8699.

To fill a prescription at a retail pharmacy, simply present your Express Scripts prescription drug ID card at the pharmacy.

To fill a prescription through the mail order program, have your physician write a new prescription for each maintenance medication for a 90-day supply. Complete and mail a home delivery order form along with your prescriptions and payment to Rx Home Delivery. Order forms are available online at www.express-scripts.com. Or, your physician can fax your prescription and a completed order form to 1-800-600-8105.

To check the status of an order, place a refill order, or speak to a pharmacist, call 1-877-782-8699.

Some specialty drugs are only available from the Express Scripts Accredo Specialty Pharmacy. These are self-injectable drugs and other specialty medications that may need special handling or refrigeration. If you are unsure if you are on a specialty medication, visit http://accredo.com/Express-Scripts for more information. If you have questions about the Program, you can talk to a specialty pharmacist 24/7 by calling 1-800-803-2523.

For specialty drugs dispensed by Express Scripts' Accredo Specialty Pharmacy, please be aware that patient assistance coupons will not be considered as true out-of-pocket expenses and may not apply to deductible and out-of-pocket maximums.

Preventive Drugs

Generic prescription drugs defined as preventive under the Affordable Care Act are covered at 100% with no deductible under the Health Select (1500 – HSA Option) Plan and Health Choice (3000 – CoPay Option) Plan, including FDA-approved contraception for females.

Under the Health Select (1500 – HSA Option) Plan, certain preventive medications bypass plan deductible requirements. For specific questions about preventive medications, you may contact Express Scripts by calling 1-877-782-8699 or by visiting the web at www.express-scripts.com.

Generics Preferred Program

Unless you direct your pharmacist otherwise, your pharmacist should automatically fill your brand-name prescription with a low-cost generic equivalent, if one is available. If you choose the brand-name drug over the generic equivalent, you will pay the applicable brand-name coinsurance amount plus the difference in cost between the brand-name and the generic. If your doctor does not allow generic substitution, you must still pay the brand-name coinsurance amount plus the difference.

Quantity Limits

Quantity limits apply to some classes of prescription drugs, such as narcotic medications, migraine medications; inflammatory agents; and medications for hypertension, urinary disorders, and viral infections. If your doctor prescribes an amount or dosage strength that exceeds the plan's limits, the prescription will be filled for the maximum amount or strength allowable. Quantity limits are designed to promote safe, appropriate, and efficient medication use, and are based on FDA dosage guidelines. If your doctor has medical reasons to prescribe an amount or dosage strength that exceeds the quantity limits, he or she may request an exception.

Prescription Drug Exclusions

These prescription drug exclusions are in addition to the exclusions listed under your medical coverage.

The prescription drug coverage does not cover the following expenses:

- Administration or injection of any drug
- Any charges in excess of the benefit, dollar, day, or supply limits stated in this Summary
- Allergy sera and extracts
- Any non-emergency charges incurred outside of the United States if you traveled to such a location to obtain prescription drugs or supplies, even if (i) otherwise covered under the plan, (ii) such drugs or supplies are unavailable or illegal in the United States, or (iii) the purchase of such prescription drugs or supplies outside the United States is considered legal
- Any drugs or medications, services, and supplies that are not medically necessary, as determined by

Express Scripts, for the diagnosis, care, or treatment of the illness or injury involved (this applies even if they are prescribed, recommended, or approved by your physician or dentist)

- Biological sera, blood, blood plasma, blood products, or substitutes, or any other blood products
- Contraception medications covered, as follows:
    - Barrier contraceptive method – diaphragms/cervical caps
    - Hormonal contraceptive methods oral, transdermal, intravaginal injectable Hormonal contraceptives
    - Emergency contraceptive method Rx and OTC – e.g. Plan B and Ella
    - Implantable medications – e.g. Implanon
    - Intrauterine contraceptives – e.g. Mirens, Skyla
    - OTC contraceptive devices – e.g. non-spermicidal condom
    - OTC contraceptive medications – e.g. anything with a spermicide
- Cosmetic drugs, medications, or preparations used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids, chemical peels, dermabrasion, treatments, bleaching, creams, ointments, or other treatments or supplies to remove tattoos or scars, or to alter the appearance or texture of the skin
- Drugs administered or entirely consumed at the time and place they are prescribed or dispensed
- Drugs that do not, by federal or state law, require a prescription order (i.e., over-the-counter (OTC) drugs), even if a prescription is written
- Drugs provided by, or while the person is an inpatient at any health care facility, or any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it
- Drugs used primarily for the treatment of infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except as described in the "Covered Medical Expenses" section
- Weight loss prescription medications are covered with Prior Authorization.
- Homeopathic medications
- Durable medical equipment, monitors, and other equipment, except that blood glucose monitors are covered with a limit of one per 365 days.
- Experimental/Investigational drugs or devices, except as described in the "Covered Medical Expenses" section. This exclusion will not apply with respect to drugs that:
    - Have been granted investigational new drug (IND) or "Group C" treatment IND status, or
    - Are being studied at the phase III level in a national clinical trial sponsored by the National Cancer Institute, and
    - Express Scripts determines, based on available scientific evidence, are effective or show promise of being effective for the illness.
- Food items: Any food item, including infant formulas, nutritional supplements, medical foods, and other nutritional items, even if it is the sole source of nutrition
- Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects
- Injectables:
    - Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by Express Scripts
    - Any refill of a designated self-injectable drug not dispensed by or obtained through the Specialty Pharmacy network. An updated copy of the list of self-injectable drugs designated by this plan to be refilled by or obtained through the Specialty Pharmacy network is available upon request or may be accessed at the Express Scripts website at www.express-scripts.com
- Insulin pumps or tubing, or other ancillary equipment and supplies for insulin pumps
- Prescription drugs for which there is an over-the-counter (OTC) product that has the same active ingredient and strength, even if a prescription is written
- Prescription drugs, medications, injectables, or supplies provided through a third-party vendor contract with the contract-holder
- Prescription orders filled prior to the effective date or after the termination date of coverage under the plan

- Prophylactic drugs for travel
- Refills in excess of the amount specified by the prescription order. Before recognizing charges, Express Scripts may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards
- Refills dispensed more than one year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed
- Replacement of lost or stolen prescriptions
- Drugs, services, and supplies provided in connection with treatment of an occupational injury or occupational illness
- Strength and performance: Drugs or preparations, devices, and supplies to enhance strength, physical condition, endurance, or physical performance, including performance-enhancing steroids
- Gender Reassignment: Any treatment, drug, or supply related to changing sex or sexual characteristics, including hormones and hormone therapy
- Sexual dysfunction/enhancement: Any drug or supply to treat sexual dysfunction, enhance sexual performance, or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; except that erectile dysfunction medications are covered with a quantity limit
- Supplies, devices, or equipment of any type, except as specifically provided in the “Covered Medical Expenses” section
- Test agents except diabetic test agents
- New speciality prescription products to market are excluded from the plan benefit.

BCBS PLAN BENEFITS

For purposes of both BCBS plans, "**covered expenses**" are services and supplies that you or a covered dependent receives that are listed as eligible expenses in the "Covered Medical Expenses" section and that are determined by BCBS to be medically necessary. Out-of-network provider expenses are covered expenses only to the extent that they are Allowable Amounts (as defined in the Glossary). If you do not find a particular expense listed below, call BCBS at 1-888-588-2896 before receiving the service or supply to find out if it is a covered expense.

COVERED MEDICAL EXPENSES

The following medical expenses are covered expenses for purposes of the BCBS plans, subject to the limitation for out-of-network expenses and the applicable deductibles and out-of-pocket maximums. For the Health Select (1500 – HSA Option) Plan, after the deductible is met, the plan pays 80% of in-network covered expenses and 50% of the Allowable Amount for out-of-network covered expenses until covered expenses reach the out-of-pocket maximum for a calendar year. For the Health Choice (3000 – CoPay Option) Plan, the plan pays 80% for in-network services and 50% of the Allowable Amount for out-of-network covered expenses, except where a copay or a different coinsurance percentage is noted below or on the chart earlier in this Summary. Once the annual out-of-pocket maximum is reached, the plan pays 100% of approved charges for the rest of that calendar year.

Abortions

Both elective and therapeutic abortions are covered expenses.

Allergy Care

Covered expenses include both testing in a physician's office and treatment for the allergies (e.g., injections administered by a physician or a nurse).

Ambulance

Emergency ambulance transportation by a licensed ambulance service to the nearest hospital where emergency health services can be performed, or from one hospital to another if the first does not have the required services or facility to treat your condition, is a covered expense. Ambulance transportation from a hospital to home or between facilities is also a covered expense if other means of transportation would be considered unsafe due to your medical condition. Air or water ambulance is covered when ground ambulance is not available, and your condition is unstable and requires medical supervision and rapid transport. Ambulance transportation is not covered if not required by your physical condition or if the type of ambulance service provided is not required for your physical condition.

BCBS Plans Percentage Coinsurance: 80% after deductible for in-network and out-of-network.

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a physician other than the operating physician, or by a Certified Registered Nurse Anesthetist (CRNA) in connection with a covered procedure.

Audiologists

Covered expenses include charges by an otolaryngologist or otologist, or by a licensed or certified audiologist for a hearing evaluation prescribed by a physician certified as an otolaryngologist or otologist, limited to one exam in any 24-month period for participants age 18 and over, or one exam in any 12-month period for participants younger than age 18.

Charges for services relating to prescription hearing aids or basic hearing evaluations are **NOT** covered expenses.

Acquired Brain Injury

Covered expenses include treatment for acquired brain injury, which is a neurological insult to the brain that is not hereditary, congenital or degenerative, and has occurred after birth and results in a change in

neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder by the participant's physician or behavioral health practitioner in a treatment plan recommended by that physician or behavioral health practitioner are available for a covered participant. Individuals providing treatment prescribed under that plan must be:

- A health care practitioner:
  - Who is licensed, certified, or registered by an appropriate agency of the state of Texas;
  - Whose professional credential is recognized and accepted by an appropriate agency of the United States; or
  - Who is certified as a provider under the TRICARE military health system; or
- An individual acting under the supervision of a health care practitioner described in the above bullets.

For purposes of this section, generally recognized services may include services such as:

- Evaluation and assessment services;
- Screening at 18 and 24 months;
- Applied behavior analysis;
- Behavior training and behavior management;
- Speech therapy;
- Occupational therapy;
- Physical therapy; or
- Medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Benefits for Autism Spectrum Disorder will not apply towards any maximum indicated on your Schedule of Coverage.

Bariatric Surgery

Bariatric surgery is a covered expense when BCBS's Medical Policy guidelines for medical necessity are met:

- Presence of severe obesity for at least the last 24 months, with a Body Mass Index (BMI) exceeding 40, or a BMI greater than 35 with a severe co-morbidity,
- Growth is completed,
- Weight loss has been attempted in the past without successful long-term weight reduction, and
- A nutrition and exercise program is completed that meets BCBS's criteria.

One morbid obesity surgical procedure is covered during a two-year period beginning on the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

Behavioral Health Services

Benefits for eligible expenses for mental health care and treatment of serious mental illness are the same as for treatment of any other sickness.

Eligible expenses for a facility determined by the Claims Administrator to be a psychiatric day treatment facility, a crisis stabilization unit or facility, or a residential treatment center for children and adolescents, for medically necessary mental health care or treatment of a serious mental illness in lieu of inpatient hospital services will be considered inpatient hospital expenses.

Inpatient treatment for chemical dependency must be provided in a Chemical Dependency Treatment Center. However, treatment in a hospital for the medical management of acute life-threatening intoxication (toxicity) is an eligible expense.

Breast Reconstruction

Breast reconstruction is a covered expense if it is required as the result of a mastectomy.

Breast Reduction

Breast reduction is a covered expense if determined by BCBS to be medically necessary and medical criteria are met.

Breastfeeding Support, Services and Supplies

Cardiac or Pulmonary Rehabilitation Services

- Cardiac or pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure, or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician.
- Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.

Membership in health clubs and exercise equipment to use at home are **NOT** covered expenses.

Cardiovascular Disease, Early Detection Tests

Covered expenses include one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

- Computed tomography (CT) scanning measuring coronary artery calcifications; or
- Ultrasonography measuring carotid intima-media thickness and plaque

Tests are available to a covered individual who is (i) a male older than 45 and younger than 76, or (ii) a female older than 55 and younger than 76. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a hospital stay is otherwise medically necessary, based on your health status.

Chiropractic Treatment

Covered expenses include charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Benefits are limited to 25 visits per year. Any visits during which no physical treatment is rendered will not count toward the visit maximum.

Clinical Trials

Covered expenses include routine patient care costs provided in connection with a phase I, II, III or IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by one of the following:

- The Centers for Disease Control and Prevention of the U.S. Dept. of Health and Human Services
- The National Institutes of Health
- The U.S. Food and Drug Administration
- The U.S. Department of Defense
- The U.S. Department of Veteran Affairs
- An institutional review board of an institution that has an agreement with the Office for Human Research Protection of the U.S. Dept. of Health and Human Services

Benefits are not available for services that are part of the subject matter of the clinical trial and are customarily paid for by the research institution conducting the trial.

Cochlear Implants

Cochlear implants are covered expenses when medical criteria are met, as determined by BCBS.

Cosmetic, Reconstructive, or Plastic Surgery

Covered expenses include the following:

- Treatment for the correction of defects incurred in an accidental injury
- Treatment for reconstructive surgery following cancer surgery
- Surgery performed on a newborn child for treatment or correction of a congenital defect
- Surgery performed on a covered dependent child (other than a newborn) under age 19 for treatment or correction of a congenital defect other than conditions of the breast
- Services and supplies for reduction mammoplasty when medically necessary and in accordance with the medical policy guidelines of the Claims Administrator
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy
- Reconstructive surgery performed on a covered dependent child under age 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Dental Care (Accident/Injury)

Dental expenses are covered expenses under this medical plan only for:

- Covered oral surgery
- Services provided to a newborn child that are necessary for treatment or correction of a congenital defect
- Correction of damages caused solely by external, violent accidental injury to health, unrestored natural teeth, and supporting tissues, and limited to treatment provided within 24 months of the initial treatment. An injury sustained as a result of biting or chewing is not considered an accidental injury.

Diabetic Equipment, Supplies, and Education

Covered expenses include charges for the following services, supplies, equipment, and training for the treatment of insulin and non-insulin dependent diabetes and elevated blood glucose levels during pregnancy:

- Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind)
- Insulin pumps (both external and implantable) and associated supplies
- Repairs and necessary maintenance of insulin pumps, and rental fees for pumps during repair
- Podiatric appliances for prevention of complications of diabetes
- Diabetic management services and diabetic self-management training

Diabetes supplies, such as test strips, lancets, and glucagon emergency kits, are covered under the Prescription Drug program with Express Scripts.

Developmental Delays

Covered expenses include certain therapies for children under age three with developmental delays, when provided in accordance with an individualized family service plan, including occupational, physical, and speech therapy evaluations and services, and dietary or nutritional evaluations. The individualized family service plan must be submitted to the Claims Administrator prior to commencement of services. After age three, services may continue to be covered if otherwise available under this plan.

Diagnostic and Pre-operative Testing

Complex imaging: The plan covers charges made on an outpatient basis by a physician, hospital, or licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury or for pre-operative testing, including:

- CAT scans
- Magnetic resonance imaging (MRI)
- Positron emission tomography (PET) scans

Durable Medical Equipment (DME)

Covered expenses include rental of DME required for therapeutic use unless purchase of the equipment is required by the plan. DME does not include equipment primarily designed for alleviation of pain or provision of patient comfort, or home air fluidized bed therapy. Examples of equipment not considered for therapeutic use include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

Emergency Care

Covered expenses include charges for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficulty breathing, and suspected heart attack.

Note: If you visit a hospital emergency room for a non-emergency condition, as determined by BCBS, the plan will not cover the expenses.

BCBS Health Select (1500 – HSA Option) Plan Percentage Coinsurance for In-Network Services: 80% after deductible. Out-of-network treated same as in-network. BCBS Health Choice (3000 – CoPay Option) Plan Percentage Coinsurance for In-Network Services: 80% after $150 copay and deductible. Out-of-network treated same as in-network.

Enteral or Parenteral Nutrition

The following accessories, supplies, and prescription drugs for direct use with enteral or parenteral nutrition are covered expenses:

- IV solutions, heparin normal saline, and other injectable agents requiring a physician's prescription
- Catheters
- Nasogastric, jejunostomy, or gastrostomy tubes
- Filters
- Infusion bottles
- Infusion pumps
- IV poles
- Needles and syringes
- Volumetric monitors (parenteral nutrition only)
- Other necessary medical supplies that are provided and charged for by a home health agency or a home IV infusion company providing home hyperalimentation (i.e., parenteral nutrition)

Family Planning

Covered expenses include charges for certain contraceptive and family-planning services, even though not provided to treat an illness or injury.

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a physician, provided they have been approved by the FDA
- Associated office visits for injection of Depo Provera and Lunelle; diaphragm fitting; and cervical cap, IUD, and Norplant devices

- Related outpatient services, such as:
  - Consultations
  - Exams
  - Procedures
  - Other medical services and supplies

Covered expenses include charges for family-planning services, including:

- Voluntary sterilization
- Voluntary termination of pregnancy

The plan does *not* cover the reversal of voluntary sterilization procedures, including related follow-up care.

Foot Care

Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes, is a covered expense.

Hearing Exams

Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A physician certified as an otolaryngologist or otologist, or
- An audiologist who:
  - Is legally qualified in audiology, or
  - Holds a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements), and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan does not cover more than one hearing exam for any 24-month period for participants age 18 and over, or one exam in any 12-month period for participants younger than age 18, except as noted in the following sentence. The plan covers a screening test for hearing loss for infants from birth through age 30 days, and necessary diagnostic follow-up care related to the screening test from birth to age 24 months (deductible does not apply).

BCBS Plans Percentage Coinsurance for In-Network Services: 100% covered, deductible does not apply.

Home Health Care Expenses

Covered expenses include charges for home health care services when ordered by a physician as part of a home health plan and provided you are:

- Transitioning from a hospital or other inpatient facility, and the services are in lieu of a continued inpatient stay, or
- Homebound.

Covered expenses include:

- Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or a Licensed Vocational Nurse (L.V.N.)
- Part-time or intermittent home health aide services consisting primarily of caring for the patient
- Physical, occupational, speech, and respiratory therapy services by licensed therapists
- Supplies and equipment routinely provided by the home health agency

Benefits for home health care visits are payable up to a maximum of 120 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to four hours is one visit.

This 120-visit maximum will not apply to care given by an R.N. or L.P.N. when:

- Care is provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient, and
- Care is needed to transition from the hospital or skilled nursing facility to home care.

When the above criteria are not met, covered expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

Home health care needs to be precertified by BCBS.

Home Infusion Therapy

Covered expenses include charges for home infusion therapy, which is the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting, including:

- Drugs and IV solutions
- Pharmacy compounding and dispensing services
- All equipment and ancillary supplies required by the therapy
- Delivery services
- Patient and family education
- Nursing services

Over-the-counter products not requiring a physician's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included.

Hospice Expenses

Charges made in connection with a hospice care program that (i) is established and reviewed from time to time by a physician, (ii) is rendered by a licensed hospice agency, and (iii) is designed to provide palliative and supportive care to terminally ill persons and supportive care to their families, are covered expenses. A person is considered terminally ill if his or her prognosis is terminal within 12 months; the terminally ill person may continue to seek curative care while under hospice care. Inpatient and outpatient charges are covered. Room and board charges are limited to the semi-private room rate. Bereavement counseling and respite care are covered.

Covered expenses include charges made on an outpatient basis by a hospice care agency for:

- Part-time or intermittent nursing care by an R.N. or L.P.N., or home health aide services for up to eight hours a day
- Medical social services under the direction of a physician, including but not limited to assessment of your social, emotional, and medical needs, and your home and family situation; identification of available community resources; and assistance provided to you to obtain resources to meet your assessed needs
- Physical and occupational therapy
- Consultation or case management services by a physician
- Medical supplies
- Prescription drugs
- Dietary and psychological counseling

Charges made by the providers below if they are not an employee of a hospice care agency, and such agency retains responsibility for your care:

- A physician for a consultation or case management
- A physical or occupational therapist
- A home health care agency for:
    - Physical and occupational therapy
    - Part-time or intermittent home health aide services for your care up to eight hours a day
    - Medical supplies
    - Prescription drugs
    - Psychological and dietary counseling

Inpatient hospice care and home health care must be precertified by BCBS.

Covered hospice expenses do not include:

- Daily room and board charges over the semi-private room rate
- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling (This includes estate planning and the drafting of a will.)
- Homemaker or caretaker services (These are services that are not solely related to your care. These include, but are not limited to sitter or companion services for you or other family members, transportation, and maintenance of the house.)

Hospital Confinements

The following services and supplies are covered expenses while an inpatient at a hospital:

- Admission and other fees
- Hospital room and board in a semi-private room
- Inpatient surgery expenses
- Physician expenses
- Radiation therapy, radiological services, laboratory testing, and diagnostic services
- Prescription drugs administered in the hospital and intravenous preparations
- All other inpatient care
- Hospital intensive care unit expenses
- Hospital services and supplies
- Discharge planning

Private hospital rooms are generally covered expenses **ONLY** up to the highest semi-private room rate for that facility, unless a private room is required because of a contagious illness or immune system problem.

Inpatient hospital services require precertification by BCBS.

Infertility

"Infertility" is defined as the failure of a presumably healthy woman to conceive:

- For a woman under age 35, after one year or more of timed, unprotected coitus or 12 cycles of artificial insemination, or
- For a woman age 35 years or older, after six months or more of timed, unprotected coitus or six cycles of artificial insemination.

The diagnosis and surgical treatment of underlying causes of infertility in a physician's office or facility are covered expenses.

Assisted reproductive technologies, including artificial insemination, in-vitro fertilization, GIFT, and ZIFT are **NOT** covered expenses.

Injections

Injections received in a physician's office when no other health service is received (such as allergy and immunotherapy) are covered expenses.

Laboratory Expenses/Diagnostic Testing

Covered expenses include expenses for diagnostic services such as lab work, X-rays, and diagnostic testing performed in the physician's office, a free-standing facility, or a hospital.

Maternity Care Expenses

Covered expenses include charges made by a physician for pregnancy and childbirth services and supplies at the same level as any illness or injury, including prenatal visits, delivery, and postnatal visits.

Delivery at a hospital or licensed birthing center is covered.

Coverage for a hospital stay following a normal vaginal delivery will be 48 hours for both the mother (if a covered person) and the newborn child unless a shorter stay is agreed to by both the mother and her attending physician. Coverage for a hospital stay in connection with childbirth following a Cesarean section will be 96 hours for both the mother (if a covered person) and the newborn child unless a shorter stay is agreed to by both the mother and her attending physician.

Precertification should be obtained as soon as reasonably possible if an extended inpatient hospital stay is required.

Covered expenses include services and supplies provided for circumcision.

If the mother or newborn is discharged before the minimum hours of coverage, the plan provides coverage for postdelivery care for the mother and newborn in the mother's home, a healthcare provider's office or a health care facility. Postdelivery care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments, and includes parent education, assistance and training in breast-feeding and bottle feeding, and the performance of any necessary and appropriate clinical tests.

Morbid Obesity

Covered expenses include charges for medically necessary treatment of morbid obesity. Benefits are available for healthy diet counseling and obesity screening/counseling as preventive benefits.

Orthopedic Braces

Covered expenses include orthopedic appliances used to support, align, or hold body parts in a correct position, including crutches; rigid back, leg, or neck braces; casts for treatment of any part of the legs, arms, shoulders, hips, or back; special surgical and back corsets; and physician-prescribed, directed or applied dressings, bandages, trusses, and splints that are custom designed for the purpose of assisting the function of a joint.

Outpatient Hospital Expenses

Covered expenses include hospital charges made for covered services and supplies provided by the outpatient department of a hospital.

Outpatient Surgery

Charges made by a physician for performing a surgical procedure, including pre-operative and post-operative visits and consultation with another physician for a second opinion, are covered expenses.

Physical Medicine Services

Covered expenses include those modalities, procedures, tests, and measurements listed in the physician's Current Procedural Terminology Manual (Procedure Codes 97010-97799), and include but are not limited to physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

Physician Visits

Covered expenses include charges made by a physician during a visit to treat an illness or injury. The visit may be at the physician's office, in your home, in a hospital or other facility during your stay, or in an outpatient facility. Covered expenses also include:

- Immunizations for infectious disease, but not if solely for your employment or travel
- Allergy testing and allergy injections
- Charges made by the physician for supplies, radiological services, X-rays, and tests provided by the physician

Preventive Care Prescribed by Your Doctor

Both BCBS plans pay 100% of your and your dependents' in-network preventive care expenses. In-network preventive care expenses do not count toward your deductible or out-of-pocket maximum for a calendar year. Preventive care includes services designated in guidelines of the U.S. Preventive Services Task Force,

the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration, as required by regulations issued under the Patient Protection and Affordable Care Act. Covered services may change as these guidelines are modified.

Covered preventive services include routine physicals, immunizations, well-child care, cancer-screening mammograms, Pap smears, testing for HPV and cervical cancer, screening for prostate cancer and colorectal cancer, bone density testing, smoking cessation counseling services, healthy diet counseling, obesity screening/counseling, and women's preventive services, including contraception and contraceptive counseling, and breastfeeding support, supplies, and counseling. Some of these services are subject to frequency, age, and other eligibility requirements in order to be covered as preventive. For a current list of covered preventive care expenses, call BCBS at 1-888-588-2896.

If you obtain preventive care from an out-of-network provider, the plan pays 50% of the Allowable Amount after the deductible is met.

Prosthetic Appliances

Covered expenses include artificial devices such as limbs, eyes, braces, or similar prosthetic or orthopedic devices that replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Replacements necessary due to growth to maturity of the patient are covered.

Radiation Therapy

Covered expenses include charges for the treatment of illness by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

Routine Cancer Screenings

Covered expenses include charges incurred for routine cancer screening as follows:

- Routine mammogram for covered females
- Routine Pap smear
- Routine gynecological exam
- Routine fecal occult blood test
- Routine digital rectal exam and routine prostate specific antigen (PSA) test for covered males age 40 and older

The following tests are covered expenses if you are age 50 and older when recommended by your physician:

- Routine sigmoidoscopy for persons at average risk
- Routine double contrast barium enema (DCBE) for persons at average risk
- Routine colonoscopy for persons at average risk for colorectal cancer

BCBS Plans Percentage Coinsurance for In-Network Services: 100% covered, deductible does not apply.

Routine Physical Exams

Covered expenses include charges made by your physician for one routine physical exam every calendar year. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and includes:

- Radiological services, X-rays, lab, and other tests given in connection with the exam
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Centers for Disease Control and Prevention
- Testing for tuberculosis

Covered expenses for children from birth through age 18 also include an initial hospital check-up and well-child visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.

Currently this includes seven exams in the first 12 months of life, three exams between 13 and 24 months, three exams between 25 and 36 months and one exam per calendar year thereafter.

In-Network Services: 100% covered, deductible does not apply.

Skilled Nursing Facility or Convalescent Facility

Covered expenses include charges made by a skilled nursing facility or convalescent facility during your stay for services and supplies, including:

- All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or a Licensed Vocational Nurse (A.V.N.)
- Room and board and all routine services, supplies, and equipment provided by the skilled nursing facility
- Physical, occupational, speech, and respiratory therapy services by licensed therapists

A stay in a skilled nursing facility for treatment of any of the following is not covered:

- Senility
- Mental disorder, disease, or condition

Admission to a skilled nursing facility must be precertified by BCBS.

Surgery

Covered expenses include charges made by a physician for:

- Performing your surgical procedure
- Pre-operative and post-operative visits
- Consultation with another physician to obtain a second opinion prior to the surgery

Temporomandibular Joint Disorder (TMJ)

Services for the evaluation and treatment of TMJ that are medical in nature are covered expenses, including exams, X-rays, injections, anesthetics, physical therapy, and oral surgery. Appliances to treat TMJ are not covered under the medical plan.

Therapy: Cognitive, Physical, Occupational, and Speech Therapy

Inpatient rehabilitation benefits for the services listed will be paid as part of your inpatient hospital and skilled nursing facility benefits.

- Physical therapy is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy is expected to significantly improve, develop, or restore physical functions lost or impaired as a result of an acute illness, injury, or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy is expected to significantly improve, develop, or restore physical functions lost or impaired as a result of an acute illness, injury, or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy is expected to restore the speech function or correct a speech impairment resulting from illness or injury, or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words, and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A 60-visit limit per calendar year applies to physical therapy and occupational therapy combined, and a 30-visit limit per calendar year applies to speech therapy. A "visit" consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment and specifies frequency and duration, and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Therapy services provided in your home are covered if you are homebound; however, home visits for therapy count toward the home health care limit of 120 visits per year as well as the therapy limit.

Transplant Services

Organ and tissue transplants are covered expenses if all of the following conditions are met:

- The transplant procedure is not Experimental/Investigational in nature;
- Donated human organs or tissue or an FDA-approved artificial device are used;
- The recipient is a participant in the plan;
- The transplant procedure is precertified;
- The participant meets all of the criteria established by the Claims Administrator in pertinent written medical policies; and
- The participant meets all of the protocols established by the hospital in which the transplant is performed.

Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to, X-rays, laboratory testing, chemotherapy, radiation therapy, procurement of organs or tissues from a living or deceased donor, and complications arising from the transplant.

Benefits are provided for a recipient covered under the plan and a donor covered under the plan.

Covered expenses include services and supplies provided for the:

- Evaluation of organs or tissues, including, but not limited to, the determination of tissue matches
- Donor search and acceptability testing of potential live donors
- Removal of organs or tissues from living or deceased donors
- Transportation and short-term storage of donated organs or tissues
- Travel expenses for the recipient, not to exceed $10,000

No benefits are available for the following:

- Expenses related to maintenance of life of a donor for purposes of organ or tissue donation
- Living and/or travel expenses of the donor
- Purchase of the organ or tissue
- Organ or tissue (xenograft) obtained from another species

Refer to the "Medical Expenses Not Covered" section for transplant limitations and exclusions.

All transplant procedures need to be precertified by BCBS. Precertification of the transplant is required even if the patient is already a patient in a hospital under another precertification authorization.

Urgent Care Treatment

Covered expenses include charges made by an urgent care provider to evaluate and treat an urgent condition.

Your coverage includes:

- Use of urgent care facilities
- Physician's services
- Nursing staff services
- Radiologist and pathologist services

If you visit an urgent care provider, you will pay your deductible and coinsurance under the Health Select (1500 – HSA Option) Plan. Under the Health Choice (3000 – CoPay Option) Plan, you'll pay a copay in-network, and your deductible and coinsurance out-of-network.

Vision Care (Injury and Illness Only)

Only charges for tests and treatment because of an illness or injury are covered expenses.

Surgery that is intended to allow you to see better without eyeglasses and other vision correction, including radial keratotomy, laser, and other refractive eye surgery, are NOT covered expenses.

Walk-In Clinics

Immunizations and routine consults performed by nurse practitioners outside of traditional office visit settings are covered expenses. Walk-in clinics are in-network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries, and the administration of certain immunizations. They are not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a walk-in clinic.

MEDICAL EXPENSES NOT COVERED

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the "Covered Medical Expenses" section. The following are not covered:

- Acupressure and acupuncture therapy, including acupuncture used in lieu of anesthesia.
- Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Any charges in excess of the benefit, dollar, day, visit, or supply limits stated in this Summary.
- Any non-emergency charges incurred outside of the United States if you traveled to such location (i) to obtain prescription drugs, or supplies, even if otherwise covered under this plan, or (ii) such drugs or supplies are unavailable or illegal in the United States, or (iii) the purchase of such prescription drugs or supplies outside the United States is considered illegal.
- Applied behavioral analysis, the LEAP, TEACCH, Denver, and Rutgers programs.
- Behavioral health services:
    - Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of his or her training in that field.
    - Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, or caffeine or nicotine use.
    - Treatment of antisocial personality disorder.
    - Treatment of mental disorder, disease, condition, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally disordered, diseased, or conditioned individuals as provided by the plan.
- Blood, blood plasma, synthetic blood, blood products, or substitutes, including but not limited to, the provision of blood, other than blood-derived clotting factors. Any related services, including processing, storage, or replacement costs, and the services of blood donors, apheresis, or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.
- Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.
- Charges submitted for services by an unlicensed hospital, physician, or other provider, or not within the scope of the provider's license.
- Cosmetic services and plastic surgery: Any treatment, surgery (cosmetic or plastic), service, or supplies to alter, improve, or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons, including:

- Face lifts; body lifts; tummy tucks; liposuctions; removal of excess skin (unless determined by BCBS to be medically necessary and all requirements are met); removal or reduction of non-malignant moles, blemishes, or varicose veins; cosmetic eyelid surgery; and other surgical procedures
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments, or other treatments or supplies to alter the appearance or texture of the skin
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); however, removal of an implant will be covered when medically necessary
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy)
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices
- Surgery to correct gynecomastia
- Breast augmentation
- Otoplasty

- Costs for services resulting from the commission of, or attempt to commit, a felony by a covered person.
- Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counseling.
- Court ordered services, including those required as a condition of parole or release.
- Custodial care.
- Dental services: Any treatment, services, or supplies related to the care, filling, removal, or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:
  - Services of dentists, oral surgeons, dental hygienists, and orthodontists, including for an apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty, and fluoride and other substances to protect, clean, or alter the appearance of teeth
  - Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace, or reposition teeth
  - Non-surgical treatments to alter the bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter the bite or alignment

  This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and orthodontic cysts.

- Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, home test kits, splints, neck braces, compresses, and other devices not intended for reuse by another patient.
- Drugs, medications, and supplies (except for contraceptive drugs with a written prescription by a health care practitioner as described in the “Covered Medical Services” section), including:
  - Over-the-counter drugs, biological or chemical preparations, and supplies that may be obtained without a prescription, including vitamins
  - Any services related to the dispensing, injection, or application of a drug
  - Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States
  - Immunizations related to travel or work
  - Needles, syringes, and other injectable aids, except as covered for diabetic supplies
  - Drugs related to the treatment of non-covered expenses
  - Performance-enhancing steroids
  - Injectable drugs, if an alternative oral drug is available

- Outpatient prescription drugs
- Self-injectable prescription drugs and medications
- Any prescription drugs, injectables, or medications or supplies provided by the policyholder or through a third-party vendor contract with the contract holder
- Any expenses for prescription drugs and supplies covered under the Prescription Drug program will not be covered under this medical plan
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy

- Educational services, except as may be covered as a preventive service:
  - Any services or supplies related to education, training or retraining services, or testing, including: special education, remedial education, job training, and job hardening programs
  - Evaluation or treatment of learning disabilities; minimal brain dysfunction; developmental, learning and communication disorders; and behavioral disorders (including pervasive developmental disorders); and training or cognitive rehabilitation, regardless of the underlying cause
  - Services, treatment, and educational testing, and training related to behavioral (conduct) problems, learning disabilities, and delays in developing skills
- Experimental/Investigational drugs, devices, treatments, or procedures
- Facility charges for care services or supplies provided in:
  - Rest homes
  - Assisted living facilities
  - Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care
  - Health resorts
  - Spas, sanitariums
  - Infirmaries at schools, colleges, or camps
- Food items: Any food item, including infant formulas, nutritional supplements, vitamins (including prescription vitamins), medical foods, and other nutritional items, even if it is the sole source of nutrition, except as covered under Enteral or Parenteral Nutrition. The following are not covered:
  - Formulas and food products modified to be low protein for people with an inherited disease of amino acid and organic acid metabolism (unless coverage is mandated by law)
  - Infant formulas and baby foods
  - Regular grocery foods (e.g., meat, fruit, vegetables, etc.), including those that can be blended and used in enteral feeding systems
  - Refrigerated storage units
- Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve the comfort or appearance of toes, feet, or ankles, including:
  - Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain, or conditions caused by routine activities, such as walking, running, working, or wearing shoes
  - Arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments, and other equipment, devices, and supplies, even if required following a covered treatment of an illness or injury
- Growth/height: Any treatment, device, drug, service, or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones.
- Health examinations:
  - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - Required by any law of a government, or required for securing insurance or school admissions, or professional or other licenses;
  - Required to travel; attend a school, camp, or sporting event; or participate in a sport or other recreational activity; and

- Any special medical reports not directly related to treatment except when provided as part of a covered service.

- Hearing:
  - Any hearing service or supply that does not meet professionally accepted standards;
  - Hearing exams given during a stay in a hospital or other facility; and
  - Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers) or to enhance other forms of communication to compensate for hearing loss, or devices that simulate speech. However, Cochlear implants are covered per medical policy.
- Home and mobility: Any addition or alteration to a home, workplace, other environment, or vehicle and any related equipment or device, including:
  - Bathroom equipment, such as bathtub seats, benches, rails, and lifts
  - Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools
  - Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, massage devices, or over-bed tables
  - Equipment or supplies to aid sleeping or sitting, including non-hospital electric beds, water beds, air beds, pillows, sheets, blankets, warming or cooling devices, elevating chairs, bed tables, and reclining chairs
  - Equipment installed in your home, workplace, or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity, or temperature
  - Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring
  - Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury
  - Removal from your home, work site, or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests, or other potential sources of allergies or illness
  - Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device
- Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.
- Home uterine activity monitoring.
- Infertility: Except as specifically described in the “Covered Medical Expenses” section, any services, treatments, procedures, or supplies that are designed to enhance fertility or the likelihood of conception, including, but not limited to:
  - Drugs related to the treatment of non-covered benefits
  - Injectable infertility medications, including, but not limited to, menotropins, hCG, GnRH agonists, and IVIG
  - Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal
  - Procedures, services, and supplies to reverse voluntary sterilization;
  - Infertility services for females with FSH levels 19 or greater mIU/ml on day three of the menstrual cycle
  - The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers, gestational carriers, or surrogacy; donor egg retrieval or fees associated with donor egg programs, including, but not limited to, fees for laboratory tests
  - Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests), and any charges associated with a frozen embryo or egg transfer, including, but not limited to, thawing charges
  - Home ovulation predictor kits or home pregnancy tests
  - Ovulation induction and intrauterine insemination services if you are not fertile

- Maintenance care: Services or supplies furnished mainly to maintain, rather than to improve, a level of physical or mental function, or to provide a surrounding free from exposures that can worsen the person's physical or mental condition.
- Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.
- Miscellaneous charges for services or supplies, including:
    - Annual or other charges to be in a physician's practice
    - Charges to have preferred access to a physician's services, such as boutique or concierge physician practices
    - Cancelled or missed appointment charges or charges to complete claim forms
    - Charges the recipient has no legal obligation to pay, or charges that would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law), including:
        - Care in charitable institutions
        - Care for conditions related to current or previous military service
        - Care while in the custody of a governmental authority
        - Any care a public hospital or other facility is required to provide
        - Any care in a hospital or other facility owned or operated by any federal, state, or other governmental entity, except to the extent coverage is required by applicable laws
- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities).
- Non-medically necessary services, including, but not limited to, those treatments, services, prescription drugs, and supplies that are not medically necessary, as determined by BCBS, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended, or approved by your physician or other health care provider.
- Over-the-counter contraceptives for male use.
- Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including telephone; television; Internet; barber, beauty or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security, or other home services; and travel, transportation, living expenses, rest cures, or recreational or diversional therapy.
- Private duty nursing during your stay in a hospital, and outpatient private duty nursing services, except as specifically described under Home Health Care Expenses in the "Covered Medical Expenses" section.
- Sex change: Any treatment, drug, service, or supply related to changing sex or sexual characteristics, including:
    - Surgical procedures to alter the appearance or function of the body
    - Hormones and hormone therapy
    - Prosthetic devices
    - Medical or psychological counseling
- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law, or any household member.
- Services of a resident physician or intern rendered in that capacity.
- Services provided where there is no evidence of pathology, dysfunction, or disease, except as specifically provided in connection with covered routine care, cancer screenings, and preventive services.
- Sexual dysfunction/enhancement: Any treatment, drug, service, or supply to treat sexual dysfunction, enhance sexual performance, or increase sexual desire, including:
    - Surgery, drugs, implants, devices, or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
    - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the "Continuation of Coverage" section of the insurance contract.
- Services that are not covered under this plan.

- Services and supplies provided in connection with treatment or care that is not covered under the plan.
- Smoking: Any treatment, drug, service, or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence, or cravings, including counseling, hypnosis, and other therapies, and except as covered as preventive services.
- Speech therapy for treatment of developmental delays in speech development, except as specifically provided in the "Covered Medical Expenses" section (e.g., the plan does not cover therapy when used to improve speech skills that have not fully developed).
- Strength and performance: Services, devices, and supplies to enhance strength, physical condition, endurance, or physical performance, including:
    - Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching
    - Drugs or preparations to enhance strength, performance, or endurance
    - Treatments, services, and supplies to treat illnesses, injuries, or disabilities related to the use of performance-enhancing drugs or preparations
- Therapies for the treatment of delays in development are not covered, unless the developmental delay results from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-covered diagnoses include pervasive developmental disorders, Down's syndrome and cerebral palsy, as they are considered both developmental and/or chronic in nature.
- Therapies and tests: Any of the following treatments or procedures:
    - Aromatherapy
    - Carbon dioxide therapy
    - Gastric irrigation
    - Hair analysis
    - Megavitamin therapy
    - Primal therapy
    - Psychodrama
    - Purging
    - Rolfing
- The following are therapies and tests primarily excluded with the exception of minimal uses as approved by Blue Cross Blue Shield Medical Policy:
    - Sensory or auditory integration therapy
    - Sleep therapy
    - Thermograms and thermography
    - Bio-feedback and bioenergetic therapy
    - Computer-aided tomography (CAT) scanning of the entire body
    - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery
    - Chelation therapy (except for heavy metal poisoning)
    - Educational therapy
    - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds
    - Lovaas therapy
    - Massage therapy
    - Recreational therapy
- Transplant: The transplant coverage does not include charges for:
    - Outpatient drugs, including biomedicals and immunosuppressants not expressly related to an outpatient transplant occurrence
    - Services and supplies furnished to a donor when the recipient is not a covered person
    - Home infusion therapy after the transplant occurrence
    - Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness
    - Harvesting and/or storage of bone marrow, tissue, or stem cells without the expectation of transplantation within 12 months for an existing illness
    - Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified by BCBS

- Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services, except as described in the "Covered Medical Expenses" section.
- Unauthorized services, including any service obtained by or on behalf of a covered person without precertification by BCBS when required. This exclusion does not apply in a medical emergency or in an urgent care situation.
- Vision-related services and supplies, except as described in the "Covered Medical Expenses" section and except as may be covered as preventive services. The plan does not cover:
    - Anti-reflective coatings
    - Special supplies, such as non-prescription sunglasses and subnormal vision aids
    - A vision service or supply that does not meet professionally accepted standards
    - Tinting of eyeglass lenses
    - Special vision procedures, such as orthoptics, vision therapy, or vision training
    - Eye exams during your stay in a hospital or other facility for health care
    - Eye exams for contact lenses or their fitting
    - Eyeglasses, duplicate or spare eyeglasses or lenses, or frames
    - Replacement of lenses or frames that are lost, stolen, or broken
    - Acuity tests
    - Eye surgery for the correction of vision, including radial keratotomy, LASIK, and similar procedures
    - Services to treat errors of refraction
- Weight: Any treatment, drug, service, or supply intended to decrease or increase body weight, control weight, or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions, except as provided under Morbid Obesity in the "Covered Medical Expenses" section or as may be covered as preventive services, including but not limited to:
    - Liposuction, surgical procedures, medical treatments, weight control/loss programs, and other services and supplies that are primarily intended to treat, or are related to the treatment of, obesity, including morbid obesity
    - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants, and other medications
    - Counseling, coaching, training, hypnosis, or other forms of therapy
    - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy, or other forms of activity or activity enhancement
- Work-related: Any illness or injury related to employment or self-employment, including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state, or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational," regardless of cause.

BENEFIT VALUE ADVISOR

If you enroll in either of the BCBS medical plans, you may use the services of Benefit Value Advisor. You may contact a Benefit Value Advisor who will serve as your personal health care advisor by recommending doctors, finding service providers in the BCBS network, and answering questions about how your plan works and charges on your medical bills. The cost for procedures can vary significantly among providers, so contact a Benefit Value Advisor to get information and cost estimates for various medical services.

BLUE ACCESS FOR MEMBERS

You can manage your BCBS medical plan benefits online and access special health programs with Blue Access for Members℠, or BAM, BCBS's secure member website.

Register at www.bcbstx.com/7eleven, using the information on your member ID card. Then use BAM to:

- Find personalized information about your health care benefits and coverage
- Check the status of a claim and your claims history
- View and print Explanation of Benefits (EOB) forms
- Locate a physician or a hospital in the network
- Print a temporary member ID card or request a new one
- Get discounts through the Blue365 program
- Access 24/7, Special Beginnings (maternity program) and National Fitness Program and Blue 365, health information, and money-saving discounts

24/7 NURSELINE

The 24/7 Nurseline is a service staffed by trained registered nurses who are available 24 hours a day, seven days a week. Call 1-800-581-0368 to get answers to your questions.

MATERNITY MANAGEMENT PROGRAM

The Special Beginnings® Maternity Program offers education and support for expectant mothers and fathers. You can receive educational materials and access online resources, as well as ongoing contact with obstetrical nurses who provide prenatal risk assessment education and can coordinate care with your physician.

DISCOUNT PROGRAM FOR BCBS MEMBERS

As a participant in one of the BCBS medical plans, you are eligible for the Blue365℠ discount program, which provides discounts on products and programs, such as Nutrisystem®, TruHearing®, TruVision, Life Time Fitness®, and Complementary Alternative Medicine. For details, log on to BAM at www.bcbstx.com/7eleven. From there, click on My Coverage, and then the Discounts link. The discount programs are subject to change.

SUBROGATION AND REIMBURSEMENT

Definitions

As used throughout this section, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness, or condition. The term Responsible Party includes the liability insurer of such party or any insurance coverage.

For purposes of this section, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this section, the term "Covered Person" includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any Plan participant or person entitled to receive any benefits from the Plan.

Subrogation

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the Plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, from such payment, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury, or condition for which a Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person; the Covered Person's representative, or agent; the Responsible Party; the Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that the Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person that is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery, regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from *any* and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his/her agents shall provide all information requested by the Plan, the Claims Administrator, or its representative, including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights, or failure to reimburse the plan from any settlement or recovery obtained by the Covered Person, may result in the

termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan. The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The Plan reserves the right to notify Responsible Party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his/her present or future domicile.

CLAIMS PROCESS

In-Network Benefits

Claims for in-network provider expenses will be filed with BCBS directly by the in-network provider. BCBS will notify your Provider of the amount, if any, that the provider should bill you for the services (depending, for example, on whether you have reached your deductible or out-of-pocket maximum for the year).

Out-of-Network Benefits

You must generally pay the full cost of covered expenses procured from out-of-network providers and then file a claim for reimbursement of part or all of those expenses with BCBS. Claim forms are available at www.bcbstx.com/7eleven or by calling BCBS. You must complete, sign, and date the form, attach all original bills and prescription drug receipts for which you are claiming benefits, and mail your completed claim form with the attached bills and receipts to BCBS at the address on the claim form.

All claims should be reported promptly. A claim will not be accepted if filed later than 12 months after the date the expense was originally incurred, provided, however, that the Health Care Financing Administration shall have the time period required by law to seek recovery from BCBS when Medicare or TRICARE paid as the primary plan, but BCBS should have paid as the primary plan. Payment of approved claims usually occurs within four weeks. Contact BCBS at 1-888-588-2896 or at the following address if you have any questions about your claim:

Blue Cross and Blue Shield of Texas
Claims Division
P.O. Box 660044
Dallas, TX 75266-0044

Complaints

If you are dissatisfied with the service you receive from the plan or want to complain about a provider, you must write BCBS Customer Service. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. BCBS will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Claims Appeals

Claims appeals are handled by BCBS. For further details on the process, see the "Claims and Review Procedures" section later in this Summary. Send any appeal to BCBS at the address on the back of your ID card.

SPECIAL MEDICAL PROGRAM PROVISIONS

PATIENT PROTECTION DISCLOSURE

The Medical Programs generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the BCBS provider network and who is available to accept you or your family members. For more information on how to select a primary care provider and for a list of the participating primary care providers, visit the BCBS online provider directory at www.bcbstx.com/7eleven.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Medical Program or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in BCBS's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit the BCBS online provider directory at www.bcbstx.com/7eleven.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to provide a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphodemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the BCBS plans.

If you would like more information on WHCRA benefits, call BCBS at 1-888-588-2896.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Medical Programs provide benefits in accordance with the Newborns' and Mothers' Health Protection Act of 1996 (the "**Newborns' Act**") in connection with hospital stays for mothers and newborn children following delivery. The Newborns' Act provides that group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to fewer than 48 hours following a normal vaginal delivery or fewer than 96 hours following a Cesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. However, the Medical Programs may pay for a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

In accordance with the Mental Health Parity and Addiction Equity Act of 2008, mental health and substance abuse benefits are provided at the same level as medical and hospital benefits.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

In accordance with the Genetic Information Nondiscrimination Act of 2008 (GINA), the Medical Programs will not use or disclose protected genetic information for underwriting purposes. Genetic information means genetic tests for you or a family member (including a fetus or embryo), the manifestation of a disease or disorder in your family members, or any request for or receipt of genetic services, or participation in clinical research that includes genetic services, by you or a family member. This genetic

information cannot be used to determine enrollment, eligibility, pre-existing conditions, benefits, coverage, premiums, deductibles, or other cost sharing under a Medical Program.

HIPAA NONDISCRIMINATION

Federal law and the Medical Programs prohibit any discrimination in eligibility or cost of coverage because of one or more Health Status-Related Factors.

"**Health Status-Related Factors**" means the following factors: health status, medical condition (includes both mental and physical illnesses), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. "**Genetic Information**" is information about genes, gene products, and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

STATE PROGRAMS FOR PREMIUM ASSISTANCE

States may elect to offer premium assistance subsidies to eligible low-income children and their families for medical coverage like that offered under the Medical Programs. These subsidies may be provided as a reimbursement to the employee, or as a direct payment to the employer. To find out whether you may be eligible for such a subsidy, contact the 7-Eleven Benefit Service Center at 1-800-601-0711.

HEALTH INSURANCE MARKETPLACES

As a result of the Affordable Care Act, each state has a Health Insurance Marketplace where you can purchase medical coverage for yourself and your family. (The Marketplaces for some states are operated by the federal government.) If you are eligible for medical coverage from 7-Eleven, it is unlikely you will find a better price for coverage from the Marketplace, since 7-Eleven pays a portion of the cost of your coverage. If you are not eligible for medical coverage from 7-Eleven, or if your 7-Eleven coverage ends due to your termination of employment or other reason, you may purchase Marketplace coverage and you may be eligible for payment assistance. During the Marketplace enrollment process, you will learn if you're eligible for payment assistance. If you or a covered dependent loses 7-Eleven coverage and is eligible for COBRA continuation coverage, Marketplace coverage may be less costly for you than COBRA continuation coverage.

DENTAL PROGRAM

7-Eleven offers dental benefits to certain eligible full-time employees under the Dental Program. The Dental Program offers two types of dental coverage, a Preferred Provider Organization ("**PPO**") and a Dental Maintenance Organization ("**DMO**").

ELIGIBILITY

Who Is Eligible for Coverage?

Employees who are eligible for Company medical coverage (other than COBRA coverage) become eligible to participate in the Dental Program on the date they are eligible for Company medical coverage.

If you are a part-time employee, you are not eligible to participate in the Dental Program.

Dependents of eligible employees are also eligible to participate in the Dental Program.

You do not have to enroll in medical coverage to enroll in the Dental Program. You may choose only dental coverage.

Eligible dependents for purposes of the Dental Program include:

- Your lawful spouse,
- A child to age 26,
- An unmarried child of any age if he or she becomes disabled and is unable to earn a living.

Eligible children include your children by birth, stepchildren, foster children, legally adopted children, children who have been placed for adoption with you, and children for whom coverage has been court-ordered.

WHEN COVERAGE BECOMES EFFECTIVE

If you elect coverage under the Dental Program, your coverage will become effective on the first day of the month coinciding with or following the day that you (i) meet the eligibility requirements specified above and (ii) complete your enrollment in the Dental Program through the 7-Eleven Benefit Service Center. Coverage for any dependents that you enroll at the same time as you enroll yourself will be effective on the same day as your coverage.

You must initially enroll in (or decline) the Dental Program within 31 days of becoming eligible. Once you initially elect (or decline to elect) coverage under the Dental Program, you may make changes to that elected coverage only during the next Open Enrollment or in accordance with the Mid-Year Change rules, discussed near the beginning of this Summary.

PAYING FOR COVERAGE

You and 7-Eleven share the cost of the Dental Program. In general, you pay your share of your dental premiums through payroll deductions before most taxes are withheld. The cost of the coverage will depend on the coverage option you select and whether you elect to cover your dependents.

WHEN COVERAGE ENDS

Your and your dependents' coverage will terminate effective at 11:59 p.m. on the date that any of the following events occurs:

- Your employment with 7-Eleven terminates
- You stop making Dental Program premium payments
- You begin any leave of absence, except if you continue to make premium payments while on a disability, or an unpaid medical or FMLA leave of absence
- You no longer qualify for disability income benefits, for an unpaid medical leave of absence, or for an FMLA leave of absence, unless you return to Active Employment

- You or any covered dependent submits (or attempts to submit) a false, altered, forged, or fraudulent claim or document requesting benefits under any 7-Eleven benefit plan
- You or your dependents are no longer eligible under the Dental Program
- The Dental Program is terminated
- 7-Eleven no longer offers any dental coverage

Your dependents' coverage will also terminate at 11:59 p.m. on the date that they are no longer eligible dependents under the Dental Program or on the date they are no longer enrolled in the Dental Program.

Note: If you are a Texas resident and enrolled in the Aetna DMO, coverage for you and your covered dependents will end on the last day of the month in which your termination of employment occurs.

If you or any of your dependents loses coverage under the Dental Program, you or your dependents may be entitled to continue group health care coverage as provided in the "COBRA — Continuation of Group Health Program Coverage" section, later in this Summary.

DENTAL PROGRAM OPTIONS

The PPO option permits you to choose coverage from in-network or out-of-network providers. When you use in-network providers, your costs are generally lower. The DMO requires you to use participating dentists and facilities to receive any benefit. The benefits generally available under each option are summarized in the chart appearing in the "Dental Program Benefits" section that follows.

The Aetna DMO is currently available in the following areas: Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New York, Nevada, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

DENTAL PROGRAM BENEFITS

Feature	Aetna Dental PPO		Aetna DMO
	In-Network Provider	Out-of-Network Provider	In-Network Provider Only
Eligibility	Any eligible employee		Eligible employees who live in an area that offers this option
Calendar Year Deductible:			
Individual	$50		None
Family	$150		None
Preventive and Diagnostic Care	100% of covered expenses, no deductible	100% of the Recognized Charge for covered expenses, no deductible	100% in most cases
Basic Care	80% of covered expenses after deductible	80% of the Recognized Charge for covered expenses after deductible	Covered expenses require only a fixed copay as defined by a fee schedule
Major Care	50% of covered expenses after deductible	50% of the Recognized Charge for covered expenses after deductible	Covered expenses require only a fixed copay as defined by a fee schedule
Orthodontia	50% of covered expenses after deductible	50% of the Recognized Charge for covered expenses after deductible	Covered expenses require only a fixed copay as defined by a fee schedule
Orthodontia Lifetime Maximum	$2,000 per person		In most cases, no maximum – one treatment per lifetime

Feature	Aetna Dental PPO		Aetna DMO
	In-Network Provider	Out-of-Network Provider	In-Network Provider Only
Plan Year Maximum (excluding orthodontia)	$2,000 per person		No limit

COVERED DENTAL EXPENSES

Aetna Dental PPO

The Dental PPO covers dentists' charges for the services and supplies listed below that (for the condition being treated) are:

- Necessary,
- Customarily used nationwide, and
- Deemed by the dental profession to be appropriate. They must meet broadly accepted national standards of dental practice.

Services are covered only if they are listed on Aetna's Dental Care Schedule. Contact Aetna for more information on whether a proposed service is included on the Dental Care Schedule. Here is a list of covered dental expenses under the Dental PPO.

Preventive and Diagnostic Care

- Office visit during regular office hours for oral examination, routine comprehensive, or recall examination (limited to two visits every year)
- Office visit during regular office hours for oral examination or problem-focused examination (limited to two visits every year)
- Prophylaxis (cleaning) (limited to two treatments per year)
- Topical application of fluoride (limited to one course of treatment per year and to children under age 16)
- Sealants, per tooth (limited to one application every three rolling years for permanent molars only, and to children under age 16)
- Bitewing X-rays (limited to one set per year)
- Complete X-ray series, including bitewings if necessary, or panoramic film (limited to one set every three rolling years)
- Vertical bitewing X-rays (limited to one set every three rolling years)
- Space maintainers, fixed (unilateral or bilateral) or removable (unilateral or bilateral), including all adjustments within six months after installation

Basic Care — Visits and Exams

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit

Basic Care — X-ray and Pathology

- Periapical X-rays (single films) (up to 13)
- Intra-oral, occlusal view, maxillary, or mandibular
- Upper or lower jaw, extra-oral
- Biopsy and histopathologic examination of oral tissue

Basic Care — Oral Surgery

- Extractions
  - Exposed root or erupted tooth
  - Coronal remnants
  - Surgical removal of erupted tooth/root tip
- Impacted teeth (removal of tooth (soft tissue))
- Odontogenic cysts and neoplasms
  - Incision and drainage of abscess
  - Removal of odontogenic cyst or tumor
- Other surgical procedures
  - Alveoplasty, in conjunction with extractions — per quadrant
  - Alveoplasty, not in conjunction with extraction — per quadrant
  - Sialolithotomy: removal of salivary calculus
  - Closure of salivary fistula
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Transplantation of tooth or tooth bud
  - Closure of oral fistula or maxillary sinus
  - Sequestrectomy
  - Crown exposure to aid eruption
  - Removal of foreign body from soft tissue
  - Frenectomy
  - Suture of soft tissue injury

Basic Care — Periodontics

- Occlusal adjustment (other than with an appliance or by restoration)
- Root planing and scaling — per quadrant (limited to four separate quadrants every two rolling years)
- Root planing and scaling — one to three teeth per quadrant (limited to once per site every two rolling years)
- Gingivectomy — per quadrant (limited to one per quadrant every three rolling years)
- Gingivectomy — one to three teeth per quadrant (limited to one per site every three rolling years)
- Gingival flap procedure, per quadrant (limited to one per quadrant every three rolling years)
- Gingival flap procedure — one to three teeth per quadrant (limited to one per site every three rolling years)
- Periodontal maintenance procedures following active therapy (limited to two per year)
- Full mouth debridement (once per lifetime)
- Localized delivery of chemotherapeutic agents

Basic Care — Endodontics

- Pulp capping
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy, including necessary X-rays
  - Anterior
  - Bicuspid

Basic Care — Restorative Dentistry

Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in one surface will be considered as a single restoration.)

- Amalgam restorations
- Resin restorations
- Sedative fillings

- Pins
  - Pin retention — per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  - Prefabricated stainless steel
  - Prefabricated resin crown (excluding temporary crowns)
- Recementation
  - Inlay
  - Crown
  - Bridge

Major Care — Oral Surgery

- Impacted teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)

Major Care — Periodontics

- Osseous surgery (including flap entry and closure) — per quadrant (limited to one per quadrant, every three rolling years)
- Osseous surgery (including flap entry and closure) — one to three teeth per quadrant (limited to one per site, every three rolling years)
- Soft tissue graft procedures

Major Care — Endodontics

- Root canal therapy, including necessary X-rays
  - Molar

Major Care — Restorative

Cast or processed restorations and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.

- Inlays/onlays — metallic or porcelain/ceramic
  - Inlay, one or more surfaces
  - Onlay, two or more surfaces
- Inlays/onlays — resin-based composite
  - Inlay, one or more surfaces
  - Onlay, two or more surfaces
- Labial veneers
  - Laminate — chairside
  - Resin laminate — laboratory
  - Porcelain laminate — laboratory
- Crowns
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - Metallic (3/4 cast)
- Post and core
- Core build-ups (including pins)
- Clinical crown lengthening (hard tissue)
- Endosteal implants

Major Care — Prosthodontics

Coverage for the first installation of removable dentures, fixed bridgework, and other prosthetic services is subject to the requirements that such services are (1) needed to replace one or more natural teeth that were removed while you were covered by the Dental Program (except for congenitally missing teeth), and (2) are not abutments to a partial denture, removable bridge or fixed bridge installed during the prior eight years.

- Bridge abutments (see Inlays/Onlays and Crowns)
- Pontics
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
- Resin with base metal
- Removable bridge (unilateral)
  - One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
- Dentures and partials (fees for dentures and partial dentures include relines, rebases, and adjustments within six months after installation; specialized techniques and characterizations are not eligible)
  - Complete upper denture
  - Complete lower denture
  - Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
  - Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests, and teeth)
  - Stress breakers
  - Interim partial denture (stayplate), anterior only
  - Office reline
  - Laboratory reline
  - Special tissue conditioning, per denture
  - Rebase, per denture
  - Adjustment to denture more than six months after installation
- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth
- Adding teeth to existing partial denture
  - Each tooth
  - Each clasp
- Repairs of crowns and bridges
- Occlusal guard, for bruxism only (limited to one every three rolling years)
- General anesthesia and intravenous sedation (only when provided in conjunction with a covered surgical procedure and/or medically necessary)

Orthodontics

- Comprehensive orthodontic treatment
- Post-treatment stabilization
- Removable inhibiting appliance to correct thumbsucking
- Fixed or cemented inhibiting appliance to correct thumbsucking
- Limited orthodontic treatment (with a limited objective)
- Interceptive orthodontic treatment

SPECIAL ORTHODONTIC PROVISIONS

Orthodontic treatment is any medical or dental service or supply furnished to prevent or to diagnose or to correct a misalignment of the teeth, the bite or the jaws, or a jaw joint relationship, whether or not for the purpose of relieving pain. Orthodontic treatment does not include the installation of a space maintainer or a surgical procedure to correct malocclusion.

Orthodontic benefits will not exceed the Orthodontic Maximum for all expenses incurred by a family member in his or her lifetime, even if there is a break in coverage. Coverage is not provided for any charges for an orthodontic procedure if an active appliance for that procedure has been installed before the first day on which the person became covered for the benefit. In addition, coverage is not provided for any charges for an orthodontic procedure for which an active appliance is installed within the two years starting with the date the person became covered for the benefit. (This applies only to a person who does not become covered by the 31st day after the first day the person is eligible to become covered.)

AETNA DMO

To request a fee schedule showing the copays you will be required to make in connection with various covered expenses, call the 7-Eleven Benefit Service Center at 1-800-601-0711 and speak with a Benefit Service Representative.

ALTERNATE TREATMENT

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the Dental Program's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the difference in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what the Dental Program will cover.

EXPENSES NOT COVERED

The following list of excluded dental expenses is not exhaustive, and the two options have slightly different excluded expenses. If you do not find an expense listed in "Covered Dental Expenses," above, call Aetna ahead of time to make sure contemplated expenses are covered by the Dental Program. However, the following expenses are generally **NOT** covered under any part of the Dental Program, or under any other plan of group benefits provided by the contract holder, in addition to any treatment, service, or supply not shown under "Covered Dental Expenses."

- Crowns, bridges, or dentures that are replaced within eight years of the original installation date (unless you are in the Aetna DMO)
- Cast restoration for teeth that could be restored by other means (such as amalgam, silicate, or composite fillings), periodontal splinting, or changes in vertical dimension
- Charges covered by workers' compensation or similar law
- Charges for orthodontic appliances, including bands or braces, installed before your effective date of coverage
- Charges in excess of Recognized Charges
- Charges made by a hospital that performs services for the U.S. government if the charges are directly related to a condition connected to military service
- Charges that the person is not legally required to pay
- General anesthesia and intravenous sedation, unless done in conjunction with another necessary covered service
- Items or treatment not medically necessary or more intensive than medically necessary

- Medical services such as those eligible for coverage under the 7-Eleven Medical Programs or HMOs
- Procedures, appliances, or restorations (other than full dentures) whose main purposes is to change vertical dimension, diagnose or treat TMJ, stabilize periodontally involved teeth, or restore occlusion
- Replacement of lost or stolen appliance
- Services or supplies that are Experimental/Investigational and not recognized by Aetna as accepted dental practice (or any requiring United States government approval not yet granted)
- Services or supplies received by someone whose coverage has ended. However, ordered inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures, fixed bridgework, and root canals will be covered when ordered if the item is installed or delivered no later than 30 days after coverage terminates
- Services or supplies received for dental disease or defect resulting from an act of war, declared or undeclared
- Services performed solely for cosmetic purposes
- Surgical removal of impacted wisdom teeth only for orthodontic reasons, except as specifically provided
- Services or supplies provided in connection with treatment or care that is not covered under the plan

ADVANCE CLAIM REVIEW

Before starting a course of treatment for which a dentist's charges are expected to be $200 or more, you should obtain an estimate of the benefits from Aetna (called Advance Claim Review) by calling 1-877-238-6200. Details of the proposed treatment should be submitted to Aetna by the dentist. Aetna must be given all the diagnostic and evaluative material it requires, including X-rays, models, charts, and written reports.

An Advance Claim Review is not required for oral exams, prophylaxis, X-rays, and treatment of any traumatic injury or condition that:

- Occurs unexpectedly,
- Requires immediate diagnosis and treatment, and
- Is characterized by symptoms such as severe pain.

If an Advance Claim Review is not obtained, the benefits for the course of treatment may be reduced by the amount of Covered Dental Expenses Aetna cannot verify.

CLAIMS PROCESS

In-Network Benefits

Claims for the covered portion of in-network provider expenses under the Dental PPO and for expenses under the Aetna DMO will be filed with Aetna directly by the providers, but you should pay your share of the bill for the dental expenses at the time the services are provided. In the case of the Aetna DMO, your share of the bill will be the copay, if any, that you owe for the particular service received. To request a fee schedule with the copays you pay for various services, call the 7-Eleven Benefit Service Center at 1-800-601-0711.

Out-of-Network PPO Benefits

You must pay your portion of the cost of covered expenses procured from out-of-network providers and then file a claim for the covered portion of those expenses with Aetna. Claim forms are available at www.aetna.com/docfind or by calling Aetna at 1-877-238-6200. Take the claim form with you to your appointment. A separate claim form must be completed for each covered person claiming expenses. You must complete, sign, and date Part I of the claim form; attach an itemized bill for which you are claiming benefits or have your dental provider complete Part II of the claim form; and mail your completed claim form with the attached bills and receipts to Aetna at the following address:

Aetna Dental Claims Center
P.O. Box 14094
Lexington, KY 40512-4094

All claims should be reported promptly. A claim will not be accepted if filed later than 27 months after the date the expense was originally incurred. Contact Aetna at 1-877-238-6200 if you have any questions about your claim.

Claims Appeals

Claims appeals are handled by Aetna. For further details on this process, see the section entitled "Claims and Review Procedures" later in this Summary. Send any appeal to Aetna at the following address:

Aetna Dental Claims Center
P.O. Box 14597
Lexington, KY 40512-4597

VISION PROGRAM

7-Eleven offers the Vision Program to certain eligible employees through VSP. The Vision Program provides coverage for vision examinations, eyeglasses, lenses and frames, and contact lenses through a network of vision care providers, which allows you to receive a greater benefit when you use an in-network provider.

ELIGIBILITY

Who Is Eligible for Coverage?

Employees who are eligible for Company medical coverage (other than COBRA coverage) become eligible to participate in the Vision Program on the date they are eligible for Company medical coverage.

If you are a part-time employee, you are NOT eligible for the Vision Program. Eligible dependents for purposes of the Vision Program include:

- Your lawful spouse
- A child to age 26
- An unmarried child of any age if he or she becomes disabled and is unable to earn a living

Eligible children include your children by birth, stepchildren, foster children, legally adopted children, children who have been placed for adoption with you, and children for whom coverage has been court-ordered.

WHEN COVERAGE BECOMES EFFECTIVE

Vision Program coverage becomes effective on the first day of the month following the month in which you become eligible for vision benefits. If you do not enroll when first eligible, you must wait until the next Open Enrollment, unless you meet one of the limited Mid-Year Change exceptions described near the beginning of this Summary.

PAYING FOR COVERAGE

You pay the full cost of the Vision Program, and your vision premium is paid in addition to any medical premiums that you pay. You generally pay your vision premiums through pre-tax deductions.

WHEN COVERAGE ENDS

Vision Program coverage for you and any covered dependents will end at 11:59 p.m. on the date that any one of the following events occurs:

- Your employment with 7-Eleven terminates
- You stop making Vision Program premium payments
- You begin any leave of absence, except if you continue to make premium payments while on a disability, unpaid medical, military, or an FMLA leave of absence
- You or any covered dependent submits (or attempts to submit) a false, altered, forged, or fraudulent claim or document requesting benefits under any 7-Eleven Program
- You are no longer eligible under the Vision Program
- The Vision Program is terminated
- 7-Eleven no longer offers any vision coverage

Your dependents' coverage will also terminate at 11:59 p.m. on the date that they are no longer eligible dependents under the Vision Program or on the date they are no longer enrolled as dependents under the Vision Program. For dependents who reach the age of 26, coverage will end on the last day of the month in which they turn 26.

If you or any of your dependents lose coverage under the Vision Program, you or your dependents may be entitled to continue group health care coverage as provided in the "COBRA — Continuation of Group Health Program Coverage" section, later in this Summary.

If you received vision services or supplies before your coverage actually ended, those expenses will be

covered as usual, but those expenses must have been incurred before your coverage ended.

VISION OPTIONS

For purposes of the Vision Program, an "**in-network provider**" is an optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials to participants of the Vision Program. For purposes of the Vision Program, an "**out-of-network provider**" is any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to participants of the Vision Program.

When you use an in-network provider, you pay a small copay. Your benefits will generally be higher if you use an in-network provider. If you select a doctor who is an out-of-network provider, you still receive benefits, but at a lower level. The Claims Administrator will automatically provide you with a list of in-network providers, free of charge, when you are enrolled in the Vision Program. You also may access the list of in-network providers at anytime on VSP's website, www.vsp.com, or by calling VSP's Customer Service Department at 1-800-877-7195.

A "**Benefit Authorization**" **MUST** be obtained before you receive benefits from an in-network provider. Covered persons should identify themselves as covered by VSP when making an appointment with an in-network provider so that the in-network provider can obtain a Benefit Authorization from VSP. If services are received from an in-network provider without a prior Benefit Authorization, the benefits available for those services will be payable as if the services had been received from an out-of-network provider.

VISION BENEFITS

The Vision Program helps you with the cost of eye exams and corrective lenses. After you pay the copay, the Vision Program generally pays 100% of the following expenses when you use an in-network provider. If you obtain services from an out-of-network provider, you will be reimbursed up to the maximum amounts for each service shown in the chart below.

If you prefer contact lenses, the Vision Program will pay toward the cost of your contacts. If you elect contact lenses, you cannot receive coverage for eyeglasses in the same year you buy contact lenses.

The following chart lists the vision care services and materials reimbursable under the Vision Program, including the in-network provider benefit rate of coverage and the out-of-network provider benefit rate of coverage.

VSP Vision Program	In-Network Provider Benefit*	Out-of-Network Provider Benefit
Annual Eye Examination	$10 copay, then covered in full*	Reimbursed up to VSP's $50 maximum*
Corrective Lenses and Frames every calendar year; provided that you pay a separate copay for each pair**		
Single Vision	$25 copay, then covered in full*	Reimbursed up to VSP's $50 maximum*
Bifocal	$25 copay, then covered in full*	Reimbursed up to VSP's $75 maximum*
Lenticular	$25 copay, then covered in full*	Reimbursed up to VSP's $125 maximum*
Trifocal	$25 copay, then covered in full*	Reimbursed up to VSP's $100 maximum*
Frames	$25 copay, then covered in full up to the $170 allowance (20% off any amount over the allowance*)	Reimbursed up to VSP's $70 maximum

VSP Vision Program	In-Network Provider Benefit*	Out-of-Network Provider Benefit
Tints, Polycarbonate Lenses (children only), and UV Coatings	Covered in full	Not covered
All Other Lens Options (such as photochromic lenses, progressives and scratch resistant coating)	Discounted by an average of 35%-40%	Not covered
Contact Lenses in lieu of lenses and frame; every calendar year provided that you pay a separate copay where applicable		
Visually Necessary (professional fees and materials)	$25 copay, then covered in full	Reimbursed up to VSP's $210 maximum
Elective (professional fees and materials)	Covered in full up to the $160 allowance for materials Plus 15% discount on the contact lens exam (fitting and evaluation) that will not exceed $60	Reimbursed up to VSP's $160 maximum
Laser Vision Correction Surgery	$600 allowance ($300 per eye) once per lifetime	$540 allowance ($270 per eye) once per lifetime

*All benefits are after applicable copay. Only one copay is charged for corrective lenses and frames if purchased together.

**VSP providers offer a selection of standard eyeglass frames for which you pay no more than a $25 copay. Please talk to your in-network provider about which frames are included in the cost of your Vision Program copay. Designer frames or non-standard frames will require an additional payment for the difference in cost.

COVERED VISION EXPENSES

Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether in-network providers or out-of-network providers.

Eye Examination

The Vision Program covers your initial vision examination as well as subsequent regular eye examinations available every calendar year by paying 100% of the cost of the exam after a $10 copay for in-network providers. The Vision Program pays up to

$50 of the cost of the exam for out-of-network providers. Examination procedures include:

- **Intermediate Examination:** brief or limited routine check-up or vision survey
- **Vision Analysis:** various tests for prescription lenses
- **Tonometry:** measurement of eye tension for glaucoma
- **Biomicroscopy:** examination of the living eye tissue
- **Central Field Study:** measurement of visual acuity in the central field of vision
- **Peripheral Field Study:** measurement of visual acuity in the peripheral field of vision

Corrective Lenses and Frames

Corrective lenses and frames are available every calendar year provided that you pay a separate $25 copay for each pair of corrective lenses and frames obtained from an in-network provider. You will only pay one copay if you purchase corrective lenses and frames together. If you obtain corrective lenses and frames from an out-of-network provider, the Vision Program will pay up to $50 for single vision lenses, up to $75 for bifocal lenses, up to $100 for trifocal lenses, up to $125 for lenticular lenses, and up to $70 for frames. In addition, if you obtain corrective lenses from an in-network provider, the Vision Program will cover 100% of the cost of lens upgrades for employees and dependents such as tints and UV coatings. Polycarbonate lenses are covered for children only. The Vision Program will not cover these costs if the corrective lenses are obtained from an out-of-network provider.

You may choose contact lenses in lieu of corrective lenses and frames according to the terms provided below. This benefit includes all types of contact lenses, including disposable lenses.

The corrective lenses and frame benefit includes professional services such as:

- Prescribing and ordering proper lenses
- Assistance in the selection of a frame
- Verifying the accuracy of finished lenses
- Proper fitting and adjustment of a frame
- Subsequent adjustments to a frame to maintain comfort and efficiency
- Progress or follow-up work as Visually Necessary

Elective Contact Lenses

If the contact lenses are deemed elective, the Vision Program will cover up to $160 of the cost of contact lenses obtained from an in-network provider or an out-of-network provider should you elect to purchase contact lenses instead of traditional corrective lenses and frames.

Visually Necessary Contact Lenses

Visually Necessary contact lenses together with necessary professional services will be provided only under one of the following circumstances:

- After cataract surgery
- To correct extreme visual acuity problems that cannot be corrected with spectacle (eyeglass) lenses
- Certain conditions of anisometropia
- Keratoconus

"**Visually Necessary**" means that the contact lenses are necessary to restore or maintain a patient's visual acuity and health and there is no less expensive, professionally acceptable alternative, as determined by VSP. If the contact lenses are deemed necessary by VSP, the Vision Program will cover 100% of the cost of the contact lenses after a $25 copay if the contacts are obtained from an in-network provider. The Vision Program pays up to $210 toward the cost of the contacts if the contacts are obtained from an out-of-network provider.

Low Vision Benefits

If a participant has severe visual problems that are not correctable with regular lenses, the following benefits are available (subject to prior approval by VSP):

Procedure	In-Network Provider Benefit	Out-of-Network Provider Benefit
Supplementary Testing	Covered in full	Up to $125
	"**Supplementary Testing**" includes complete low vision analysis and diagnosis, including a comprehensive examination of visual functions and the prescription of corrective eyewear or vision aids where indicated.	
Supplemental Care Aids	75% of cost	75% of cost
	Subsequent low vision aids as Visually Necessary.	
Benefit Maximum	The maximum benefit available is $1,000 (excluding the 25% coinsurance for Supplemental Care Aids) every 2 years.	

EXPENSES NOT COVERED

- Extra costs for cosmetic visual needs. When you select any of the following, the Vision Program will pay the basic cost of the allowed lenses, and you will pay the additional costs for the following options:
  - Blended lenses
  - Contact lenses (except as noted elsewhere herein)
  - Oversize lenses
  - Progressive (no line) multifocal lenses
  - Photochromic lenses
  - The coating of the lens or lenses
  - The laminating of the lens or lenses
  - A frame that costs more than the Vision Program allowance
  - The limitations specified on low vision care
  - Cosmetic lenses
  - Optional cosmetic processes
- Professional services or materials connected with:
  - Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a +/-.50 diopter power) or two pairs of glasses in lieu of bifocals
  - Replacement of lenses and frames furnished under the Vision Program that are lost or broken except at the normal intervals when services are otherwise available
  - Medical or surgical treatment of eyes, except through an in-network provider as described in this Summary
  - Corrective vision services, treatments, or materials of an Experimental/Investigational nature, meaning that the procedure or lens is not used universally or accepted by the vision care profession, as determined by VSP

CLAIMS PROCESS

You may select any licensed vision care provider for services. If you use an out-of-network provider, your reimbursement schedule does not guarantee full payment.

In-Network Provider

Remember to get a Benefit Authorization before your appointment. At your appointment, the in-network provider will provide you with an eye examination and determine if eyewear is Visually Necessary. If so, the in-network provider will coordinate the prescription with a VSP-approved contract laboratory. The in-network provider will itemize any non-covered expenses and have you sign a form to document that you received services. VSP will pay the in-network provider directly for covered expenses.

You are responsible for paying the doctor a copay for the eye examination and lenses and/or frames. You are responsible for any additional costs resulting from cosmetic options, non-standard frames, cosmetic visual needs, or non-covered expenses you have selected. Selecting an in-network provider from VSP's network assures direct payment to the doctor and enhances quality services and materials.

Out-of-Network Provider Services

To receive benefits for an out-of-network provider, pay the out-of-network provider the full amount of the bill and request a copy of the bill that shows the cost of the eye examination. Send a copy of the itemized bill(s) to VSP. You may submit the claim online through vsp.com or by mail at the address below. The following information **must** also be included in your documentation for you to receive reimbursement:

- Your name and mailing address
- Your identification number (usually the last four digits of your Social Security number)
- Your employer or group name
- Patient's name, relationship to you, and date of birth

You may submit the above information on any generic insurance claim form available from your out-of-network provider upon request. Mail the itemized bill(s) and form to VSP at the following address:

VSP
P.O. Box 385018
Birmingham, AL 35238-0518

Claims for reimbursement must be filed within 12 months of the date services were completed. If approved, claim payment usually occurs within two weeks.

Claims Appeals

If you disagree about your eligibility for or the amount of your benefit, first either:

Call VSP toll-free at 1-800-877-7195
Or write to VSP at: VSP
3333 Quality Drive Rancho Cordova, CA 95670

For more information regarding the appeal of denied claims, please refer to the "Claims and Review Procedures" section later in this Summary.

SPECIAL GROUP HEALTH PROGRAM PROVISIONS

FAMILY AND MEDICAL LEAVE

In accordance with the Family and Medical Leave Act of 1993, as amended ("**FMLA**"), medical coverage under the Medical Programs, Dental Programs and Vision Program (collectively, the "Group Health Programs") will be continued during an approved leave.

If you take a paid leave under FMLA, your coverage will continue (and you will continue to pay for it) as before the leave. If you take an unpaid leave under FMLA, the following terms and conditions will apply when you resume employment, to the extent required by applicable federal law.

You may revoke or change an election you elected prior to your FMLA leave regarding your coverage under the applicable Group Health Programs (or any other Program subject to FMLA).

Subject to the requirements in the next paragraph, you may reinstate coverage on the same terms in effect prior to the FMLA leave, subject to any changes or amendments in such Program that became effective during the FMLA leave.

To retain coverage under the applicable Group Health Programs (or any other Program subject to FMLA), you must pay your portion of the costs of coverage as they come due during the FMLA leave (on an after-tax basis). Other options for paying your portion may be available in special circumstances.

If coverage under an applicable Group Health Program lapses, you will not be reimbursed for claims that were incurred after the lapse and prior to the reinstatement of coverage.

If you miss payments for coverage during FMLA Leave, your coverage will be terminated effective as of the last date for which you have paid for coverage.

MILITARY LEAVE

The Uniformed Services Employment and Reemployment Rights Act of 1994 (**"USERRA**") provides that upon notification by the employee/service member to the employer of pending uniformed service, an employer who provides the employee health plan coverage, including the Group Health Programs, must allow the employee/service member to elect to continue personal coverage and coverage for his or her dependents.

The maximum period of coverage of an employee/service member and his or her covered dependents under such an election shall be the lesser of:

- The 24-month period beginning on the date on which the employee/service member's absence begins; or
- The day after the date the employee/service member was required to apply for (or return to) employment as specified in section 4312(e) of USERRA.

An employee or covered dependent who elects to continue health plan coverage may be required to pay up to 102% of the full premium under the applicable Group Health Programs, except a person on active duty for 30 days or fewer cannot be required to pay more than the employee's share, if any, for the coverage. Your payment options are the same as for FMLA leave, above.

An employee, who applies for reemployment within the time limit specified under USERRA, will have coverage under the applicable Group Health Programs reinstated for the employee and his or her dependents. An exclusion or waiting period 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 or waiting period 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.

HIPAA PRIVACY

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") as amended by relevant provisions of the American Recovery and Reinvestment Act (ARRA), requires health plans to protect the confidentiality of your private health information. More detailed information is given in the notices of HIPAA privacy rights from the Plan Administrator, Aetna, and VSP, as applicable. You may request a copy of the privacy notices by contacting the 7-Eleven Benefit Service Center at 1-800-601-0711.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Dependent coverage will be provided to the extent required by a Qualified Medical Child Support Order ("**QMCSO**") if you continue to meet the eligibility requirements of the applicable Group Health Programs. A QMCSO is a court order, administrative notice, or a National Medical Child Support Order (as defined by ERISA) requiring the applicable Group Health Programs and you to provide health coverage for your child. No order or notice will be followed unless and until it is determined by the Plan Administrator to be a QMCSO. Any payment for benefits made by a Group Health Program pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian. If you need additional information concerning QMCSOs, please contact the Plan Administrator for a copy of the Group Health Programs' QMCSO procedures, which will be furnished to you free of charge.

MEDICAID AND TRICARE

The Group Health Programs will not take into account your eligibility or your dependents' eligibility for medical assistance or benefits payable under Medicaid (42 U.S.C. §1396, et seq.). The Group Health Programs will not provide financial or other incentives for TRICARE-eligible persons not to enroll (or to terminate enrollment) under a Group Health Program that would be the primary plan. Employees who are eligible for TRICARE will have the same opportunities to elect to participate in a Group Health Program and to receive the same primary coverage under that program as do similarly situated employees who are not eligible for TRICARE.

COBRA — CONTINUATION OF GROUP HEALTH PROGRAM COVERAGE

Qualified beneficiaries who lose medical, dental or vision coverage because of a qualifying event may have the option to continue that coverage through COBRA. Alternatively, for a loss of medical coverage, they may wish to consider choosing medical coverage through the new health insurance marketplace or exchanges offered under the Affordable Care Act.

Option to Continue Coverage

The option of electing COBRA Continuation Coverage must be offered during a period beginning no later than when the individual would otherwise lose coverage under the applicable Group Health Programs because of a qualifying event (the termination date), and ending 60 days after the later of:

- The date the individual is notified of his or her COBRA Continuation Coverage rights by the employer, or
- The date on which coverage terminates under the applicable Group Health Program.

Any election by a qualified beneficiary (other than a dependent child) is considered an election by other qualified beneficiaries who would otherwise lose coverage by reason of the same qualifying event. Therefore, a spouse or former spouse who is a qualified beneficiary under one or more of the Group Health Programs may elect COBRA Continuation Coverage on his or her own behalf and on behalf of qualified dependent children.

COBRA Continuation Coverage may not be conditioned (directly or indirectly) upon the insurability of the qualified beneficiary.

If you are an individual who qualifies for trade assistance under the Trade Act of 2002, you may be entitled to a second COBRA election period. Please contact the Plan Administrator if you need more information about this.

Qualifying Events

"**Qualifying events**" include the:

- Death of the covered employee (which qualifies only the covered surviving dependents);
- Termination of employment of the covered employee other than by reason of the employee's gross misconduct;
- Reduction of hours of the covered employee to less than the minimum required to meet eligible status;
- Divorce or legal separation of the covered employee from the employee's spouse;
- Covered employee's commencement of Medicare coverage (which qualifies only dependents not covered under Medicare); and
- Cessation of dependent child coverage under the terms of the applicable Group Health Program (e.g., upon attainment of the limiting age of the relevant Group Health Program).

It is your responsibility to notify the 7-Eleven Benefit Service Center — **within 60 days of the later of the event or the date coverage is lost because of the event** — of a qualifying event that is your divorce or legal separation or your dependent ceasing to be eligible under the applicable Group Health Programs, or of a second qualifying event such that your dependents are eligible for an extension of COBRA Continuation Coverage from 18 months (or 29 months, as applicable) to 36 months. If you do not notify the 7-Eleven Benefits Service Center of these events within this time period, your dependents will not be eligible for COBRA Continuation Coverage.

Qualified Beneficiaries

"**Qualified beneficiaries**" are individuals who immediately prior to a qualifying event were covered under the applicable Group Health Program as a dependent spouse or child. In addition, any child born to or placed for adoption with a former covered employee during COBRA Continuation Coverage is also a qualified beneficiary. Only with respect to termination of employment (or reduction in hours) are you, the employee, also considered a qualified beneficiary.

Except as otherwise specifically provided in the applicable Group Health Program, each individual who receives COBRA Continuation Coverage will have the same rights and obligations — and only such rights and obligations — as those provided to participants under the terms of the applicable Group Health Program, including those regarding enrollment, amendment, termination, or change of coverage, coordination of benefits, subrogation, claims procedure and review, and provision of information.

Benefit Levels

In general, COBRA Continuation Coverage must be identical to coverage provided under the Group Health Program to similarly situated persons for whom a qualifying event has not occurred. If coverage under the Group Health Program is changed for active employees or their dependents, the same changes will be applied to qualified beneficiaries purchasing COBRA Continuation Coverage. The qualified former employee/dependent will be provided with notification of any Group Health Program changes.

Duration of Coverage

Coverage for each qualified beneficiary electing COBRA Continuation Coverage benefits shall begin no later than the date of the qualifying event and continue until the earliest of the following:

- In the case of termination of employment or reduction in hours, 18 months after the qualifying event. In the case of any other qualifying event, 36 months after the qualifying event. If, during an 18-month continuation period, a qualified beneficiary who is a spouse or dependent child incurs a second qualifying event (other than termination of employment or reduction in hours), the qualified beneficiary will be entitled to continue coverage for up to 36 months, measured from the beginning of the 18-month continuation period under which the person was covered. This COBRA Continuation Coverage will be subject to all other terms of the applicable Group Health Program; or
- For a qualified beneficiary who is determined before or within the first 60 days of COBRA Continuation Coverage to have been disabled under Title II or XVI of the Social Security Act at the time of termination or reduction in hours, the maximum period will be extended to 29 months, but only if the qualified beneficiary has provided notice of the disability determination before the latest of (i) 60 days

after the date of the disability determination by the Social Security Administration, (ii) the date of the qualifying event, or (iii) the date the qualified beneficiary loses coverage as a result of the qualifying event, but in no event later than the end of the initial 18-month period.

Termination of Coverage

Coverage will be terminated before the end of the applicable maximum period previously described on the earliest of the following:

- The date the Company ceases to provide coverage under any group health plan to any employee;
- The date coverage ceases under the Group Health Program because the qualified beneficiary fails to pay the required premiums within the latest of (i) 30 days after the date the premium is due, (ii) the last date that a participant is permitted to make any required contribution under the applicable Group Health Program, or (iii) if applicable, the last date that the Company is permitted to pay for coverage of similarly-situated participants under the terms of a contract between the Company and a third party (such as an insurer) that provides Group Health Program benefits on behalf of the Company;
- The first date (after a valid COBRA election is made) that the qualified beneficiary becomes covered as an employee or otherwise under another group health plan;
- The first date (after a valid COBRA election is made) that a qualified beneficiary becomes enrolled in Medicare benefits; or
- In the case of extended COBRA Continuation Coverage provided because of a disability, the first month that starts at least 30 days after a final determination under the Social Security Act that the qualified beneficiary is no longer considered disabled.

The Plan Administrator will provide notice to each affected qualified beneficiary of any termination of COBRA Continuation Coverage that takes effect earlier than the end of the maximum period of COBRA Continuation Coverage for the applicable qualifying event.

Cost of Coverage

The cost of COBRA Continuation Coverage will be the responsibility of the covered employee and any other qualified beneficiary who elects COBRA Continuation Coverage. The premiums charged for COBRA Continuation Coverage may be up to 102% of the full cost of the coverage. A covered employee or any other qualified beneficiary who is entitled to an extended continuation coverage period as a result of a disability may be required to pay up to 150% of the full cost for any coverage during the extended 11-month period of coverage.

COORDINATION WITH OTHER BENEFITS

Some individuals may have other medical coverage in addition to the coverage provided under the Group Health Programs. When a Group Health Program is determining what benefits it should pay, similar benefits payable from other plans will be taken into consideration with respect to benefits the Group Health Program pays. A Group Health Program will pay the benefits without regard to the other plan coverage if the Group Health Program's coverage is considered primary under these rules. If its coverage is considered secondary to one or more other plan's coverage, it will pay what it would have paid if it had been primary minus what the other plan that is the primary plan paid.

"Other plan" means any other plan of medical expense coverage under:

- Group insurance; or
- Any other type of coverage for persons in a group, including plans insured and those not insured.

To find out whether the applicable Group Health Program's regular benefits will be reduced, the order in which various plans will pay benefits (primary, which means it pays first, versus secondary) is determined by the following rules:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan that contains such rules.
2. A plan with coordination rules that covers an individual as an active participant will be deemed to pay its benefits before a plan that covers the person as a COBRA-qualified beneficiary.

3. A plan with coordination rules that covers a natural parent with the earliest birthdate (month and day only) will be deemed to pay its benefits for dependents before a plan that covers a natural parent with a later birthdate.
4. If 1, 2 and 3 above do not establish an order of payment, the plan with coordination rules under which the person has been covered for the longest will be deemed to pay its benefits first.
5. For children of separated or divorced parents, the following rules will apply instead:
    - If a court order requires one parent to provide medical insurance coverage for the couple's children, that parent's coverage will pay first; and
    - In the absence of a court order, the plan of the parent having custody pays first, followed by the plan of the stepparent, and then by the plan of the parent without custody.

Here is an example of how benefits will be paid by Coordination of Benefits, if the 7-Eleven Program is secondary:

	Group Health Program Pays
Total Allowable Billed Amount	$100.00
Allowable Benefits Under 7-Eleven Program	$80.00
Other Employer's Plan Paid	$70.00
Amount 7-Eleven Program Paid	$10.00

The Group Health Programs always pay primary to Medicare, TRICARE, and the Children's Health Insurance Program (CHIP), except as noted below under Medicare as Secondary Payor.

MEDICARE

Automatic Eligibility Because of Age

Persons age 65 and over who are entitled to receive monthly Social Security benefits are automatically eligible for Medicare. A person becomes entitled to Medicare Part A coverage on the first day of the month in which he or she turns age 65, but he or she must enroll for Part A to become effective. Part B automatically becomes effective at the same time, unless the individual declines coverage.

Social Security considers a person's birthdate to be the day before their actual birthdate. This means a person born on the first day of a month is actually considered by Social Security as being born the previous month.

Most individuals age 65 or over who are not eligible for coverage under the Group Health Programs (either automatically or through a spouse) may obtain Medicare Part A and Part B by enrolling and paying premiums for both parts.

Age 65 Dependent Spouse Not Eligible for Medicare

An employee age 62–64, who would qualify for Medicare except for age, may enroll a spouse (age 65 or over, who does not qualify on his or her own behalf) for both Medicare Part A and Part B coverage. The employee must file for Medicare coverage and pay the Medicare Part B premium.

Eligibility Because of Disability

Individuals who have received Social Security disability benefits for 24 consecutive months automatically become entitled to Medicare beginning with the 25th month. After such a disability ceases, a person who again becomes disabled within five years is automatically entitled to Medicare without having to wait another 24 months.

Eligibility Because of End Stage Renal Disease ("ESRD")

If you become totally disabled because of End Stage Renal Disease, Medicare begins the 30th month after the month kidney dialysis begins. If an individual participates in self-dialysis training after the 30th month and is expected to start self-dialysis, Medicare coverage begins in the first month of treatment. Medicare coverage can also begin the month an individual is admitted to the hospital for a kidney transplant. For persons entitled to Medicare only because of ESRD, Medicare coverage ends 12 months after the month

they no longer need dialysis or 36 months after the month of a successful kidney transplant.

Medicare as a Secondary Payor

In most instances, the Medical Programs will pay benefits to covered participants before Medicare does. Medicare pays second for:

- Active employees and spouses of active employees;
- Expenses incurred by active employees or dependents of active employees who are eligible for Medicare because of disability other than due to End Stage Renal Disease; or
- The first 30 months after an individual under age 65 begins treatment for End Stage Renal Disease.

Medicare as Primary Payor

Medicare pays first (or, is Primary):

- Beginning the 31st month after an individual under age 65 begins treatment for End Stage Renal Disease, when services were rendered during the first 30 months of treatment; or
- On the date the employee terminates Medical Program coverage, terminates employment, retires, or ceases to be in an eligible class for Medical Program coverage.

Coordination of Benefits with Medicare

For purposes of the Medical Programs, Medicare coverage will be assumed if you are eligible, whether or not you have actually enrolled in Part A or Part B.

A person is eligible for Medicare if he or she:

- Is covered under it;
- Refused it;
- Dropped it; or
- Failed to make a proper request for it.

If, according to the above, a person is eligible for Medicare and if Medicare is to be the primary payor, regular benefits under the Medical Programs may be reduced by benefits paid by Medicare if the total of the benefits payable under both plans would exceed 100% of the covered allowable expense. In no event will the Medical Programs pay more than the regular benefits payable in the absence of other coverage.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining if this provision will be applicable, the Company may, without consent of or notice to any person, release or obtain information, with respect to any person that may be needed to apply the terms of the Coordination of Benefits ("**COB**") provision or any similar provision of any other plan. Any person who claims benefits under the applicable Group Health Program must furnish to the Plan Administrator or Claims Administrator any information that may be needed to apply the COB provision. For the purposes of this provision only, any person who is covered under the applicable Group Health Program will be deemed to have authorized the Plan Administrator or Claims Administrator to secure the information necessary to apply the terms of this provision. This includes the right to use and disclose private health information, subject to the limitations imposed by HIPAA as amended by ARRA, in connection with payment, treatment, and health-care operations.

FACILITY OF PAYMENT

If any payment that should have been made under the applicable Group Health Program according to the COB provision is made under any other plan, the applicable Group Health Program shall have the right to pay to the organization that made such payment any amount that, in the Company's judgment, will satisfy the intent of the COB provision. Any amount so paid will be deemed a benefit paid under the applicable Group Health Program and fully discharge the Company and the applicable Group Health Program from liability for the payment under the applicable Group Health Program.

RIGHT OF RECOVERY

If a payment made by a Group Health Program is more than the total amount required from the Group Health Program to satisfy the intent of the section of the Summary, titled "Coordination With Other Benefits," the Plan Administrator has the right to recover any excess amount paid by (or for) a Group Health Program from any person, insurance company, or other organization to whom such payment was made in any manner that the Plan Administrator, in its sole discretion, deems to be appropriate.

DEPENDENT CARE SPENDING ACCOUNT

7-Eleven offers a Dependent Care Spending Account ("DCSA") known as the Dependent Care Assistance Program, which allows employees to use tax-free dollars to pay certain expenses incurred for the care of an eligible dependent (or childcare). A "spending account" is set up for each employee choosing this benefit, and eligible expenses are reimbursed from the spending account as incurred and submitted for payment. For some employees, a substantial reduction in the effective cost of the care being provided can be achieved by buying it with pre-tax dollars through this Program.

ELIGIBILITY

This benefit allows "eligible employees" with "eligible dependents" to pay "eligible expenses" with pre-tax dollars.

Who Is Eligible for Coverage?

Employees who are eligible for Company medical coverage (other than COBRA coverage) become eligible to participate in the DCSA on the date they are eligible for Company medical coverage.

Employees in pay grades 24 or higher are not eligible to participate.

In addition, to be an "**eligible employee**" for this Program, you must satisfy at least one of the following requirements:

- Both you and your spouse are employed
- Your spouse is disabled
- Your spouse is a full-time student
- You are single

An "**eligible dependent**" must live in your home and be one (or more) of the following:

- A child under age 13 who is your dependent (as defined by the IRS rules)
- A dependent parent or other dependent who is disabled and lives in your home eight hours a day or more (a person you cannot claim as a dependent for income tax purposes because that person has more than $3,500 of income can be an eligible dependent for this purpose.)
- Your disabled spouse

Additionally, to claim your child as an eligible dependent if you are divorced, separated, or living apart from the other parent, you must be the custodial parent for the greater portion of the calendar year.

WHEN PARTICIPATION BECOMES EFFECTIVE

Participation becomes effective on January 1 of each year if the eligible employee elects during Open Enrollment to participate for the year. For newly eligible employees, participation becomes effective on the first day of the month following or coinciding with the date that you meet the eligibility requirements and elect to participate.

To take advantage of the special tax status under this Program, several requirements must be satisfied. If you do not comply with all of the requirements, you could lose some or all of your money allocated to your DCSA. Understanding the rules reduces the chances of this happening. The requirements are:

1. You must say in your enrollment materials the amount you wish to set aside in your DCSA. If you are divorced, separated, or living apart from the other parent for a child you plan to claim, you must verify that you will be the custodial parent for the greater portion of the calendar year.
2. Once the calendar year or your participation has begun, you cannot change the amount during the year for any reason other than a Mid-Year Change. Mid-Year Changes are discussed near the beginning of this Summary.
3. Any money credited to a DCSA can be paid to you only to reimburse eligible expenses.
4. Any amount remaining in your DCSA after the claims deadline for the year has ended will be forfeited. (Unspent amounts do not carry forward.)

Once you initially elect (or decline to elect) coverage under this program, you may make changes to that elected coverage only during the next Open Enrollment or in accordance with the Mid-Year Change rules discussed near the beginning of this Summary.

If your custodial status changes so that you will no longer be the custodial parent for the greater portion of the calendar year, you must notify the 7-Eleven Benefit Service Center as soon as you learn of this change.

PAYING FOR PARTICIPATION

Your DCSA benefits are funded by pre-tax deductions that you elected to have deducted from your compensation throughout the year.

WHEN PARTICIPATION ENDS

Participation in the DCSA will end at 11:59 p.m. on the date that any one of the following events occurs:

- You cease to be an eligible employee (for example, your employment with 7-Eleven terminates)
- You stop contributing to your DCSA
- You begin any leave of absence
- You or any covered dependent submits (or attempts to submit) a false, altered, forged, or fraudulent claim or document requesting reimbursement under the Program
- 7-Eleven no longer offers the Program
- Your election to participate for the year expires or is terminated

Elections to participate in the DCSA Program do not carry-forward from year to year. Each year during Open Enrollment you must make a new election for the coming year if you wish to continue to participate.

If you have a DCSA when your employment with 7-Eleven terminates, the following rules will apply:

- The amount going into your account will stop with your last paycheck.
- You may continue to submit claims for reimbursement of eligible expenses incurred while you were still employed with 7-Eleven, but claims must be submitted no later than March 31 following the year of employment termination. Claims will be reimbursed as long as funds remain in the account. Funds left over in the account (after the March 31 deadline for submitting claims) will be forfeited. Claims for expenses incurred after employment termination will be denied.

DCSA OPTIONS

You should estimate the dependent day care expenses you expect to incur between the effective date of your DCSA and March 15 of the following year. Go to the Benefits Center website for more information.

The minimum amount you can contribute is $120 per year, and the maximum is generally $5,000, but the law limits how much you can contribute to a DCSA. The limits are:

- If you are married and file a separate tax return, the limit is $2,500
- For all others, the limit is $5,000

Your contribution may not exceed the income of you or your spouse, whichever is lower, and special rules apply when the spouse is a student or is disabled.

If you use the dependent care tax credit on your IRS tax return, as explained later, these limits are reduced by the amount of expenses claimed to use the credit.

Your contributions are made throughout the year by payroll deduction. The entire amount you have elected for the year is not available for claims as of the effective date of your DCSA. Instead, the amount available to pay claims accrues through each payroll deduction during the year.

DEPENDENT CARE TAX CREDIT VS. DCSA

Currently, the amount of federal income taxes (but not FICA) you owe may be reduced by a percentage of the money you have spent on eligible dependent care expense. This is called a tax credit. The percentage varies, depending on the combined income of you and your spouse. The total amount of expenses eligible

for the credit is $3,000 for one child and $6,000 for two or more children.

Remember, only a percentage of these expenses may be claimed as a tax credit. The credit is between 20% and 35% of your dependent care expenses, and depends on your adjusted gross income for federal income tax purposes.

The expenses you would use to claim a childcare tax credit are also eligible to be reimbursed from your DCSA, but the same expenses cannot be used twice. You cannot use the same expenses for both the Dependent Care Tax Credit and the DCSA. You should look at both possibilities each year to determine which option may be more beneficial to you.

Expenses reimbursed through your DCSA reduce dollar-for-dollar the amount of expenses allowable under the Dependent Care Tax Credit. Depending on your personal situation, one approach may give you a greater tax break than the other. A publication providing detailed information on the tax choices for dependent care expenses is available from the IRS.

DCSA BENEFITS

The DCSA allows you to pay for certain dependent-care-related expenses with pre-tax deductions. As its name implies, a "pre-tax deduction" is one that is deducted from your pay BEFORE taxes are calculated.

For example: Assume your gross pay for a pay period is $1,000 and you are having $100 withheld for your DCSA. Without that withholding, your taxes are calculated based on $1,000. Under the pre-tax deduction approach, your DCSA contributions are deducted first, so that your taxes are computed on only $900. Less tax is withheld, and the savings are yours.

FORFEITURES

According to IRS rules, any money left in your DCSA after all eligible dependent care expenses for the Plan Year have been processed will be forfeited. It will not be returned to you. Leftover amounts will be used to pay administrative expenses of the DCSA.

COVERED DEPENDENT CARE EXPENSES

In order for expenses to be reimbursable from your DCSA, the money must be spent for the well-being and protection of an eligible dependent, and can include care-related household services. The costs of a baby-sitter or dependent care center are common examples, but a housekeeper or cook could qualify if the service is performed as part of the dependent care for the well-being and protection of a qualifying individual. In addition, to be "**eligible expenses**," the expenses for dependent care must enable you to work, and be for the benefit of:

- Your children under age 13 whom you can claim as dependents on your income tax return, and for whom you are the custodial parent for the greater portion of the calendar year;
- An older child who lives with you and is physically or mentally incapable of self-care and relies upon you for more than half of his or her support; or
- A spouse or parent who is mentally or physically incapable of self-care, as long as he or she lives with you at least eight hours per day and depends on you for more than half of his or her support.

The dependent care can be provided in your home, in a baby-sitter's home (with no more than six children), at a nursery school or pre-school, at a licensed day care facility, or with a relative (so long as the relative is not your child under age 19, your or your spouse's dependent, your spouse, or the child's parent).

EXPENSES NOT COVERED

The following are **NOT** "eligible expenses" and may not be reimbursed from your DCSA:

- Expenses claimed as a deduction or credit on your federal income tax return.
- Expenses incurred before you became covered under the Program or after the following March 15.
- Expenses incurred before the calendar year of participation.
- Expenses for private school tuition from kindergarten up or for overnight camp expenses.

- Dependent care expenses paid to a relative who is your child under age 19, your or your spouse's dependent, your spouse, or the child's parent.
- Dependent care expenses that in any calendar year are more than your earned income or your spouse's earned income (whichever is less) unless you are married and your spouse is a full-time student or mentally or physically disabled.
- Dependent care expenses for which you do not obtain and submit a dated invoice or receipt.

CLAIMS PROCESS

To use the money credited to your DCSA, you pay your eligible dependent care expense to your care provider and ask for a receipt. Then, complete a claim form from PayFlex and indicate the amount of the expense, the period of time it covers, and the federal tax ID or Social Security number of the dependent care provider. You can obtain a claim form online at www.payflex.com or call PayFlex at 1-800-284-4885 to request a claim form.

Claims may be submitted online. Or, attach your receipt to the claim form and mail the packet to the Claims Administrator at the following address:

PayFlex
Flex Dept.
P.O. Box 981158
El Paso, TX 79998-1158

If your claim is approved, you will be reimbursed for the expense, up to the balance in your account at the time you file your claim. If your claim is for more than the amount in your account, you will be reimbursed for the rest of your expense as deductions come out of your paycheck.

If you feel that your DCSA benefit has been incorrectly determined, you may appeal by writing to PayFlex at the above address.

The IRS requires that you use the money you contribute to your DCSA for a Plan Year to reimburse expenses that you incur by the March 15 following the end of that Plan Year. If you decide to contribute to the account, you should carefully estimate your expenses for this time period.

Important Reminders

The DCSA operates on a "use it or lose it" basis, meaning you forfeit any money you have left in your account after all of your eligible expenses for the year have been paid.

Any funds in your DCSA for a year that remain after eligible expenses for the year have been processed will be forfeited. Only expenses incurred during a Plan Year for which you are contributing to your DCSA can be paid from the DCSA.

- You have until March 15 of the year after the year in which you make DCSA contributions to incur claims for that Plan Year. Claims for a Plan Year must be filed with PayFlex by March 31 of the following year. For example, you have until March 15, 2018, to incur claims against your 2017 DCSA contributions. **And you have until March 31, 2018, to file those claims**.

SHORT-TERM DISABILITY

The 7-Eleven, Inc. Short-Term Disability Program ("STD Program") offers eligible employees the opportunity to purchase coverage that will replace part of their income if they become temporarily disabled for a period of 27 weeks or less. The STD Program coverage is coordinated with Social Security and any other disability income benefit payments received by an eligible employee. The STD Program is insured and administered by Unum Life Insurance Company of America (Unum).

ELIGIBILITY

Who Is Eligible for Coverage?

Full-time exempt employees (store and non-store) and hourly non-store full-time employees are eligible for the STD Program on the first day of the month following 90 days of continuous Active Employment. Variable-hour employees are eligible to participate after averaging 30 hours or more per week during a 12-month measurement period.

You are not eligible for coverage under the STD Program if you are a part-time, temporary or seasonal employee.

WHEN COVERAGE BECOMES EFFECTIVE

If you elect to participate in the STD Program within 31 days of when you first become eligible, coverage will be effective on your eligibility date, without providing Evidence of Insurability (**EOI**). **If you do not elect to participate within those 31 days, or if you voluntarily cancel your coverage under the STD Program and then wish to re-enroll, you will not have coverage unless you:**

- Complete and sign an EOI Form (contact the 7-Eleven Benefit Service Center at 1-800-601-0711 if you have questions or need an EOI Form);
- Submit your completed signed EOI Form to the Claims Administrator (Unum) at the address on the EOI Form; AND
- Are approved by the Claims Administrator for coverage.

If you are required to complete an EOI questionnaire, your STD Program coverage will become effective on the later of the effective date of your election to participate or the first day of the month following (or coinciding with) your approval by the Claims Administrator for the STD Program.

If you are not Actively at Work on the date your STD Program coverage would otherwise effectively begin, coverage will become effective on the day you return to work at 7-Eleven.

Once you initially elect (or decline to elect) coverage under the STD Program, you may make changes to that elected coverage only during the next Open Enrollment.

PAYING FOR COVERAGE

You pay the entire cost of the STD Program on an after-tax basis.

By paying the full cost of the STD Program after taxes, you will not pay federal income taxes on any benefit you may receive from Unum under the STD Program. If you are enrolled in other 7-Eleven Programs, you will be billed for the required premiums for those coverages.

WHEN COVERAGE ENDS

Your coverage under the STD Program ends at 11:59 p.m. on the date that the earliest of the following events occurs:

- The date the STD Program is cancelled
- The date you are no longer in a group eligible for coverage
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are in Active Employment

Payment of any STD Program benefits to you will end on the earliest of the following:

- When you are able to work in your regular occupation on a part-time basis but you choose not to
- The date on which the maximum period of payment ends
- The date you are no longer disabled under the terms of the Program, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance Program
- The date you fail to submit proof of continuing disability
- After 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of six months or more during any 12 consecutive months of benefits.
- The date your disability earnings exceed the amount allowed under the Program
- The date you die

STD BENEFITS

The STD Program pays benefits for up to 26 weeks of a disability, following a seven-day waiting period.

After you have been disabled (as defined below) for seven days, your doctor has certified that you have a qualified disability, and Unum determines that you qualify for benefits under the STD Program, you will receive a benefit of up to 60% of your Average Weekly Earnings up to $6,250 per month or $1,442 per week. The minimum benefit is $50 per week. The STD Program pays no benefit for the first seven days of your total disability; however, you may be eligible to use any available paid time off under 7-Eleven's Paid Time Off (PTO) Program or vacation time under 7-Eleven's vacation program during that time.

You may become eligible for Social Security disability benefits after five full months of disability. If you are reasonably expected to be disabled for more than five months, you should apply for Social Security disability benefits with your local office of the Social Security Administration and appeal any denial of those claims.

Your STD Program benefits are reduced by Deductible Sources of Income as defined in the next paragraph. If you live in California, New York, New Jersey, Hawaii, Rhode Island, or the Commonwealth of Puerto Rico, your STD Program benefit will be offset by state disability benefits.

If Unum overpays your claim due to fraud, any error Unum makes in processing your claim, or your receipt of Deductible Sources of Income, Unum has the right to recover the overpayment in full. Unum will determine the repayment method. Unum will not recover more money than the amount it paid to you.

"**Deductible Sources of Income**" means income you receive or are entitled to receive while you are disabled, and includes:

- The amount you are entitled to receive as disability income payments under any state compulsory benefit act or law, any other group insurance plan or automobile liability insurance policy
- The amount you receive under Title 46, United States Code Section 688 (the Jones Act)
- The amount you receive from a third party (after subtracting attorney's fees) by judgment, settlement, or otherwise
- The amount you:
    - Receive as disability payments under the Company's retirement plan
    - Voluntarily elect to receive as retirement payments under the Company's retirement plan
    - Receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in the Company's retirement plan
    - Receive as retirement payments under any governmental retirement system

COVERED DISABILITIES

You are considered "**disabled**" under the STD Program when Unum determines that due to your sickness or injury:

- You are unable to perform the material and substantial duties of your regular occupation with 7-Eleven, and
- You are not working in any occupation.

You must be under the regular care of a physician in order to be considered disabled. The loss of a professional or occupational license or certification does not, in itself, constitute disability. Unum may require you to be examined by a physician, other medical practitioner or vocational expert of Unum's choosing. Unum will pay for this examination. Unum can require an examination as often as it is reasonable to do so. Unum also may require you to be interviewed by an authorized Unum representative.

"**Material and substantial duties**" are those that are normally required for the performance of your regular occupation and that cannot reasonably be omitted or modified. "**Regular care of a physician**" means that you personally visit a doctor as frequently as is medically required for your disability and you are receiving the most appropriate treatment and care that conforms with generally accepted medical standards for that disability from a doctor whose specialty or experience is most appropriate for that disability.

DISABILITIES NOT COVERED

The STD Program does not cover any disabilities caused by, contributed to by, or resulting from your:

- Occupational sickness or injury
- Intentionally self-inflicted injuries
- Active participation in a riot
- Loss of a professional license, occupational license or certification
- Commission of a crime for which you have been convicted
- Attempt to commit, or commission of, a crime
- Participation in a war, declared or undeclared

In addition, STD benefits will not be paid during any period for which you are incarcerated.

RECURRENT DISABILITY

Unum will treat a current disability as part of a prior claim if you are continuously insured and the recurrent disability occurs within 30 consecutive days or less from the end of the prior claim.

VOCATIONAL REHABILITATION AND RETURN TO WORK

Unum has a Vocational Rehabilitation and Return to Work Assistance Program available to assist you in returning to work. Unum will pay an additional benefit of 10% of your gross disability payment, up to a maximum additional benefit of $250 per week if you participate.

CLAIMS PROCESS

SUBROGATION AND REIMBURSEMENT

In some situations, a third party, such as another person or insurance company, may be legally responsible for your disability. This might happen, for example, in an automobile accident.

When this occurs, Unum is entitled to be reimbursed for all disability benefits that have been paid under the Program. Unum may take any actions necessary to enforce its rights to be reimbursed. When you accept payment from the STD Program, you agree to provide any documents that would help Unum to recover payments it has made on your behalf. The legal term for this right of recovery is "subrogation."

In situations where Unum has a subrogation interest, you may be asked to sign certain documents acknowledging those rights. Unum is entitled to subrogation even if you fail to sign the requested documents.

Job-Related Injuries

If you become injured on the job, report the work-related injury to your supervisor immediately. Your supervisor will notify the appropriate workers' compensation carrier. Occupational injuries are not covered under the STD Program.

Other Disabilities

If you become unable to work because of any other type of disability, notify your supervisor immediately. You should notify Unum of your claim as soon as possible so that a timely claim decision can be made. Written notice of a claim should be sent within 30 days after the date your disability begins. You must send Unum written proof of your claim no later than 90 days after your seven-day waiting period. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

You must notify Unum immediately when you return to work in any capacity.

To file a claim, call Unum at 1-855-502-4711 and provide your claim information to Unum's representative. You will be required to sign an authorization form in order for Unum to obtain medical information from your doctor. Should Unum be unable to obtain your medical information, Unum will send a letter and appropriate forms to you for completion, to be returned by the date in the letter.

Your proof of claim is provided at your expense, and must show:

- You are under the regular care of a physician
- The appropriate documentation of your weekly/monthly earnings
- The date your disability began
- The cause of your disability
- The extent of your disability, including restrictions and limitations preventing you from performing your Regular Occupation
- The name and address of any hospital or institution where you received treatment, including all attending physicians

Unum may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by Unum.

In some cases, you will be required to give Unum authorization to obtain additional medical information, and to provide non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim or stop sending you payments if the appropriate information is not submitted.

You should review the "Claims and Review Procedures" section of this Summary for your rights in connection with Unum's review of your claim. You can start legal action regarding your claim 60 days after proof of claim has been given and up to two years from the time proof of claim is required, unless otherwise provided under federal law.

Contact Unum if you have any questions about your claim, either at the telephone number provided above or at the following address:

Unum Life Insurance Company
P.O. Box 9793
Portland, ME 04104-5093

Claims Appeals

If your disability benefits claim is denied or your benefit payments are reduced, you will receive a written explanation of the reason for the denial, termination, or reduction. You have the right to have your claim reviewed and reconsidered in accordance with the "Claims and Review Procedures" section later in this Summary.

LONG-TERM DISABILITY

The 7-Eleven, Inc. Long-Term Disability Program ("LTD Program") offers eligible employees the opportunity to purchase coverage that will replace part of their income if they become disabled for a period longer than 27 weeks. The LTD Program coverage is coordinated with Social Security, workers' compensation, and any other disability benefit payments received by an eligible employee. The LTD Program is insured and administered by Unum Life Insurance Company of America (Unum).

ELIGIBILITY

Who Is Eligible for Coverage?

Full-time exempt employees (store and non-store) and hourly non-store full-time employees are eligible for the LTD Program on the first day of the month following 90 days of continuous Active Employment.

You are not eligible for coverage under the LTD Program if you are a variable-hour employee, a part-time employee, an hourly store full-time employee, or a temporary or seasonal employee.

PRE-EXISTING CONDITION EXCLUSION

The LTD Program does not pay benefits for a Pre-Existing Condition. You have a Pre-Existing Condition if:

- You received medical treatment, consultation, care, or services, including diagnostic measures, or took prescribed drugs or medicines in the six months just prior to your effective date of coverage; and
- The disability begins in the first 12 months after your effective date of coverage unless you have been Treatment-Free for six consecutive months after your effective date of coverage.

WHEN COVERAGE BECOMES EFFECTIVE

If you elect coverage under the LTD Program, your coverage will begin at 12:01 a.m. on the latest of:

- The date you are initially eligible for coverage, if you elect to participate on or before that date, in accordance with the Plan's enrollment procedures
- The date you apply, if you apply within 31 days after your initial eligibility date
- The date Unum approves your application, if evidence of insurability is required
- January 1 of the year following Open Enrollment, if you apply during Open Enrollment

Evidence of Insurability (EOI) is required if you are a late applicant, meaning that you did not apply for coverage within 31 days after your initial eligibility date. It is also required if you voluntarily cancelled coverage and are reapplying. EOI forms are available from the 7-Eleven Benefit Service Center.

If you are not in Active Employment on the date your LTD Program coverage would otherwise begin, coverage will become effective on the day you return to Active Employment at 7-Eleven.

Once you initially elect (or decline to elect) coverage under the LTD Program, you may make changes to that elected coverage only during the next Open Enrollment.

PAYING FOR COVERAGE

You pay the entire cost of the LTD Program on an after-tax basis. By paying the full cost of the LTD Program after taxes, you will not pay federal income taxes on any benefit you may receive under the LTD Program.

WHEN COVERAGE ENDS

Your coverage under the LTD Program ends at 11:59 p.m. on the date that the earliest of the following events occurs:

- The date the LTD Program is cancelled
- The date you are no longer in a group eligible for coverage
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions

- The last day you are in Active Employment

Benefit payments under the LTD Program will end on the earliest of the following:

- During the first 12 months of payments, when you are able to work in your Regular Occupation on a part-time basis but you choose not to
- After 12 months of payments, when you are able to work in any Gainful Occupation on a part-time basis but you choose not to
- The end of the Maximum Period of Payment
- The date you are no longer disabled under the terms of the LTD Program
- The date you fail to submit proof of continuing disability
- The date your Disability Earnings exceed the allowable amount
- The date you die

The "**Maximum Period of Payment**" means the longest period of time Unum will make payments to you for any one period disability. If your age at disability is less than 60, the Maximum Period of Payment is to age 65, but not less than five years. If your age at disability is 60 or older, the Maximum Period of Payment is determined by this table:

If your disability begins at this age:	The Maximum Period of Payment is:
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Disabilities due to Sickness or Injury that are primarily based on Self-Reported Symptoms and disabilities due to Mental Illness have a limited pay period up to 12 months. Unum will not pay beyond the limited pay period as indicated below, or the Maximum Period of Payment above, whichever occurs first. Unum will continue to send you payments beyond the limited 12-month period if you meet one or both of these conditions:

- If you are confined to a hospital or institution at the end of the 12-month period, Unum will continue to send you payments during your confinement. If you are still disabled when you are discharged, Unum will send you payments for a recovery period of up to 90 days. If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that additional confinement and for one additional recovery period up to 90 more days.
- In addition, if, after the 12-month period for which you have received payments, you continue to be disabled and subsequently become confined to a hospital or institution for at least 14 days in a row, Unum will send payments during the length of the reconfinement.

LTD OVERVIEW

The LTD Program provides benefits after an Elimination Period (discussed below) if:

- You are eligible and have elected LTD coverage during your initial eligibility period or have been approved by Unum;
- You have paid the premiums for such coverage; and
- Unum determines you are disabled (as defined below).

LTD BENEFITS

Disability Benefits Generally

Before any benefits are payable under the LTD Program, you must first complete the Elimination Period. The Elimination Period is the later of 189 days (27 weeks) or, if you are receiving benefits under the STD Program, the date those benefits end. You must be continuously disabled through your Elimination Period. Unum will treat your disability as continuous if it stops for 30 days or less during the Elimination Period, but those days you are not disabled will not count toward the Elimination Period.

After you have been continuously disabled for the Elimination Period, then you are eligible to receive monthly disability benefits under the LTD Program, provided Unum approves your claim for benefits.

Unum calculates your monthly benefit payment as follows:

1. Multiply your Monthly Earnings by 60%.
2. Compare Item 1 to $6,250, which is the maximum monthly benefit payable under the LTD Program.
3. Choose the lesser of the amount in Item 1 or $6,250. This is your Gross Disability Payment.
4. From your Gross Disability Payment, subtract any Deductible Sources of Income. The result will be your monthly disability benefit payment.

The maximum monthly disability benefit is $6,250. The minimum is $100 or 10% of your Gross Disability Payment, whichever is greater, after the elimination period. If you are disabled for less than one month after the Elimination Period, Unum will send you 1/30 of your benefit payment for each day of the disability.

Unum will make the initial payment for a payable claim within 60 days from the date acceptable proof is received. Unum will make the payments to you.

If Unum overpays your claim due to fraud, an error Unum makes in processing your claim, or your receipt of Deductible Sources of Income, Unum has the right to recover the overpayment in full. Unum will determine the repayment method. Unum will not recover more money than the amount it paid to you.

"**Deductible Sources of Income**" means income you receive or are entitled to receive while you are disabled. Categories of Deductible Sources of Income include:

1. The amount you receive or are entitled to receive under workers' compensation, occupational disease, and other similar laws;
2. The amount you receive or are entitled to receive as disability income payments under any state compulsory benefit law, automobile liability insurance policy, other group insurance plan, or governmental retirement system as a result of your job with 7-Eleven;
3. The amount that you, your spouse, and your children receive or are entitled to receive as disability payments because of your disability under Social Security, the Canada Pension Plan, the Quebec Pension Plan, or similar acts;
4. The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under Social Security, the Canada Pension Plan, the Quebec Pension Plan, or similar acts;
5. The amount you receive under the Jones Act; and
6. The amount that you receive from a third party (after subtracting attorneys' fees) by judgment, settlement, or decree.

Except for retirement payments, Deductible Sources of Income must be payable as a result of the same disability.

Deductible Sources of Income do not include Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments. Deductible Sources of Income also do not include 401(k) plans, profit sharing plans, thrift plans, tax sheltered annuities, stock ownership plans, non-qualified plans of deferred compensation, pension plans for partners, military pension and disability income plans, credit disability insurance, franchise disability income plans, a retirement plan from another employer, payments made under the 7-Eleven Executive Protection Plan, individual retirements accounts (IRA), individual disability income plans, and accumulated sick leave plans.

If Unum determines that you may qualify for Deductible Sources of Income in categories 1, 2, and 3 above, Unum will estimate your entitlement to those benefits. Unum can reduce your monthly LTD Program benefit by the estimated amounts if the Deductible Source of Income has not been awarded and has not been denied, or if denied, is being appealed. However, your monthly LTD Program benefit will not be reduced by the estimated amount if you apply for the Deductible Sources of Income in categories 1, 2, and 3 and you appeal your denial to all administrative levels Unum feels are necessary, plus you sign Unum's payment option form, which states that you promise to pay Unum any overpayment caused by an award. If your payment has been reduced by an estimated amount, Unum will adjust your payment when it receives proof of the amount awarded, or proof that benefits have been denied and all appeals Unum feels are necessary have been completed, in which case Unum will make a lump-sum refund of the estimated amount to you.

If you receive a lump-sum payment from any Deductible Sources of Income the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, Unum will use a reasonable one.

Special Rules If Disabled and Working

Special rules apply if you are disabled and working. You must notify Unum immediately when you return to work in any capacity. If you are disabled and working, Unum will send you the monthly disability payment for which you are eligible if your monthly Disability Earnings are less than 20% of your Indexed Monthly Earnings, due to the same Sickness or Injury. If your monthly Disability Earnings are 20% or more than your Indexed Monthly Earnings due to the same Sickness or Injury, Unum will figure your payment while working based on the percentage of income you are losing due to your disability, as follows:

1. Subtract your Disability Earnings from your Indexed Monthly Earnings.
2. Divide the answer in Item 1 by your Indexed Monthly Earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in Item 2. This is the amount Unum will pay each month.

During the first 12 months of disability payments, if your monthly Disability Earnings exceed 80% of your Indexed Monthly Earnings, Unum will stop sending you payments and your claim will end. After 12 months of disability payments, if your monthly Disability Earnings exceed 60% of your Indexed Monthly Earnings, Unum will stop sending you payments and your claim will end.

Unum may require you to send proof of your monthly Disability Earnings at least quarterly. Unum will adjust your payment based on your quarterly Disability Earnings. As part of your proof of Disability Earnings, Unum can require that you send appropriate financial records to substantiate your income.

If your Disability Earnings routinely fluctuate widely from month to month, Unum may average them over the most recent three months to determine if your claim should continue. If Unum averages your Disability Earnings, Unum will not terminate your claim for excessive Disability Earnings unless during the first 12 months of disability payments the average of your Disability Earnings from the last three months exceeds 80% of your Indexed Monthly Earnings, or after the first 12 months of payments, the average of your Disability Earnings from the last three months exceeds 60% of your Indexed Monthly Earnings.

Unum will not pay benefits for any month during which Disability Earnings exceed the amount allowed.

Survivor Benefit

If Unum receives proof that you have died, Unum will pay your Eligible Survivor a lump-sum benefit equal to three months of your Gross Disability Payment if on the date of your death your disability had continued for 180 or more consecutive days and you were receiving or were entitled to receive payments under the LTD Program.

Before paying any survivor benefit, Unum will first apply the survivor benefit to any overpayment on your claim.

Your Eligible Survivor means your spouse if living or, if none, your children under age 25 equally. If you have no Eligible Survivors, payment will be made to your estate. If there is no estate, no payment will be made.

Other Services

The LTD Program will reimburse 7-Eleven up to the greater of $1,000 or the equivalent of two months of your monthly benefit for the cost of a worksite modification that Unum and 7-Eleven agree is likely to help you remain at or return to work. This benefit is available with respect to you only once.

The LTD Program also offers a voluntary occupational rehabilitation service to help you return to work if Unum determines that such services might help you to return to gainful employment.

The LTD Program can also provide you with advice and assistance regarding the application or appeal of a claim for disability benefits from the Social Security Administration.

COVERED DISABILITIES

You are "**disabled**" under the LTD Program when Unum determines that:

- You are limited from performing the Material and Substantial Duties of your Regular Occupation due to your Sickness or Injury;
- You have a 20% or more loss in your Indexed Monthly Earnings due to the same Sickness or Injury; and
- During the Elimination Period, you are unable to perform any of the Material and Substantial Duties of your Regular Occupation.

After 12 months of payment, you are "**disabled**" for purposes of the LTD Program when Unum determines that, due to the same Sickness or Injury, you are unable to perform the duties of any Gainful Occupation for which you are reasonably fitted by education, training, or experience.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Unum may require you to be examined by a physician, other medical practitioner, or vocational expert of Unum's choosing. Unum will pay for this examination. Unum can require an examination as often as it is reasonable to do so. Unum may also require you to be interviewed by an authorized Unum representative.

Special rules apply if you return to work full time and your disability occurs again. If you have a Recurrent Disability, Unum will treat your disability as part of your prior claims and you will not have to complete another Elimination Period if:

- You were continuously insured under the LTD Program for the period between your prior claim and your Recurrent Disability; and
- Your Recurrent Disability occurs within six months of the end of your prior claim.

Your Recurrent Disability will be subject to the same terms of the LTD Program as your prior claim. Any disability that occurs after six months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the LTD Program provisions. If you are covered under another group long-term disability plan on the date of your Recurrent Disability and are entitled to payments under that plan, you will not be eligible for further payments under the LTD Program.

DISABILITIES NOT COVERED

You will **NOT** receive disability benefits under the LTD Program for any of the following types of disabilities caused by, contributed to by, or resulting from your:

- Intentionally self-inflicted injuries
- Loss of a professional license, occupational license, or certification
- Active participation in a riot
- Commission of a crime for which you are convicted under state or federal law
- Pre-Existing Condition (until after the Pre-Existing Conditions exclusion period has been satisfied — see below)

In addition, the LTD Program will not cover a disability due to war, declared or undeclared, or any act of war.

An LTD benefit will not be paid for any period of disability during which you are incarcerated.

SUBROGATION AND REIMBURSEMENT

In some situations, a third party, such as another person or insurance company, may be legally responsible for your disability. This might happen, for example, in an automobile accident.

When this occurs, Unum is entitled to be reimbursed for all disability benefits that have been paid under the Program. Unum may take any actions necessary to enforce its rights to be reimbursed. When you accept payment from the LTD Program, you agree to provide any documents that would help Unum to recover payments it has made on your behalf. The legal term for this right of recovery is "subrogation."

In situations where Unum has a subrogation interest, you may be asked to sign certain documents acknowledging those rights. Unum is entitled to subrogation even if you fail to sign the requested documents.

CLAIMS PROCESS

Job-Related Injuries

If you become injured on the job, report the work-related injury to your supervisor immediately. Your supervisor will notify the appropriate workers' compensation carrier. If you participate in the LTD Program, you should also call Unum at 1-855-502-4711. Workers' compensation benefits will be coordinated with any benefits you may be eligible to receive under the LTD Program.

Other Disabilities

If you become unable to work because of any other type of disability, notify your supervisor immediately. If you participate in the LTD Program, you should also call Unum at 1-855-502-4711.

Unum encourages you to notify it of your claim as soon as possible, so that a timely claim decision can be made. Written notice of a claim should be sent within 30 days after the date your disability begins. You must send Unum written proof of your claim no later than 90 days after your Elimination Period. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required except in the absence of legal capacity.

You must notify Unum immediately when you return to work in any capacity.

To file a claim, call Unum at 1-855-502-4711 and provide your claim information to Unum's representative. You will be required to sign an authorization form in order for Unum to obtain medical information from your doctor. Should Unum be unable to obtain your medical information, Unum will send a letter and appropriate forms to you for completion to be returned by the date on the letter.

Your proof of claim is provided at your expense. It must show:

- That you are under the regular care of a physician
- The appropriate documentation of your monthly earnings

- The date your disability began
- The cause of your disability
- The extent of your disability, including restrictions and limitations preventing you from performing your Regular Occupation
- The name and address of any hospital or institution where you received treatment, including all attending physicians

Unum may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by Unum.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. Unum will deny your claim or stop sending you payments if the appropriate information is not submitted.

You should review the "Claims and Review Procedures" section of this Summary for your rights in connection with Unum's review of your claim. You can start legal action regarding your claim 60 days after proof of claim has been given and up to two years from the time proof of claim is required, unless otherwise provided under federal law. Contact Unum if you have any questions about your claim, either at the telephone number provided above or at the following address:

Unum Life Insurance Company
P.O. Box 9793
Portland, ME 04104-5093

Claims Appeals

If your disability benefits claim is denied or your benefit payments are reduced, you will receive a written explanation of the reason for the denial, termination, or reduction. You have the right to have your claim reviewed and reconsidered in accordance with the "Claims and Review Procedures" section later in this Summary.

LIFE/ACCIDENTAL DEATH & DISMEMBERMENT

7-Eleven offers the opportunity for eligible employees to participate in both the Basic Life Insurance Programs and Optional Life Insurance Programs. Each of these Programs has both Term Life and Accidental Death and Dismemberment insurance benefit options available. The Life Insurance Programs are insured by Sun Life.

ELIGIBILITY

Who Is Eligible for Coverage?

BASIC TERM LIFE

All employees of 7-Eleven are covered by Basic Term Life insurance.

OCCUPATIONAL AD&D

All store employees and all store managers are also covered by Occupational AD&D insurance.

OPTIONAL TERM LIFE/OPTIONAL AD&D

Employees who are eligible for Company medical coverage (other than COBRA coverage) become eligible to purchase Optional Term Life and Optional AD&D insurance, separately or together, on the date they are eligible for Company medical coverage. Optional Term Life and Optional AD&D may be purchased by eligible employees to cover family members as well.

Unmarried dependent children are eligible for coverage from live birth to age 26 for Optional Term Life and Optional AD&D. If a covered child reaches the age limit and at that time is incapable of self-sustaining employment because of mental retardation, developmental disability or physical handicap and is dependent on the employee for support, coverage will continue as long as the child is incapacitated, provided that proof is supplied to the insurance carrier within 31 days of reaching the age limit and premiums are timely paid. If both parents work at 7-Eleven, only one parent can cover the dependent children.

WHEN COVERAGE BECOMES EFFECTIVE

You are automatically covered by Basic Term Life beginning on the first day you are Actively at Work. If you are eligible for Occupational AD&D, you are automatically covered by it beginning on the first day you are Actively at Work.

If you elect Optional Term Life, Optional AD&D, or both when first eligible to do so, coverage becomes effective on the first of the month following (or coinciding with) the date when you meet the eligibility requirements or upon approval from the insurance carrier, whichever is later. If you elect to participate during Open Enrollment, coverage becomes effective on the following January 1, or upon approval by the insurance carrier, if later.

If you are not Actively at Work on the date your coverage would normally begin, coverage becomes effective on the day you are once again Actively at Work with 7-Eleven.

If your spouse or child is confined for medical care or treatment, at home or elsewhere, on the date Optional Term Life coverage would normally begin, their coverage becomes effective on the day they are no longer confined. This does not apply to a newborn child born to you if the child is your first eligible dependent or you already have dependent coverage.

Once you initially elect (or decline to elect) Optional Term Life coverage and Optional AD&D coverage, you may make changes to that elected coverage only during the next Open Enrollment or in accordance with the Mid-Year Change rules discussed near the beginning of this Summary.

If you do not enroll yourself or your spouse in Optional Term Life coverage when you are first eligible and later enroll during Open Enrollment, you or your spouse is required to complete an Evidence of Insurability (EOI) form and be approved by the insurer for coverage.

You or your spouse will also be required to complete an EOI form and be approved for coverage if:

- As a new hire, you elect an amount greater than five times your salary or $300,000 for yourself (until the EOI form is approved by the insurer, you will have coverage for the highest salary multiple not exceeding $300,000, or $300,000 if your salary is over $300,000)
- For your spouse, you elect an amount of $25,000 or more
- You elect to increase Optional Term Life coverage for you or your spouse during Open Enrollment.
- You convert to an individual term life policy and later become eligible again for group insurance
- You voluntarily elect to end your Optional Term Life insurance and then ask to enroll again later
- Your Optional Term Life insurance ends because you fail to pay premiums but later ask to enroll again

These restrictions do not apply to dependent children or to Optional AD&D coverage.

PAYING FOR COVERAGE

7-Eleven pays the entire cost of Basic Term Life and Occupational AD&D insurance for eligible employees.

You pay the full cost of any Optional Term Life and any Optional AD&D insurance coverage that you elect. You may pay the premium costs for Optional Term Life and Optional AD&D insurance through payroll deductions before most taxes are withheld; if you elect dependent coverage, however, premiums for your dependents' coverage must be paid after taxes. Premiums for Optional Term Life are established by the insurer and are based on factors such as the coverage amount, your age, and whether you are a smoker or a non-smoker.

If you become totally disabled before your 60th birthday while insured under Basic or Optional Term Life coverage and you continue to be totally disabled for longer than six months, premiums for your Term Life coverage may be waived until the benefits under this Waiver of Premium Rider stop. If approved, the waiver of premiums will end with the earliest of:

- The date your disability ends
- The date you refuse to give Sun Life proof of your continuing disability
- The date you refuse to be examined by a doctor of 7-Eleven's or Sun Life's choice
- Your 65th birthday

WHEN COVERAGE ENDS

Basic Term Life and Occupational AD&D coverage ends at 11:59 p.m. on the date of the first of the following events to occur. Optional Term Life and Optional AD&D coverage ends at 11:59 p.m. of the date through which your premiums have been paid, following the first of the following events:

- You stop paying premiums for the optional coverage under the Life/AD&D Program, if required. (However, if you stop paying premiums only for dependent optional coverage, your employee coverage will not terminate.)
- Your employment with 7-Eleven terminates after a disability leave of absence
- 7-Eleven no longer offers the Life/AD&D Program coverage
- You no longer satisfy the eligibility requirements for Life/AD&D Program coverage
- Your employment with 7-Eleven terminates, including due to retirement
- The group contract ends
- If you are on leave of absence due to a sickness or injury, life insurance can be continued up to 12 months

Dependent coverage ends when:

- The dependent ceases to be eligible, such as a divorced spouse or a child who reaches the last day of the month in which he/she turns age 26
- Your employee coverage ends
- You elect to stop dependent coverage, either during Open Enrollment or after a Qualifying Life Event

CONTINUING COVERAGE

If you leave 7-Eleven and wish to maintain any of the life and/or AD&D coverages you have for yourself, spouse, or dependents, you may be eligible to "port" or "convert" those coverages. "Porting" or "portability" refers to continuing a group policy. "Converting" refers to changing from a group policy to an individual policy. If you wish to port or convert, you must do so no later than 31 days after your employment ends. For more information on continuing or converting life and AD&D coverages, including election forms, rate information, and eligibility, contact the 7-Eleven Benefit Service Center at 1-800-601-0711.

LIFE/AD&D OPTIONS

Accidental death & dismemberment ("**AD&D**") insurance provides a cash payment to you for paralysis or the loss of limbs, eyesight, or hearing — or an additional benefit payment to your beneficiary if you die as a result of an *accident*.

Basic Term Life and Occupational AD&D

Both (i) Basic Term Life insurance equal to one times your Annual Pay up to $1 million (rounded up to the next $100) and (ii) $25,000 of Occupational AD&D (store employees only) are provided to you automatically, at no cost to you. The minimum benefit for Basic Term Life Insurance is $15,000.

Optional Term Life

You may choose Optional Term Life coverage for yourself in amounts from one to eight times your Annual Pay (rounded up to the next $100), up to a maximum of $2 million.

You may also choose to cover your eligible dependents under the Term Life family option, including your spouse and eligible children. You may elect Optional Term Life coverage for your spouse equal to 50%, 100%, 150%, 200%, 250%, 300%, 350%, or 400% of your Annual Pay, up to a maximum of $100,000. The guaranteed issue is $25,000. The amount of spousal coverage cannot exceed 50% of your Optional Term Life coverage. Coverage for your children is $10,000 for each child.

Optional AD&D

You may choose Optional AD&D coverage for yourself in amounts from one to 10 times your Annual Pay (rounded up to the next $100), up to a maximum of $1 million.

You may also choose to cover your eligible dependents under the AD&D family option, under which your spouse will be insured for 60% of the benefit amount you have elected for yourself if you have no children or 50% of your benefit amount if you do have eligible children. Each eligible child is insured for 15% of your elected benefit amount. You may also elect single-parent coverage under the AD&D family option, under which each eligible child is insured for 20% of your elected benefit amount. Your spouse's AD&D coverage cancels when he or she reaches age 70, if it has not already ended.

Beneficiary Designation

You must complete a "Beneficiary Designation Form" for Basic Term Life, Occupational AD&D, and any Optional Term Life or Optional AD&D you elect for yourself. The form must be submitted to the 7-Eleven Benefit Service Center. If you do not designate a beneficiary, or if your designated beneficiary is not living at the time of your death, your benefits will be paid to the first of the following: your (i) surviving spouse; (ii) surviving child(ren) in equal shares; (iii) surviving parents in equal shares; (iv) surviving siblings in equal shares; (v) estate.

You are automatically the beneficiary of any Optional Term Life you elect for your spouse or eligible children, or Optional AD&D you elect for your family.

LIFE/AD&D BENEFITS

Basic Term Life and Occupational AD&D

The Basic Term Life Program pays a benefit to your beneficiary equal to one times your annual salary up to $1 million (rounded up to the next $100) in the event of your death.

The Occupational AD&D Program pays a benefit to your beneficiary based on a $25,000 Benefit Amount (as defined below) in the event of your accidental death or dismemberment as a result of an accident while performing your duties as a 7-Eleven employee.

Optional Term Life

	Your minimum coverage is:	Your maximum coverage is:
Yourself	One times your Annual Pay	8 times your Annual Pay (up to a maximum of $2 million)
Your spouse	½ times your Annual Pay	50% of your Optional coverage or $100,000, whichever is less
Each child, from birth to age 26	$10,000	$10,000

Occupational AD&D and Optional AD&D

In this situation:	The Occupational AD&D and Optional AD&D Programs pay:
Loss of life	Full Benefit Amount
Quadriplegia (total paralysis of both upper and lower limbs)	Full Benefit Amount
Loss of speech and hearing in both ears	Full Benefit Amount
Paraplegia (total paralysis of both lower limbs)	75% of Benefit Amount
Loss of one member* or speech or hearing in both ears	50% of Benefit Amount
Hemiplegia (total paralysis of upper and lower limbs — one side of body)	50% of Benefit Amount
Loss of thumb and index finger on the same hand	25% of Benefit Amount

*A "**member**" refers to a hand or foot, or the total and permanent loss of sight in one eye.

The "**Benefit Amount**" is the Optional AD&D benefit level you have elected, as described in the "Life/AD&D Options" section above.

The maximum amount of AD&D benefit for any one accident is 100%.

Accelerated Death Benefit

If you become terminally ill (i.e., have a diagnosed life expectancy of less than 12 months), you may receive an advanced payment from your Basic or Optional Term Life coverage of up to 90% of the life insurance benefit or $500,000, whichever is less, with the remaining benefit payable upon the covered person's death. Payment will be made as a single lump sum. Sun Life has the right to request a second opinion regarding the prognosis of the covered person from a doctor of its choice at its expense.

Special AD&D Benefits

When you elect any level of Optional AD&D coverage, you will receive the following benefits in addition to any other AD&D benefits that are available to you. These benefits will apply to you if you have AD&D coverage for yourself only, and will apply to you or a covered dependent if you elect family AD&D coverage, as noted below.

- ***Coma Benefits.*** If, while insured, you or your spouse suffers an accidental injury that results in you or your spouse being in a coma for at least 31 days, a coma benefit will be payable. It is payable for 100 months in equal monthly installments based on your or your spouse's amount of AD&D coverage

at the time of the accident, reduced by any amount previously payable as a result of the same accident. The coma benefit ceases when you or your spouse regains consciousness or 100 monthly installments have been paid.

- ***Child Care Benefits.*** If you elect family coverage and die in a covered accident, the AD&D Program will pay benefits equal to the lesser of the actual cost charged by the child care center per year, 10% of the Benefit Amount or $10,000, for up to four consecutive years for each eligible dependent child up to age 13 who is enrolled in a licensed child care facility no more than 365 days after your death.
- ***Dependent Child Education Benefits.*** If you die in a covered accident, the AD&D Program will pay benefits equal to the lesser of 10% of the Benefit Amount, incurred expenses or $10,000, for up to four consecutive years (or, if less, as long as your child continues higher education) for each eligible dependent child up to age 26 who is enrolled as a full-time student in a school above the 12th grade no more than one year after your death.
- ***Dependent Spouse Education Benefits***. If you die in a covered accident, the AD&D program will pay benefits equal to the expenses paid directly to such school or $3,000, whichever is less if your covered spouse enrolls in any school within 12 months of the date of your death, for the purpose of retraining or developing skills needed for employment.
- ***Seat Belt Benefits.*** If you or a covered dependent dies as a result of a covered accident in which the deceased individual was seated in an automobile with his or her seatbelt properly fastened, the Optional AD&D Program will add 10% or $10,000, whichever is less, to the Benefit Amount.
- ***Air Bag Benefit.*** If you or a covered dependent dies in an automobile accident in a private passenger car equipped with air bags, the air bag for the covered person's seat deployed, and the covered person's seatbelt was properly fastened, the Optional AD&D program will add 10% or $10,000, whichever is less, to the Benefit Amount.
- ***Rehabilitative*** Training Benefit. If you or a covered dependent is injured in a covered accident, suffers a loss, and requires occupational training, the Optional AD&D Program will pay the lesser of $10,000, 10% of the Benefit Amount or your actual expense incurred for rehabilitative training reduced by any amount you receive from other sources. The rehabilitative training expenses must be incurred within two years following the date of the accident that caused the accidental injury.
- ***Home Alteration or Vehicle Modification Benefit.*** If you or a covered dependent receives an AD&D benefit under the Program for the loss of both feet or legs, both hands or arms, the loss of sight, or quadriplegia, paraplegia or hemiplegia, the Optional AD&D Program will pay benefits equal to the lesser of the actual expenses incurred for the modification or alteration reduced by any reimbursement you receive from other sources, 10% of the Benefit Amount or $10,000. This benefit is payable for the out-of-pocket reasonable and necessary expenses incurred within three years of the date of your loss for the cost of alterations of your principal residence or the cost of modification to one motor vehicle utilized by you.
- ***Felonious Assault Benefit.*** If an AD&D benefit is payable to you due to a felonious assault while you are at work or traveling on business for the Company, an additional felonious assault benefit will be paid equal to the lesser of 25% of your Benefit Amount or $5,000. The felonious assault cannot be inflicted by another employee of the Company, a family member, or a member of your household.

INCIDENTS NOT COVERED

Optional Term Life

The Optional Term Life program will **NOT** pay death benefits for your or your covered dependent's death if the death occurs:

- No amount of Optional Life Insurance is payable if the suicide occurs within 24 months after the Employee's Optional Life Insurance is effective. Any period of time the Employee was insured for the same amount of Optional Life Insurance under the previous insurer's group Life policy will count towards completion of the 24 months.
- No increased or additional amount of Optional Life Insurance is payable if the suicide occurs within 24 months after the increased or additional amount of Optional Life Insurance is effective.

- No amount of Optional Life Insurance in excess of the Guaranteed Issue Amount is payable if the suicide occurs.

Occupational and Optional AD&D

The Occupational AD&D and Optional AD&D Programs will **NOT** pay death or dismemberment benefits if the loss occurs more than 365 days after the date of the covered accident, or as a result of any of the following:

- Committing or attempting to commit suicide, whether sane or insane
- Injuring oneself intentionally
- A sickness or infection including a physical or mental condition that is not caused solely by or as a direct result of a covered accident
- War or an act of war, or any involvement in any period of any type of armed conflict (not including acts of terrorism)
- Active participation in a riot, rebellion or insurrection
- Riding in or driving any motor-driven vehicle in a race, stunt show, speed test or while intoxicated
- Injuries sustained from any aviation activities, other than riding as a fare-paying passenger
- Committing or attempting to commit an assault, felony or other criminal act
- Voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless administered on the advice of a physician and used as directed.

TRAVEL ASSISTANCE

In connection with the Basic Term Life coverage, all employees are covered by the Assist America Travel Assistance Program. If you are traveling internationally or within the U.S. more than 100 miles from home, you can access travel assistance services for emergencies by calling 1-800-872-1414 (within the U.S.) or 1-609-986-1234 (outside the U.S., call collect). Services available include:

- Medical assistance (but not medical care), including referrals to English-speaking doctors and hospitals, assistance in admission to a hospital if your insurance is not recognized, critical care monitoring, and assistance with replacement of prescription medicine
- Medical evacuation if adequate medical facilities are not available locally
- Return of mortal remains if you or a family member dies while traveling
- Political evacuation, if the U.S. government determines that a country must be evacuated
- Transportation for a family member to join you, if traveling alone and hospitalized for more than seven days
- Emergency cash and bail assistance

CLAIMS PROCESS

If a covered person dies or suffers an AD&D-covered loss, 7-Eleven can help the survivors file claims for any 7-Eleven benefits for which they are eligible. The survivors should call the 7-Eleven Benefit Service Center at 1-800-601-0711 and provide the requested information as soon as possible following the death of, or AD&D-covered loss suffered by, the covered person. The representative can also help determine what other 7-Eleven benefits may be payable as a result of the event.

Please see the "Claims and Review Procedures" section later in this Summary for more information about what to do if you disagree with a benefit determination.

STATE REQUIREMENTS

Some states have specific requirements that may change the provisions under the insurance contracts providing the benefits described in this section. If you live in such a state, you will be provided with a separate description of those requirements. The separate description applies to your benefits and is incorporated by reference into this Summary.

CRITICAL ILLNESS INSURANCE

7-Eleven offers Critical Illness Insurance to certain employees that can help ease the financial impact of certain critical illnesses by paying for things not typically covered by other types of insurance.

ELIGIBILITY

Who Is Eligible for Coverage?

Employees may purchase $10,000 of optional Critical Illness Insurance. If you are a part-time employee, you are NOT eligible for Critical Illness Insurance.

Spouses of eligible full-time employees are also eligible to participate in Critical Illness Insurance.

A "**dependent child**" may be enrolled if he or she is your unmarried natural or adopted child or stepchild from birth to 26 years of age. This includes your unmarried grandchild who is your dependent for federal income tax purposes on the date the grandchild is first eligible under the Children's Critical Illness Rider, and a child for whom you must provide medical support under a court order.

This definition includes your child age 26 or older who remains dependent on you for support and maintenance because the child is incapable of working due to physical or mental handicap. Written proof of the child's incapacity must be furnished to Voya at our home office within 31 days prior to the child reaching the limiting age while insured under the Children's Critical Illness Rider. Voya may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to Voya that the handicap is continuing.

"**Spouse**" means your lawful spouse.

No person can be enrolled in Critical Illness Insurance as both an employee and a spouse.

If both parents work at 7-Eleven, only one parent can cover the dependent children. You do not have to enroll in medical coverage to enroll in Critical Illness Insurance.

WHEN COVERAGE BECOMES EFFECTIVE

Critical Illness Insurance becomes effective on the first day of the month following the month in which you become eligible for benefits coverage or upon approval from the insurance carrier, whichever is later, if you are Actively at Work on that date. If not, your insurance takes effect on the date you return to Active Work. If you do not enroll when first eligible, you must wait until the next Open Enrollment, unless you meet one of the limited Mid-Year Change exceptions described in the summary you will receive from Voya.

Coverage for a covered dependent is effective on the date your coverage is effective or upon approval from the insurance carrier, whichever is later, if the dependent is not confined at home under a physician's care, receiving or applying for disability benefits, or hospitalized. If this requirement is not met, coverage takes effect when the dependent is no longer confined, receiving or applying for disability benefits, or hospitalized.

PAYING FOR COVERAGE

You may purchase $10,000 of critical illness coverage by paying the full cost. You pay your Critical Illness Insurance premiums through post-tax deductions.

WHEN COVERAGE ENDS

Critical Illness Insurance for you and any covered dependents will end at 11:59 p.m. on the date that any one of the following events occurs:

- You stop making Critical Illness Insurance premium payments
- You begin any leave of absence, except if you continue to make premium payments while on a disability, unpaid medical, military, or an FMLA leave of absence

- You or any covered dependent submits (or attempts to submit) a false, altered, forged, or fraudulent claim or document requesting benefits under any 7-Eleven Program
- You are no longer eligible for Critical Illness Insurance (except as provided in the "Continuation of Insurance" section below)
- The Critical Illness Insurance program is terminated
- 7-Eleven no longer offers any Critical Illness Insurance
- Your employment with 7-Eleven terminates (except as provided in the "Continuation of Insurance" section below)

Your dependents' coverage will also terminate at 11:59 p.m. on the date that they are no longer eligible dependents under the Critical Illness Insurance program or on the date they are no longer enrolled as dependents under the Critical Illness Insurance program.

See the following section for another circumstance under which coverage will end.

CRITICAL ILLNESS BENEFITS

Critical Illness Insurance will pay a lump sum if you or a covered dependent experiences any of these covered medical conditions:

- Cancer
- Heart attack
- Stroke
- End-stage renal failure
- Coma
- Major organ failure
- Permanent paralysis
- Coronary artery bypass

The benefit for carcinoma in situ and coronary artery bypass is $2,500. The benefit for skin cancer is $1,000. For the other conditions in this list, the benefit is $10,000. Benefits reduce by 50% on the January 1 following your 70th birthday, but premiums do not reduce.

The conditions listed above are the only conditions for which a Critical Illness benefit is payable. Each of these conditions and the requirements to establish that the condition has occurred are specifically defined in the Certificate for the Critical Illness Insurance, which can be obtained by calling the 7-Eleven Benefit Service Center at 1-800-601-0711. Not all conditions that may be called by the above listed terms in everyday language will meet the definition of those terms for purposes of benefit payment. For example, "cancer" does not include certain skin cancers, and "permanent paralysis" does not include paralysis due to a stroke.

The lump-sum payment is paid to you for any covered conditions experienced by you or a covered dependent, and you decide how to spend it — perhaps for copays, deductibles, mortgage payments, or child care. If you are not legally competent to receive the benefits, benefits may be paid to anyone related to you by blood or marriage whom the insurance company believes is entitled to it. You may designate a beneficiary for payments made after your death.

RECURRENCE

If you experience a recurrence of a critical illness for which a benefit has already been paid, following 12 consecutive months during which you had no occurrence of any critical illness covered by this Program and you were free of the critical illness for which benefits were previously paid, 100% of your benefit will be paid for the recurrence. This recurrence of benefits will occur up to a maximum of three times.

This recurrence provision does not apply to cancer.

EXCLUSIONS

Benefits will not be paid for a covered condition that is caused in whole or directly by:

- Participation or attempt to participate in a felony or illegal activity
- Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane
- War or any act of war, whether declared or undeclared (excluding acts of terrorism)
- Loss sustained while on active duty as a member of the armed forces of any nation, however, upon written notice of such service, the insurance company will refund any premium that was accepted for any period not covered as a result of this exclusion
- Alcoholism, drug abuse or misuse of alcohol or taking of drugs, other than under the direction of a doctor, as permitted by state law

CONTINUATION OF INSURANCE

You may continue coverage for yourself and your covered dependents after your 7-Eleven employment ends or after you transfer to part-time status by making a written request to the insurance company and paying the premium directly to the insurance company during the 31 days after your coverage is scheduled to end.

Evidence of insurability is not required to continue coverage. Premiums will be based on the insurance company's portability rates in effect when you apply, and will be different from the premiums for 7-Eleven coverage.

CLAIMS PROCESS

To file a claim, contact the insurance company within 30 days of the date the covered condition occurs. You will receive a claim form and instructions on how to complete it. Submit the claim form and any required proof of the condition within 90 days after the covered condition occurs. If approved, the benefit will be paid no later than 60 days after receipt of the completed claim form and proof.

Please see the "Claims and Review Procedures" section later in this Summary for more information about what to do if you disagree with a benefit determination.

GROUP LEGAL SERVICES

7-Eleven offers the MetLaw Group Legal Services program, administered by Hyatt Legal Plans. The Group Legal Services program provides legal representation for you and your dependents at a reasonable price. The program's network of attorneys provides fully covered legal services for a wide range of personal legal matters.

ELIGIBILITY

Who Is Eligible for Coverage?

Employees who are eligible for Company medical coverage (other than COBRA coverage) become eligible to participate in the Group Legal Services program on the date they are eligible for Company medical coverage. If you are a part-time employee, you are NOT eligible for the Group Legal Services program.

When you enroll in the Group Legal Services program, your spouse and dependents are also eligible to obtain legal services through the program. For purposes of this program, dependent means your unmarried child up to age 21 who depends on you for support, and any other person whom you claim as a dependent on your federal tax return.

WHEN COVERAGE BECOMES EFFECTIVE

Coverage by the Group Legal Services program becomes effective on the first day of the month following the month in which you become eligible for benefits coverage. If you do not enroll when first eligible, you must wait until the next Open Enrollment. The program has a minimum participation period of one year, so you must maintain the coverage for the entire year. Changes cannot be made mid-year due to a Qualifying Life Event.

PAYING FOR COVERAGE

You pay the full cost of the Group Legal services program, through post-tax deductions.

WHEN COVERAGE ENDS

Employees are no longer eligible to participate in the Group Legal Services program when any of the following occurs:

- Their employment with 7-Eleven terminates, including by retirement
- They fail to return to Active Employment with 7-Eleven upon the conclusion of an approved leave of absence
- They are no longer eligible to participate in the Group Legal Services program
- 7-Eleven terminates the Group Legal Services program

If you cease to be eligible to participate or your employment with the Company ends, the program will cover the legal fees for any covered services that were opened and pending during the period you were enrolled in the program.

COVERED LEGAL SERVICES

You may have an initial consultation with a Hyatt Legal Services attorney, either in his or her office or by telephone, to discuss any personal legal problems that are not excluded in the following section. The attorney will explain your rights and your options and determine whether the matter is covered by the program. If the matter is covered by the program, you will not be charged for the attorney's services. If the matter is not covered by the program and the Hyatt Legal Services attorney recommends that you have legal representation, he or she will provide a written fee statement in advance. You may choose whether to retain the Hyatt Legal Services attorney at your own expense, seek other counsel, or do nothing. There is no limit on the number of times you may utilize the initial consultation, but you may not use this service to seek ongoing advice to allow you to represent yourself.

A complete list of legal services covered by the program, including limitations and conditions that must be met, may be obtained from Hyatt Legal Services by calling 1-800-GETMET8 or by going online to metlife.com/mybenefits (click on Group Legal Services after entering the site).

The following is a brief summary of covered services:

- Consumer protection
  - Consumer protection matters
  - Small claims assistance
  - Personal property protection
- Debt matters
  - Debt collection defense
  - Identity theft defense
  - Personal bankruptcy or wage earner plan
  - Tax audits
- Defense of civil lawsuits
  - Administrative hearing representation
  - Civil litigation defense
  - Incompetency defense
- Document preparation
  - Affidavits
  - Demand letters
  - Mortgages
  - Notes
  - Document review
  - Elder law matters
- Family law
  - Name change
  - Prenuptial agreement
  - Protection from domestic violence
  - Adoption and legitimization (contested and uncontested)
  - Guardianship or conservatorship (contested or uncontested)
  - Divorce
- Immigration assistance
- Personal injury (fee of 25% of the gross award)
- Real estate matters
  - Boundary or title disputes (primary residence)
  - Eviction and tenant problems (primary residence, as tenant only)
  - Security deposit assistance (primary residence, as tenant only)
  - Home equity loans (primary residence or second/vacation home)
  - Property tax assessment (primary residence)
  - Refinancing of home (primary residence or second/vacation home)
  - Sale or purchase of home (primary residence or second/vacation home)
  - Zoning application
- Traffic and criminal matters
  - Juvenile court defense
  - Traffic ticket defense (no DUI)
  - Restoration of driving privileges
- Wills and estate planning
  - Trusts
  - Living wills
  - Powers of attorney
  - Probate (fee of 10% less than the attorney's normal fee)
  - Wills and codicils

SERVICES NOT COVERED

The following legal services are not covered by the program:

- Employment-related matters, including Company or statutory benefits
- Matters involving your employer or any benefits your employer provides, MetLife and affiliates, or program attorneys
- Matters in which there is a conflict of interest between the employee and spouse or dependents, in which case services are excluded for the spouse and dependents
- Appeals and class actions
- Farm and business matters, including rental issues when you are the landlord
- Matters for which you are entitled to receive legal representation from any other organization, such as an insurance company or a government agency; or from another legal plan (except that if you are eligible for legal aid or Public Defender services, you may receive benefits from this program)
- Matters that are clearly without merit, frivolous, or for the purpose of harassing another person

If you are represented by a Hyatt Legal Services attorney and the court awards attorneys' fees as part of a settlement, the Group Legal Services program must be reimbursed from this award to the extent it paid the fee for your attorney.

TO OBTAIN LEGAL SERVICES

To obtain services, call Hyatt Legal Plans' Client Service Center at 1-800-GETMET8. Be prepared to give the last four digits of your Social Security number and zip code. A spouse or eligible dependent will need the last four digits of the employee's Social Security number. The Client Services representative who answers the call will:

- Verify your eligibility for services
- Make an initial determination of whether your case is covered (the Hyatt Legal Services attorney will make the final determination of coverage)
- Give you a case number (you will need a new case number for each new case you have)
- Give you the telephone number of the attorney most convenient to you
- Answer any questions about the program

You then call the attorney and schedule an appointment. If you choose, you may select your own attorney. If you live where there are no participating law firms, you will be asked to select your own attorney. In both cases, the program will reimburse you for the fees up to an amount specified in a fee schedule.

For services to be covered, you or your eligible dependent must have obtained a case number and retained an attorney, and the attorney must begin work on the covered legal matter while you are covered by the Group Legal Services program.

CONFIDENTIALITY, ETHICS & INDEPENDENT JUDGMENT

Your use of the program and the legal services is confidential. Your attorney will maintain strict confidentiality of the traditional lawyer-client relationship. 7-Eleven will not be told about your legal problems or the services you use under the program.

7-Eleven will not interfere with your attorney's independent exercise of professional judgment when representing you. Attorney services provided under the program are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the Group Legal Services program and he or she will not receive any further instructions, direction, or interference from anyone else connected with the program.

The program has no liability for the conduct of any program attorney. You have the right to file a complaint with the state bar concerning attorney conduct. You have the right to retain at your own expense any attorney authorized to practice law in your state.

If you have a complaint about the legal services you receive or the conduct of a program attorney, call Hyatt Legal Plans at 1-800-821-6400. You will receive a response within two business days of your call.

CLAIMS PROCESS

If you are denied coverage by Hyatt Legal Plans or by a program attorney, you may appeal by sending a letter to:

Hyatt Legal Plans, Inc.
Director of Administration Eaton Center,
1111 Superior Ave.
Cleveland, OH 44114-2507

Please see the "Claims and Review Procedures" section later in this Summary for more information about what to do if you disagree with a claim determination.

ADOPTION ASSISTANCE PROGRAM

7-Eleven offers adoption assistance benefits to all full-time employees through the 7-Eleven, Inc. Adoption Assistance Program ("**Adoption Program**").

ELIGIBILITY

Who Is Eligible for Coverage?

Full-time and variable-hour employees who are eligible for Company medical coverage (other than COBRA coverage) become eligible to participate in the Adoption Assistance Program on the date they are eligible for Company medical coverage.

WHEN COVERAGE BECOMES EFFECTIVE

Coverage under the Adoption Program becomes effective when an eligible employee meets the eligibility requirement above.

PAYING FOR COVERAGE

Adoption Program benefits are paid from the general assets of 7-Eleven. There are no employee premiums for benefits under the Adoption Program.

All or part of the benefits received under the Adoption Program may be exempt from federal income tax, depending on your adjusted gross income for federal income tax purposes. For example, if your adjusted gross income for 2017 is $203,540 or less, the benefits will be exempt. If your adjusted gross income for 2017 is $243,540 or more, the benefits will be taxable. If your adjusted gross income falls between these two amounts, some portion of the benefit will be exempt, and the remainder will be taxable.

WHEN COVERAGE ENDS

Employees are no longer eligible to participate in the Adoption Program when any of the following occurs:

- Their employment with 7-Eleven terminates, including by retirement
- They fail to return to Active Employment with 7-Eleven upon the conclusion of an approved leave of absence
- They are no longer eligible to participate in Company medical coverage (other than COBRA coverage)
- 7-Eleven terminates the Adoption Program

ADOPTION BENEFITS

The Adoption Program will reimburse eligible employees up to $2,000 for the qualified adoption expenses that they have paid to adopt that child.

Not more than 5% of the total benefits paid under the Adoption Program in any given year will be paid to the class of shareholders or owners (or their spouses or dependents) individually owning more than 5% of the stock, capital, or profits of 7-Eleven on any day in that year.

COVERED ADOPTION EXPENSES

The following costs are "**qualified adoption expenses**":

- Adoption agency fees
- Placement fees
- Legal fees associated with the adoption
- Court fees associated with the adoption
- Travel expenses to pick up the child

EXPENSES NOT COVERED

- Expenses for a child age 18 or older at the time of adoption, unless that child is physically or mentally disabled
- Any expenses associated with the adoption of a stepchild
- Donations to an adoption agency
- Legal guardianship fees

CLAIMS PROCESS

To receive benefits, after your child's adoption has been finalized, request an Adoption Reimbursement Application from the 7-Eleven Benefit Service Center. Attach original receipts to your completed application, along with a photocopy of your child's adoption certificate, and return the completed application packet to the address printed at the top of the application. Call the 7-Eleven Benefit Service Center at 1-800-601-0711 if you have any questions. If you feel that your Adoption Assistance benefit has been incorrectly determined, you may appeal to the 7-Eleven Benefit Service Center. The Adoption Program will be construed according to federal law and the laws of the State of Texas. If you wish to bring a lawsuit regarding the Adoption Program, you must file suit with the appropriate court in Dallas County, Texas, no later than two years after the date on which the alleged cause of action first arose.

SEPARATION PAY PROGRAM

The 7-Eleven, Inc. Separation Pay Program ("**Separation Pay Program**") under the 7-Eleven Comprehensive Welfare Benefits Plan provides severance benefits ("**Separation Pay**") to certain employees whose positions are eliminated because of reductions in force, reorganizations of operations, divestitures, outsourcing, or similar changes.

ELIGIBILITY

Full-Time and Variable Hour Employees

The Separation Pay Program applies to all full-time employees of the Company who have worked at least 12 months for the Company. "Full-time" means regularly working at least 32 hours per week for the Company. The Separation Pay Program also applies to all Variable Hour employees who have worked at least 12 months for the Company, provided they have worked an average of at least 32 hours per week over the most recent rolling 12-month period. Part-time and temporary employees are not eligible.

Requirements

To receive benefits under the Separation Pay Program if you are a full-time employee, you must meet **all** of the following requirements:

1. Job Eliminated: Your position is being eliminated due to a reduction in force, reorganization of operations, outsourcing, or other similar change.
2. No Alternative Position: The "company" does not offer you an alternative position, or it does offer an alternative position but the position requires a reduction in base pay of at least 10 percent or changes the work location (i) by at least 50 miles for non-store employees and store managers or (ii) by an unreasonable distance as determined by the local Human Resources representatives (generally no more than an additional 30 minutes travel time) for hourly store staff. For this purpose, "company" means 7-Eleven, Inc., any subsidiary or other related entity, any separate franchisee, and — in connection with a merger, acquisition, or divestiture — either the buyer or the seller.
3. Good Standing: You are in "good standing" at the time of termination. You are not in "good standing" if you are being terminated for performance-related or disciplinary reasons, are involved in the disciplinary process at the time of termination, or within 12 months prior to termination were under a performance improvement plan, received a written warning, or received a final warning.
4. Involuntary: You are not resigning voluntarily.
5. Release: You sign the required release, without revoking it.

SEPARATION PAY PROGRAM BENEFITS

Separation Pay Schedule

Separation Pay is based on the employee's pay grade and completed (not partial) years of service immediately prior to the separation, according to the following schedule:

Pay Grade	Amount of Separation Pay
Grades 60–66, and 1–3	The greater of: One week of base pay for every complete year of service (maximum of 20 weeks) –OR– Two weeks of base pay
Grades 21–25	The greater of: One week of base pay for every complete year of service (maximum of 30 weeks) –OR– Four weeks of base pay

Pay Grade	Amount of Separation Pay
Grades 26 & 27	The greater of: One week of base pay for every complete year of service (maximum of 30 weeks) –OR– 12 weeks of base pay
Grades 50–52	The greater of: One week of base pay for every complete year of service (maximum of 30 weeks) –OR– 26 weeks of base pay

Pay in Place of Notice

If an employee is eligible for benefits under the Separation Pay Program but is not given two weeks of notice (or such greater notice period as may be required by law) of an impending planned elimination of his or her position (or other involuntary separation) because of a reduction in force, reorganization of operations, outsourcing, or other similar change, the employee will be paid for each working day during which notice was not given, up to the maximum of two weeks of base pay. Any benefits due under the Separation Pay Schedule above will be reduced by any Pay in Place of Notice.

Release

Any employee otherwise eligible to receive benefits under the Separation Pay Program will be required to sign, and **not** revoke within the time that may be permitted by law, a release of liability form, in such form as may be required by 7-Eleven in its sole discretion. Failure to sign the release, or revocation of the release, means the employee will not receive any benefits under the Separation Pay Program. Signing the release does not guarantee the payment of benefits under the Separation Pay Program. The other requirements listed in the "Eligibility" section must also be satisfied.

PAYMENT LIMITATIONS

Benefits under the Separation Pay Program are paid in a lump sum. An employee's Separation Pay will not exceed the lesser of two times (i) the employee's annualized compensation as of the tax year prior to separation (but adjusted if a pay raise was received during that year), or (ii) the compensation limit under Section 401(a)(17) of the Internal Revenue Code ($270,000 for 2017, adjusted for future years). In no event will Separation Pay be paid later than the last day of the second tax year following the employee's separation from service. The employee does not have the right to designate the tax year of payment.

PAYMENT PROCESS

7-Eleven determines whether Separation Pay is due with respect to any particular employee, and, if due, the amount. If you disagree with your determination and wish to appeal, you must use the procedures described in "Claims and Review Procedures" later in this Summary to appeal that determination. You have 60 days within which to appeal. You must complete the appeals process before filing suit in court.

EDUCATIONAL ASSISTANCE PROGRAM

7-Eleven offers educational assistance benefits to all full-time and part-time employees (other than hourly store staff or variable-hour employees) through the 7-Eleven, Inc. Educational Assistance Program.

ELIGIBILITY

Who Is Eligible for Coverage?

All full-time employees (regularly working an average of at least 32 hours per week) or part-time employees (regularly working an average of at least 24 hours per week) are eligible for the Educational Assistance Program, except that hourly store staff are not eligible to participate. Store managers, all Market Division and corporate office employees, and employees in a pay grade of 24 or higher participate on an after-tax basis. To be eligible, you must:

- Have at least 12 months of service with 7-Eleven,
- Not have received a performance notice in the 12 months prior to the start of participation, and
- Have received at least an "A" or "B" (Meets Requirements) on your most recent appraisal.

7-Eleven in its discretion may limit the participation of "highly-compensated employees" as defined in Internal Revenue Code §414(q) as necessary to comply with nondiscrimination requirements.

If you are reemployed by 7-Eleven you will be treated as a new employee for purposes of eligibility for the Program.

WHEN PARTICIPATION BECOMES EFFECTIVE

If you meet all of the above criteria for eligibility and you wish to participate in the Program, you must submit a completed enrollment form to 7-Eleven, requesting participation. If your request is approved, participation begins at that time.

PAYING FOR COVERAGE

Educational Assistance Program benefits are paid from the general assets of 7-Eleven. There are no employee premiums for benefits under the Educational Assistance Program.

All of your benefits under the Educational Assistance Program may be excluded from federal income tax each year. The excluded amount will not appear on your Form W-2. The excluded amount cannot be used for any other deduction or credit, including the Hope credit or the lifetime learning credit.

WHEN COVERAGE ENDS

Employees are no longer eligible to participate in the Educational Assistance Program when any of the following occurs:

- Their employment with 7-Eleven terminates, including by retirement
- Their employment classification changes so they no longer satisfy the eligibility requirements
- They fail to return to Active Employment with 7-Eleven upon the conclusion of an approved leave of absence
- They or any of their dependents who are covered under any 7-Eleven benefit plan or program submits or attempts to submit a false, altered, forged or fraudulent claim or document requesting benefits under any 7-Eleven benefit plan or program
- 7-Eleven terminates the Educational Assistance Program

EDUCATIONAL ASSISTANCE BENEFITS

The Educational Assistance Program will reimburse participating employees for 100% of their qualified educational expenses, up to a maximum of $3,000 per calendar year for full-time employees and a maximum of $2,250 per calendar year for part-time employees. Benefits are payable only after you complete the course with a grade of "C" or better (or with a "pass" if the course is graded pass/fail).

Not more than 5% of the total benefits paid under the Educational Assistance Program in any given year will be paid to shareholders or owners (or their spouses or dependents) individually owning more than 5% of the stock, capital, or profits of 7-Eleven on any day in that year.

COVERED EDUCATIONAL EXPENSES

"**Qualified Educational Expenses**" are expenses for tuition, fees, and books incurred for your education at an accredited college or accredited academic institution. The course must be required for a degree program related to your job at 7-Eleven, or the course must be directly related to your current or reasonably-anticipated future job at 7-Eleven.

EXPENSES NOT COVERED

- Meals and lodging
- Transportation
- Expenses for tools or supplies that may be retained by you after completion of the course
- Expenses related to sports, games, or hobbies

CLAIMS PROCESS

You must complete and submit an enrollment form before enrolling for each semester or quarter. Within 31 days after a course is completed, you must submit an official grade report showing a grade of "C" or better (or a "pass" if the course is graded pass/fail) and an original receipt or cancelled check as proof of payment for the Qualified Educational Expenses. You should retain a photocopy of the entire submission. 7-Eleven in its discretion will determine whether the claim is eligible for payment under the Program. If you feel your benefits have been incorrectly determined, you may appeal to the Benefits Department.

REPAYMENT OF BENEFITS

If your employment with 7-Eleven ends within 12 months after payment of your most recent benefits under the Program, you will be required to repay 100% of the benefits you received during the 12 months prior to the termination of your employment.

7-Eleven may waive the repayment requirement if your employment ends because of a layoff, reduction in force, or other downsizing by 7-Eleven.

TRANSIT AND PARKING SPENDING ACCOUNTS

7-Eleven offers Transit and Parking Spending Accounts, which allow you to set aside pre-tax dollars to pay for public transit and parking costs up to the applicable IRS limits.

ELIGIBILITY

Who Is Eligible for Coverage?

All 7-Eleven employees working in California, New York, Texas, or Washington D.C. are eligible for transit and parking spending accounts.

WHEN COVERAGE BECOMES EFFECTIVE

The deadline for the initial enrollment period is January 1st if you wish to have funds available in your account to pay for your January 2017 expenses. You may choose to elect the benefit for a single month or you may select a recurring election.

PAYING FOR COVERAGE

Your contribution will be taken via pre-tax payroll deduction from a single paycheck each month to cover the entire monthly amount. Your cards or vouchers will be mailed to your home in time for your first month of usage.

IRS LIMITS

The IRS limits on each type of expense are as follows:

- $255 per month for Transit Expenses
- $255 per month for Parking Expenses

TRANSIT ELIGIBLE EXPENSES

Eligible expenses for the Transit Spending Account are:

- Mass public transit passes
- Vanpool fees

You can elect to have your transit passes, fare cards, or vouchers automatically mailed to your home each month. You can also elect to receive a prepaid MasterCard and have funds loaded to it each month.

PARKING ELIGIBLE EXPENSES

Eligible expenses for the Parking Spending Account are:

- Parking fees at or near your place of work
- Parking at mass transit centers

You can elect to receive a prepaid MasterCard and have funds loaded to it each month. Alternatively, you can elect the Parking Reimbursement option, which allows you to be refunded for eligible parking expenses. Claims for reimbursement can be filed online or by fax.

NON-ELIGIBLE EXPENSES

Expenses that are not eligible are:

- Gas
- Highway tolls or toll tag expenses
- Car rentals
- Taxi fares
- Other driving-related expenses

USING THE BENEFITS

To review the enrollment calendar or to make an election, go to www.ebenefitscenter.com/7-eleven.

GENERAL INFORMATION

GENERAL

This Summary describes 7-Eleven's benefits programs. Most of these benefits are governed by plan documents and insurance contracts, which are available from the Plan Administrator upon request. If there is a conflict between the official plan document or insurance contract and this Summary, the plan document or insurance contract controls. However, this Summary and the official plan documents will control over insurance contracts as to the eligibility criteria of the underlying Program.

Because the Plan documents do not address every possible individual situation, the Plan Administrator has discretionary authority to interpret the intent of the Plan with respect to specific situations, as needed. The Plan Administrator will make determinations regarding such things as the terms of the Plan, eligibility for benefits, and the nature and amount of benefits, if any. The Plan Administrator's interpretation of the Plan and decisions concerning the Plan will be final and binding.

If you have any questions regarding 7-Eleven's benefits programs, you may visit www.ebenefitscenter.com/7-Eleven, or call the 7-Eleven Benefit Service Center at 1-800-601-0711.

PLAN ADMINISTRATION

The primary responsibility for the general administration of the Plan is placed with the Plan Administrator. The Plan Administrator appoints Claims Administrators to be responsible for the claims processing (the initial approval or denial of claims and decisions regarding the appeal of any denied claims) for those benefit Programs for which a separate Claims Administrator has been appointed; provided, however, that in carrying out such responsibility, the Claims Administrator shall comply with the requirements of ERISA. In the case of certain benefit Programs, the Plan Administrator has also delegated to the Claims Administrator the responsibility for the general administration of those Programs. The Plan Administrator and each Claims Administrator, as appropriate, in its sole discretion and within the scope of its authority, shall have the power and absolute discretion to decide benefit claims and appeals, make reasonable rules and regulations, administer the Programs, and interpret the terms of the Programs and the Plan. Their good faith determinations and interpretations shall be binding and conclusive on all persons.

PLAN INFORMATION

Plan Names and Plan Numbers	Plan 525: 7-Eleven, Inc. Comprehensive Welfare Benefits Plan Plan 527: 7-Eleven, Inc. Voluntary Benefits Plan
Type of Plan	Plan 525: Welfare plan, including group health, accident, disability, death, and unemployment Plan 527: Insured welfare benefit plan, providing group legal services and critical illness insurance
Plan Year	Calendar year
Plan Sponsor and Plan Administrator	7-Eleven, Inc. 3200 Hackberry Road Irving, TX 75063 972-828-7011
Plan Sponsor Tax ID Number (EIN)	75-1085131

Trustee	The benefits provided under Plan 525 are funded through a trust called the 7-Eleven, Inc. Welfare Benefit Trust. The trustee of the trust is: Wells Fargo Institutional Retirement Trust 1445 Ross Ave. Dallas, TX 75202 214-777-4009
Agent for Service of Legal Process	7-Eleven, Inc. Attention: Plan Administrator 3200 Hackberry Road Irving, TX 75063 972-828-7011 Service of process for Plan 525 may also be made on the Trustee.
Recordkeeper	Conduent 7-Eleven Benefit Service Center P.O. Box 199407 Dallas, TX 75219 1-800-601-0711
Type of Funding	Self-insured by 7-Eleven and participant contributions: □ BCBS Medical Programs □ Dental PPO Program Insurance contract, premiums paid by 7-Eleven from its general assets: □ Basic Life and Occupational AD&D Insurance contract, premiums paid by 7-Eleven and participants: □ Dental — DMO only Insurance contract, premiums paid solely by participants: □ Vision Program □ Optional Life/AD&D Insurance □ Short-Term Disability Program □ Long-Term Disability Program □ Hyatt Legal □ Critical Illness Insurance Program Paid by 7-Eleven from its general assets: □ Separation Pay
Types of Administration	**BCBS Medical:** Contract administration by BCBS, contract #ASA-724748 **Dental Program:** Contract administration by Aetna Life Insurance Company, contract #ASA-724748 for the Dental PPO. Insurer administration by Aetna Life Insurance Company for the DMO **Vision:** Insurer administration by VSP, policy #12077865 **Short-Term and Long-Term Disability:** Contract administration by Unum, policy #530432001 (LTD) **Life/AD&D:** Insurance contract with Sun Life, policy # 237380-001 and 002 **Critical Illness Insurance:** Contract administration by Voya Financial, policy #68507-1 **Group Legal Services:** Contract administration by Hyatt Legal Plans, a MetLife company, Hyatt plan number 609/0195 **Separation Pay:** Administered by 7-Eleven, Inc. For the addresses and phone numbers of these administrators, see page 7.

AMENDMENT OR TERMINATION OF PROGRAMS

Each Program may be amended by 7-Eleven from time to time and at any time, prospectively or retroactively, without notice to any party or the consent of any party, in the sole and absolute discretion of 7-Eleven. All amendments must be in writing and approved by 7-Eleven's Chief Executive Officer or its Board of Directors.

Unless automatically terminated, each Program may be terminated, in whole or in part, by 7-Eleven at any time, without notice to any party or the consent of any party, in the sole and absolute discretion of 7-Eleven, without regard to any provision of this Summary or the formal document for any Program to the contrary.

No amendment or termination may diminish any vested accrued benefits arising from the incurred but unpaid claims as of the effective date of the amendment or termination.

NO ALIENATION OF BENEFITS

Your rights and benefits under the Programs cannot be assigned, sold, or transferred to your creditors or anyone else, except that your life insurance benefits may be assigned as a gift. However, you may assign your right to benefits to a Provider who rendered medical, dental, or vision services.

NO CONTRACT OF EMPLOYMENT

The Programs do not constitute a contract of employment between you and the Company. Your participation in the Programs does not give you any rights to continue as an employee of the Company. All employees remain subject to termination, layoff, or discipline as if the Programs had not been put into effect.

CONTACT INFORMATION AND FORFEITURES

Participants must inform the Plan Administrator of the current mailing address for themselves and any of their covered dependents and beneficiaries, and must timely update the Plan Administrator if that address changes. If a Participant fails to keep the Plan Administrator informed of these addresses, neither the Plan Administrator, the trustee, the employer, the third-party administrator, nor any fiduciary will be responsible for any late or lost payment of a benefit or for failure of any notice to be timely provided. If the Plan Administrator is unable to locate the person to whom a benefit is payable, the Plan Administrator can determine that the benefit will be forfeited. If the Participant or beneficiary later makes a valid claim to the forfeited amount, the forfeited amount will be restored.

CLAIMS AND REVIEW PROCEDURES

Each of the Programs has its own procedures and time limits for making claims. Please refer to the appropriate section of this Summary (or to your certificate of insurance, if applicable) for more information about the claims procedures that may be specific to a particular Program or benefit option. If the claims procedures in the appropriate section or certificate do not address an issue or are ambiguous, then the rules below apply to the extent they address the issue or resolve the ambiguity.

For each Program, the Claims Administrator makes all claims decisions. For insured benefits, the insurance carrier is the Claims Administrator. For self-insured welfare benefits, the third-party administrator is the Claims Administrator, except that

7-Eleven is the Claims Administrator for the Adoption Assistance Program, the Educational Assistance Program, and the Severance Pay Program.

Unless the procedures and time limits for making a claim under a Program specifically provide otherwise, any legal or equitable action regarding a claim for benefits under that Program must be filed, if at all, in a court of competent jurisdiction (or with an arbitrator, if applicable) no later than two years after the date on which written notice of the adverse decision on the final level of mandatory appeal is provided. Except as otherwise required by law or unless waived by the Claims Administrator, you must complete the Program's claims procedures before filing any suit regarding that claim.

The following procedures for processing benefit claims do not apply to the DCSA, the EAP, the Educational Assistance Program, or the Adoption Assistance Program. Please look at the section of the Summary for each of those Programs for its claims procedure.

Claims Procedures for Group Health Program Benefits

Pre-Service Claims

Urgent Care Claims. If a person or his or her duly authorized representative files with a Claims Administrator for a Group Health Program (defined as the Medical Program, Dental Program, and Vision Program) a pre-service claim that is an urgent care claim, as defined below, the Claims Administrator shall initially notify the claimant of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim unless the claimant fails to provide sufficient information for the Claims Administrator to make a determination.

A "**pre-service claim**" means any claim for medical benefits under a Group Health Program with respect to which the terms of the Group Health Program condition receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. An "**urgent care claim**" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
- In the opinion of a doctor with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

An individual acting for the applicable Group Health Program will determine whether a claim is an urgent care claim.

If the information received by the Group Health Program is insufficient for the Group Health Program to make a determination, the Claims Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. In such a case, the claimant shall be afforded at least 48 hours to provide the specified information. The Claims Administrator shall notify the claimant of the Group Health Program's determination as soon as possible, but in no case later than 48 hours after the earlier of:

- The Group Health Program's receipt of the specified information; or
- The end of the period afforded the claimant to provide the specified additional information.

The Claims Administrator may notify the claimant of its decision orally, in writing, or electronically within the applicable 48-hour time period described above; provided, however, that in the case of oral notification, the Claims Administrator shall provide written or electronic notification to the claimant not later than three days after the oral notification. If the claimant does not receive notice that the claim has been denied within the initial 48-hour time period, the claim will be deemed to have been denied as of the end of such period, and the claimant may request a review of his or her claim.

Urgent Care Extensions

If a claimant makes a request to extend the course of treatment beyond the period of time or number of treatments approved for an urgent care claim, the Claims Administrator shall make a claim determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the request by the Group Health Program, provided that any such request must be made to the Group Health Program at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

The Claims Administrator may notify the claimant of its decision orally, in writing, or electronically within the 24-hour time period described above, provided, however, that in the case of oral notification, the Claims Administrator shall provide written or electronic notification to the claimant not later than three days after the oral notification.

NON-URGENT CARE CLAIMS

A person or his or her duly authorized representative may file a written claim with the Claims Administrator for a determination of benefits for a pre-service claim that is not an urgent care claim.

The Claims Administrator will notify the claimant of its decision. Notification of a claim denial will be given orally, in writing, or electronically within a reasonable time, but not later than 15 days after the claim is received by the Claims Administrator. If the claimant does not receive notice that the claim has been denied within the initial 15-day period, or prior to the expiration of an extension period, if applicable, the claim will be deemed to have been denied as of the last day of such period, and the claimant may request a review of his claim.

If a person or his or her duly authorized representative submits the claimant's name; specific medical condition; and specific treatment, service, or product to a person or unit customarily responsible for handling benefits matters, but fails to follow the Group Health Program's procedures for pre-service claims, the claimant shall be notified of the failure and the proper procedures to be followed in filing a pre-service claim for benefits. This notification shall be provided to the claimant, as soon as possible, but not later than five days following the failure. Notification may be oral, in writing, or electronic unless written notification is requested by the claimant.

CONCURRENT CARE CLAIMS

A person or his or her duly authorized representative may file a claim with the Claims Administrator for a determination of benefits for concurrent care. "**Concurrent care**" means any ongoing course of treatment approved by the Group Health Program to be provided over a period of time or number of treatments.

If there is any reduction or termination by the Group Health Program of concurrent care (other than by Group Health Program amendment or termination) before the end of its approved period of time or number of treatments, and the concurrent care does not involve an urgent care claim, the Claims Administrator will notify the claimant of such reduction or termination within a reasonable period of time, not fewer than 15 days, before any such reduction or termination. If the concurrent care involves an emergency or urgent care claim, the Claims Administrator will make notification of a claim determination as soon as possible but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment.

POST-SERVICE CLAIMS

If any person believes that he or she is improperly being denied any benefits under the Group Health Program for a post-service claim, such person or his or her duly authorized representative may file a written claim with the Claims Administrator. "**Post-service claim**" means any claim for medical benefits under the Group Health Program that is not a pre-service claim as defined above (i.e., for which no advance approval is required).

Notification of a claim denial will be given within a reasonable time, but not later than 30 days after the post-service claim is received by the Claims Administrator. If the claimant does not receive written notice that the claim has been denied within the initial 30-day period, or prior to the expiration of an extension period, if applicable, the claim will be deemed to have been denied as of the last day of such period, and the claimant may request a review of his or her claim.

Claims Procedures for Life, AD&D and Disability Benefits

If any person believes that he or she is improperly being denied any life, AD&D, or disability benefits under the Life/AD&D Program, STD Program, or the LTD Program (collectively, the "**Life or Disability Programs**") or if a determination of a disability must be made to receive any benefits under any other Program, such person or his or her duly authorized representative may file a written claim with the appropriate Claims Administrator for the correct Program. If another party outside the applicable Disability Program must make a disability determination before all benefits are payable under the applicable Disability Program, these procedures are not applicable for those benefits.

Notification of only a claim denial will be given. Such a notice will be given within a reasonable time, but no later than 45 days after the claim is received by the Claims Administrator. If the claimant does not receive notice that the claim has been denied within the initial 45-day period, or prior to the expiration of an extension period, if applicable, the claim will be deemed to have been denied as of the last day of such period, and the claimant may request a review of his or her claim.

Claims Procedures for All Other Types of Benefits

If any person believes that he or she is improperly being denied benefits under any of the other Programs described in this Summary ("**all other claims**"), such person or his or her duly authorized representative may file a written claim with the appropriate Claims Administrator for the Program that would otherwise provide the benefit.

Notification of only a claim denial will be given within a reasonable time, but not later than 90 days after the claim is received by the Claims Administrator. If the claimant does not start receiving benefits and does not receive notice that the claim has been denied within the initial 90-day period, or prior to the expiration of an extension period, if applicable, the claim will be deemed to have been denied as of the last day of such period, and the claimant may request a review of his or her claim.

Extensions of the Period to Make Initial Determinations of Disability Claims, Post-Service Claims, Non-Urgent Claims, Pre-Service Claims, and All Other Claims

The claim review period may be extended (i) once for up to 15 days in the case of initial determinations of post-service claims and non-urgent pre-service claims, (ii) twice for up to 30 days each in the case of life, AD&D, or disability claims, and (iii) once for up to 90 days for all other claims, provided that the Claims Administrator for the appropriate Program both determines that such extension is needed for reasons beyond the Claims Administrator's control, and notifies the claimant of the circumstances requiring the extension of time and the date the Claims Administrator expects to render a decision prior to the expiration of the initial permissible response period (or subsequent 30-day extension period in the case of life, AD&D, or disability claims). A notice of extension regarding life, AD&D, or disability benefits shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

If an extension is necessary with regard to life, AD&D, or disability benefits, or because of a failure of the claimant to submit the information necessary to decide a claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. The benefit determination period shall be put on hold from the date of the notice of extension until the earlier of (i) the date the claimant responds to the request for additional information, or (ii) the last day of the 45-day period. Once the claimant has provided the additional information or, if earlier, the 45-day period has ended, the benefit determination period shall recommence.

The claimant and the Claims Administrator may extend any claim filing deadline by mutual written consent.

Notification Requirements for All Claims Denials

If any claim is wholly or partially denied, the notification will be set forth in a manner calculated to be understood by the claimant and must contain: (i) the specific reason or reasons for the adverse determination, (ii) the specific reference to the provisions of the relevant Program on which the determination is based, (iii) a description of any additional material or information necessary for the person to perfect his or her claim and an explanation of why such material or information is necessary,

(iv) information as to the steps to be taken if the claimant wishes to submit a request for review, including applicable time limits, and (v) the claimant's right to bring a civil action under section 502(a) of ERISA. For medical and disability claims, if the benefit determination was adverse, the notification must also contain any internal rule, guideline, protocol, or other similar criterion (collectively "Protocols") that were relied upon in making the adverse determination and must state that a copy of such Protocols will be available to the claimant, free of charge, upon his or her request.

For medical and disability claims only, if the benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notification must also contain either an explanation of the scientific or clinical judgment for the determination, applying the terms of the relevant Program, as applicable, to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. For health claims, the denial will include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, the denial code, and a statement describing the availability upon request to receive the diagnosis, treatment, and denial codes and their meanings.

For denials of all urgent claims for medical benefits, the notification must also contain a description of the expedited review process applicable to such claims. To appeal an urgent medical claim, you may call BCBS's Customer Service Unit at the toll-free phone number on your ID card.

Review Procedures for Appeals of Denials

Time Period for Review

Medical, Dental, Vision, Life, AD&D or Disability. Within 180 days after the date that the claimant receives notice of a claim denial for medical, dental, vision, life, AD&D, or disability benefits, or if applicable, within 180 days after the date on which such denial is deemed to have occurred, the claimant or his or her duly authorized representative may file a request that the Claims Administrator review his or her denied claim.

For concurrent claims, the claimant or his or her duly authorized representative may file a written request with the Claims Administrator for a review of his or her denied claim on or before the date his or her benefits are reduced or terminated. Such request must be filed within a reasonable time but not later than five days before a concurrent claim benefit is reduced or terminated.

The claimant may request an expedited review of his or her urgent care claim by contacting the Claims Administrator orally or in writing if his or her urgent care claim has been wholly or partially denied. If the claimant requests an expedited review, all necessary information, including the Group Health Program's benefit determination on review, shall be transmitted expeditiously between the Group Health Program and the claimant.

All Other Claims

Within 60 days after the date that the claimant receives notice of a claim denial for benefits under one of the Programs other than the Group Health Programs, Life/AD&D, or Disability Programs, or if applicable, within 60 days after the date on which such denial is deemed to have occurred, the claimant or his or her duly authorized representative may file a request that the Claims Administrator review his denied claim.

Standards to Review a Claims Denial of Medical Benefits

The Medical Programs provide two levels of appeal, with an additional voluntary level that is not required. As the Claims Administrator for the medical program, BCBS administers all appeals for medical benefits.

LEVEL ONE APPEAL

A level one appeal of a claim denial shall be provided by BCBS personnel not involved in making the claim denial.

Urgent Care Claims (may include concurrent care claim reduction or termination). BCBS shall issue a decision within 36 hours of receipt of the request for an appeal.

Pre-Service Claims (may include concurrent care claim reduction or termination). BCBS shall issue a decision within 15 calendar days of receipt of the request for an appeal.

Post-Service Claims. BCBS shall issue a decision within 30 calendar days of receipt of the request for an appeal.

You may submit written comments, documents, records, and other information relating to your claim, whether or not they were submitted in connection with the initial claim.

A copy of the specific rule, guideline, or protocol relied upon in the denying the claim will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

LEVEL TWO APPEAL

If BCBS upholds a claim denial at the first level of appeal, you or your authorized representative has the right to file a level two appeal. The appeal must be submitted within 60 calendar days following your receipt of denial of a level one appeal.

A level two appeal of a denial of an urgent care claim, a pre-service claim, or a post-service claim shall be provided by BCBS personnel not involved in making the level one claim denial.

Urgent Care Claims (May include concurrent care claim reduction or termination). BCBS shall issue a decision within 36 hours of receipt of the request for a level two appeal.

Pre-Service Claims (May include concurrent care claim reduction or termination). BCBS shall issue a decision within 15 calendar days of receipt of the request for level two appeal.

Post-Service Claims. BCBS shall issue a decision within 30 calendar days of receipt of the request for a level two appeal.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

EXHAUSTION OF PROCESS

You must exhaust the applicable level one and level two processes of the appeal procedure before you establish any litigation, arbitration, or administrative proceeding regarding an alleged breach of the policy terms by BCBS Life Insurance Company; or any matter within the scope of the appeals procedure.

MEDICAL CLAIMS — VOLUNTARY APPEALS

You may file a voluntary appeal for external review of any final standard appeal determination that qualifies. If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

EXTERNAL REVIEW

BCBS may deny a claim for reasons that involve medical judgment, such as medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or such as Experimental/Investigational treatments, or nonquantitative treatment limitations. In these situations, or upon a rescission of coverage, you may request an external review if you or your provider disagrees with BCBS's decision. An external review is a review by an independent physician, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received notice of the denial of a claim by BCBS;
- Your claim was denied because BCBS determined that the care was not medically necessary or was Experimental/Investigational; and
- You have exhausted the applicable internal appeal processes.

The claim denial letter you receive from BCBS will describe the process to follow if you wish to pursue an external review.

You must submit your request for external review to BCBS within four months of the date you received the final claim denial letter. You must include a copy of the final claim denial letter and all other pertinent information that supports your request.

BCBS will determine within five business days after receiving your request whether the requirements for external review have been met. Within one business day after completing this review, BCBS will notify you in writing if your request is or is not eligible for external review, or if it is incomplete. If your request is incomplete, the written notice will describe the information necessary for completion and allow you to complete your request within the remainder of the four-month filing period or the 48-hour period after receiving the notice, whichever is later.

BCBS will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. The External Review Organization will notify you in writing of your request's eligibility and acceptance for external review and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt any additional information for the External Review Organization to consider when conducting the external review. In making a decision, the external reviewer may consider any appropriate credible information that you send within 10 business days of notification, and will follow BCBS's contractual documents and plan criteria governing the benefits.

You will be notified of the decision of the External Review Organization, usually within 45 calendar days of BCBS's receipt of your request and all necessary information. A quicker review is possible if your physician certifies (by telephone or in writing) that a delay in receiving the service would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal. After referral to an External Review Organization, the External Review Organization will render a decision on an expedited review as expeditiously as necessary but in no event more than 72 hours after receiving the request for review. If the decision is not in writing, the External Review Organization will provide written confirmation of the decision within 48 hours after the date of notification of the decision.

BCBS, the Company, and the Plan will abide by the decision of the External Review Organization, except where BCBS can show conflict of interest, bias, or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to BCBS. BCBS is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about BCBS's External Review process, call the toll-free Customer Services telephone number shown on your ID card.

Standards to Review a Claims Denial of Benefits Other Than Medical

Each Program other than medical requires only one level of appeal for all benefits. In order for a claimant to pursue his or her rights as explained in the "Rights After Appeal" section below, he or she must first exhaust the appeal rights under the applicable Program.

The claimant and/or his or her authorized representative may inspect, or request copies of, free of charge, all documents and other information relevant to the denied claim, and may submit written comments, documents, records, and other information to the Claims Administrator in connection with the review of his or her claim. The review of the claimant's appeal of a denied claim shall be reviewed without affording deference to the initial adverse benefit determination and will not be conducted by the individual who made the initial review, nor a subordinate of such individual, but shall be conducted by the Claims Administrator in its capacity as the Program's fiduciary designated to resolve claims appeals for the Program. If the claim is denied upon review and notice of such denial upon review is provided to the claimant as provided in these procedures, the claimant may pursue his or her rights as set forth in the "Rights After Appeal" section described below.

Additional Procedures Applicable Only to Appeal of Certain Denied Disability Claims

If a denial of a disability claim was based in whole or in part on a medical judgment, the appropriate person(s) determining the appeal shall consult with a health care professional (not consulted in the initial claim that is being appealed nor a subordinate of such health care professional) who has appropriate training and experience in the field of medicine involved in the medical judgment and shall provide the claimant with such information regarding such health care professionals as the Claims Administrator determines is appropriate. The claimant shall be provided with the identification of medical or vocational experts who were consulted for the appeal, without regard to whether the Claims Administrator relied upon the expert's advice.

Notification of Decision on Review

The Claims Administrator will notify the claimant of its decision. If an expedited method such as oral notification is used, it must be followed up with a transmission of the Claims Administrator's decision, usually in writing or electronically.

Notifications will be set forth in a manner calculated to be understood by the claimant and will contain: (i) the specific reason or reasons for the denial, (ii) specific references to the provisions of the applicable Program on which the benefit determination is based, (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all material and required information relevant to the claim for benefits, (iv) a statement describing any voluntary appeals offered by the applicable Program, including information concerning the procedures of the voluntary appeal that would allow the claimant to make an informed decision about whether to appeal and such other information that the Claims Administrator determines is appropriate regarding alternative dispute resolution options, (v) a statement of the claimant's right to bring an action under section 502(a) of ERISA, (vi) a description of the Protocols, if any, used to make the decision and that a copy of the Protocols will be available free of charge upon request, and (vii) for medical and disability claims, the identification of medical or vocational experts whose advice was obtained in connection with the decision, without regard to whether the advice was relied upon in making the decision. If the notice of denial on appeal concerns a denied claim under a Group Health Program or a denied disability benefit, it will also contain a statement that an explanation of the clinical and scientific judgment used in making the determination will be available free of charge upon request by the claimant if such a judgment was used in denying the appeal, and the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and state insurance regulatory agency."

Response Dates for Appeals of Denials Other Than Medical

For life/AD&D and disability claims, the decision on review will be made within 45 days after the request for review is received by the Claims Administrator, or within 90 days if special circumstances require an extension of time. If such an extension of time is taken, the Claims Administrator shall notify the claimant in writing within the initial 45-day period and shall state the circumstances for extension. If the claimant does not receive notice of the decision within the initial 45-day period, or within the 45-day extension period, if applicable, the claim shall be deemed to have been denied on review.

For all other claims, the decision on review will be made within 60 days after the request for review is received by the Claims Administrator, or within 120 days if special circumstances require an extension of time. If such an extension of time is taken, the Claims Administrator shall notify the claimant in writing within the initial 60-day period and shall state the circumstances for extension. If the claimant does not receive notice of this decision within the initial 60-day period, or within the 60-day extension period, if applicable, the claim shall be deemed to have been denied on review.

Written or Electronic Notifications

All notifications regarding claim decisions shall be either written or electronic, except as discussed in the section on urgent care. Electronic notification shall comply with standards imposed by the Claims Administrator consistent with applicable guidance. This written or electronic notification can be included as part of an expedited method used as provided above (e.g., if facsimile transmission is used).

Rights After Appeal

If the participant is dissatisfied with the Claims Administrator's review of the decision, the participant has the right to file suit in a federal or state court within 24 calendar months immediately following the date of such Claims Administrator's decision on appeal. No action may be brought for benefits provided by any Program or to enforce any right thereunder until after a claim has been submitted to and determined by the Claims Administrator and all appeal rights under the Program have been exhausted. Thereafter, the only action that may be brought is one to enforce the decision of the Claims Administrator. The participant's beneficiary should follow the same claims procedure in the event of the participant's death.

STATEMENT OF ERISA RIGHTS

This section applies only to the 7-Eleven, Inc. Comprehensive Welfare Benefits Plan and the 7-Eleven, Inc. Voluntary Benefits Plan (the Plans). Benefits provided under the Plans are medical, dental, vision, life, AD&D, disability, critical illness insurance, group legal services, and separation pay. Adoption assistance, educational assistance, dependent care assistance, and the EAP are not part of the Plans, and are not covered by ERISA. This section does not apply to those benefits.

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of each Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Coverage

- Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of that coverage as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary and the documents governing the appropriate health program on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to

$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, or if you have an unresolved issue with respect to a Qualified Domestic Relations Order, you may file suit in a state or federal court. If it should happen that a Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance With Your Questions

If you should have any questions about the Plans, please contact the Plan Administrator. If you have any questions about this Summary Plan Description or about your rights under ERISA, you may contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210 to discuss questions about this statement of rights or about any rights under ERISA. The Plan Administrator will be happy to furnish the address and telephone number.

GLOSSARY

Active Employment — You are working for 7-Eleven for earnings that are paid regularly, are performing the Material and Substantial Duties of your Regular Occupation, and are working at least the minimum number of hours required for eligibility for such Programs. Your work site must be 7-Eleven's usual place of business, an alternative work site at the direction of 7-Eleven (including your home), or a location to which your job requires you to travel. Normal vacation is considered Active Employment. This definition applies to the STD and LTD Program.

Actively at Work — Performing regular employment duties for a full work day scheduled by the company, either at one of 7-Eleven's business establishments or at a location traveled to on business for 7-Eleven. You are considered actively at work during normal vacation or holiday if you were actively at work on your immediately preceding scheduled workday and you are not hospital confined or disabled due to an injury or sickness. This definition applies to the Life, AD&D, Critical Illness, and the STD and LTD Programs.

Allowable Amount — The maximum amount of an out-of-network charge eligible for consideration for payment by the BCBS medical plan for a particular service, supply, or procedure, as determined by BCBS. The Allowable Amount is the lesser of (i) the provider's billed charges, or (ii) the BCBS-determined amount, developed from base Medicare participating reimbursements adjusted by a predetermined factor established by BCBS that is not less than 75% and excludes any Medicare adjustment based on information on the claim.

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount will be the average contract rate in aggregate for in-network providers adjusted by a predetermined factor established by BCBS that is not less than 75% and is updated not less than every two years.

The Allowable Amount for out-of-network providers does not equal the provider's billed charges and you are responsible for the difference between the Allowable Amount and the billed charge, which may be considerable. To find out the Allowable Amount for a particular service, you may call customer service at the number on the back of your ID card.

Post-Tax Deductions — Deductions from your compensation after federal (and most state and local) taxes have been withheld. Post-tax deductions generally do not affect the amount of your income considered for tax-withholding purposes.

Annual Pay — Your Average Weekly Earnings multiplied by 52. This amount, as of the date that the calculation is performed each year, is used to determine the amount of Optional Term Life or Optional AD&D coverage you may elect for a given year, for example.

Average Weekly Earnings — The average of your benefit accrual eligible wages from 7-Eleven in effect for the 52 weeks preceding the date of measurement, before taxes and any pre-tax deductions and including overtime pay and other income (including bonuses) actually received during that 52-week period. If you have worked fewer than 52 weeks as of the applicable measurement date, your Average Weekly Earnings are calculated on your base rate of pay until the first of the year following a full annual calculation. For purposes of the Disability Programs, the date of measurement will be the date of your disability; when calculating your Annual Pay for purposes of the Life/AD&D Program, the date of measurement will be the date of your or your covered dependent's death or loss.

Beneficiary — The person or persons you name to receive any benefits provided by a Program if you die.

Brand-Name Prescription Drug — A prescription drug with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by Express Scripts or an affiliate.

Chemical Dependency — The abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

Chemical Dependency Treatment Center — A facility that provides a program for the treatment of chemical dependency pursuant to a written treatment plan approved and monitored by a behavioral health practitioner and which facility is also:

- Affiliated with a hospital under a contractual agreement with an established system for patient referral;
- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations;
- Licensed as a chemical dependency program by the Texas Commission on Alcohol and Drug Abuse; or
- Licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to do so.

Claims Administrator — The company responsible for determining what claims should be paid under a Program and, if delegated the authority to do so by the Plan Administrator, for administering such Program.

COBRA — The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, which defines the rules for health care continuation coverage ("**COBRA Continuation Coverage**").

Code — The Internal Revenue Code of 1986, as amended.

Copay or Coinsurance — A specific dollar amount or percentage you pay for a covered expense.

Covered Expenses — Expenses that are reasonable and otherwise eligible for reimbursement under one of the Group Health Programs.

Custodial Care — Care comprised of services and supplies, including room and board and other institutional services, provided to an individual primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. Custodial care is care that is not a necessary part of medical treatment for recovery, and includes, but is not limited to, helping an individual walk, bathe, dress, eat, prepare special diets, and take medication.

Deductible — The portion of a covered expense that you must pay before the Plan starts to pay benefits.

Disability Earnings — The earnings you receive while you are disabled and working, plus the earnings you could receive if you were working to your Maximum Capacity. This definition applies to the LTD Program.

Exempt Employee — An employee whose compensation is exempt from the overtime provisions of the Fair Labor Standards Act; usually, these are employees who are paid a salary, rather than an hourly rate.

Experimental/Investigational — The use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical treatment of the condition being treated or any of such items requiring federal or other government agency approval not granted at the time services were provided. Approval by a federal agency means the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and that:

- Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- Are appropriate for the hospital or other facility in which they are performed; and
- The physician or other professional provider has had the appropriate training and experience to provide the treatment or procedure.

BCBS (or the applicable Claims Administrator if for other programs) will determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational, except as explained in Clinical Trials in the "**Covered Medical Expenses**" section.

Although a physician or other professional provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, BCBS (or the applicable Claims Administrator) still may determine such services or supplies are Experimental/Investigational within this definition.

FMLA Leave — A period of no more than 12 work weeks of leave of absence (paid or unpaid) during any 12-month Plan Year for one or more of the following:

- Birth of your son or daughter and to care for the newborn child
- Placement with you of a son or daughter for adoption or foster care and to care for the newly placed child
- Care of your spouse, son, daughter, or parent with a serious health condition
- A serious health condition of yours that makes you unable to perform one or more of the essential functions of your job
- A “qualifying exigency leave.” This means the employee's spouse, son, daughter, or parent must be on “covered active duty” in the Armed Forces (or have been notified of an impending call or order to such duty). For members of a regular component of the Armed Forces, covered active duty means duty during deployment to a foreign country; for members of a reserve component, it means duty during deployment to a foreign country under a call or order to active duty pursuant to specified provisions of federal law.
- A “Covered Servicemember Leave.” This means an employee’s leave to care for a covered servicemember with a serious injury or illness. It applies when the employee is the spouse, son, daughter, parent, or next of kin of a veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness and who was a member of the Armed Forces (including the National Guard or Reserves) at any time during the five-year period preceding the date of the treatment, recuperation, or therapy. “Serious injury or illness” includes injuries or illnesses that existed before a servicemember's active duty began and were aggravated by service in the line of duty on active duty in the Armed Forces. For veterans, a serious illness or injury is a “qualifying injury or illness” (as defined by the Department of Labor) that was incurred in the line of duty while on active duty in the Armed Forces (or that existed before the beginning of active duty and was aggravated by service in the line of duty on active duty) and that manifested itself before or after the servicemember became a veteran.

Gainful Occupation — An occupation that is or can be expected to provide you with an income at least equal to 60% of your indexed monthly earnings within 12 months of your return to work. This definition applies to the LTD Program.

Generic Prescription Drug — A prescription drug, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent to and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medi-Span or any other publication designated by Express Scripts or an affiliate.

Gross Disability Payment — The benefit amount before Unum subtracts Deductible Sources of Income. This definition applies to the LTD Program.

Group Health Program — The Medical Programs, Dental Programs, or Vision Program.

Hospital — A short-term acute care facility that:

- Is duly licensed as a hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a hospital under Medicare; and
- Is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of chemical dependency, hospice, or place for the provision of rehabilitative care.

This definition applies to the BCBS Medical Programs.

Hospital or Institution — An accredited facility licensed to provide care and treatment for the condition causing your disability. This definition applies to the LTD Program.

Injury — A bodily injury that is the direct result of an accident and not related to any other cause. To be an Injury under the STD or LTD Program, the disability must begin while you are covered under that Program. This definition applies to the STD and LTD Programs.

Indexed Monthly Earnings — Your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but they will never decrease. This definition applies to the LTD Program.

Intensive Outpatient Program — A freestanding or hospital-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse, or alcoholism, or specializes in the treatment of co-occurring mental illness with drug addiction, substance abuse, or alcoholism. These programs offer integrated and aligned assessment.

Material and Substantial Duties — Duties that are normally required for the performance of your Regular Occupation, and that cannot be reasonably omitted or modified. This definition applies to the STD and LTD Programs.

Maximum Capacity — Maximum Capacity means, based on your restrictions and limitations during the first 12 months of disability, the greatest extent of work you are able to do in your Regular Occupation, that is reasonably available; beyond 12 months of disability, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience. This definition applies to the LTD Program.

Medically Necessary or Medical Necessity (Medical Program) — Those services or supplies covered under the plan that are:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, or injury; or bodily malfunction;
- Provided in accordance with and consistent with generally accepted standards of medical practice in the United States;
- Not primarily for the convenience of the patient, the physician, behavioral health practitioner, hospital or other provider; and
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the patient. When applied to hospitalization, this further means that the patient requires acute care as a bed patient due to the nature of the services provided or the patient's condition, and the patient cannot receive safe or adequate care as an outpatient.

The medical staff of the Claims Administrator shall determine whether a service or supply is medically necessary under the plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer-reviewed literature. Although a physician, behavioral health practitioner, or other professional provider may have prescribed treatment, such treatment may not be medically necessary within this definition.

Medically Necessary or Medical Necessity (Dental Program) —Dental services and supplies or prescription drugs that a dental Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating a dental condition, and that provision of the service, supply, or prescription drug is

- In accordance with generally accepted standards of dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's dental condition;
- Not primarily for the convenience of the patient or the dental Provider; and

- Not more costly than an alternative service or sequence of services that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's dental condition.

For these purposes, “generally accepted standards of dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant dental community, or otherwise consistent with dental specialty society recommendations and the views of dentists practicing in relevant clinical areas and any other relevant factors.

Mental Health Care — Any one or more of the following:

- The diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system as used by the Claims Administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin
- Electroconvulsive treatment
- Psychotropic drugs
- The diagnosis or treatment of any symptom, condition, disease, or disorder by a physician, behavioral health practitioner, or other professional provider (or by any person working under the direction or supervision of these) when the Eligible Expense is:
    - Individual, group, family, or conjoint therapy
    - Counseling
    - Psychoanalysis
    - Psychological testing and assessment
    - The administration or monitoring of psychotropic drugs
    - Hospital visits or consultations in a hospital, facility other provider, or other licensed facility or unit providing the care described above

Monthly Earnings — The average of your gross monthly income from the Company for the 52 weeks prior to your date of disability. It includes your total income before taxes and any deductions made for pre-tax contributions under the Profit Sharing/401(k) Plan or the Section 125 Plan. It includes overtime pay and income actually received from bonuses averaged for the 25 weeks prior to your disability, but it does not include commissions or any other extra compensation or income received from sources other than the Company. This definition applies to the LTD Program.

Network — A group of pre-screened physicians and hospitals that meet certain standards of quality established and monitored by a network manager and have agreed to provide medical services at lower negotiated fees.

In-Network Provider — A provider who participates in the network offered by a Program.

Out-of-Network Provider — A Provider who does not participate in the network offered by a Program.

Non-Occupational Illness — A non-occupational illness is an illness that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an illness that does.

An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that illness under such law.

Non-Occupational Injury — A non-occupational injury is an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury which does.

Open Enrollment — the period held once a year, usually in the fall, during which you may make changes to your benefit option elections for the following calendar year.

Out-of-Pocket Maximum — The most you pay for covered, reasonable, medically necessary medical costs in a calendar year, including the deductible. After you pay this amount, the BCBS plans generally pay 100% of any additional covered expenses.

Part-Time Basis — The ability to work and earn 20% or more of your Indexed Monthly Earnings. This definition applies to the LTD Program.

Physician — For the BCBS Medical Plans, physician means a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is properly licensed or certified to provide medical care (within the scope of his or her license) under the laws of the state where the individual practices.

Under the STD and LTD Programs, physician means a person who is licensed to practice medicine, prescribe and administer drugs, or perform surgery; a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or a person who is a legally qualified medical practitioner according to the laws and regulations of a governing jurisdiction. A physician must be performing tasks that are within the limits of his or her medical license. Unum will not recognize you, or your spouse, children, parents, or siblings as a physician for a claim that you submit.

Placed for Adoption or Placement for Adoption — The assumption and retention by the employee of a legal obligation for total or partial support of an individual in anticipation of adoption of such child prior to the date on which such individual attains age 18. The child's placement with such person terminates upon the termination of such legal obligation.

Plan Administrator — 7-Eleven is designated as the Plan Administrator under the applicable Program documents. 7-Eleven has the right to delegate these powers, responsibilities, and duties as Plan Administrator to one or more individuals or to a committee.

Plan Year — The 12-month period on which the records of a Program are kept. The Plan Year for all of the Programs is the calendar year (January 1 through December 31).

Precertification or Precertify — A process where BCBS is contacted before certain services are provided (such as hospitalization or outpatient surgery) or prescription drugs are prescribed to determine whether the services being recommended or the drugs being prescribed are considered covered expenses under the Plan. It is not a guarantee that benefits will be payable.

Pre-Tax Deductions — Deductions from your compensation before federal (and most state and local taxes) have been withheld. Pre-tax deductions generally decrease the amount of your income considered for tax purposes, so a lesser amount is generally withheld.

Preventive Care — Services that the applicable Claims Administrator considers preventive, including routine physicals.

Recognized Charge — Only that part of a charge which is less than or equal to the recognized charge is a covered benefit. The Recognized Charge is the amount charged by healthcare providers with similar professional backgrounds for a specific service within a certain area, as determined by Aetna for the dental plan.

Recurrent Disability — A disability that is caused by a worsening of your condition, and due to the same cause(s) as your prior disability for which Unum made payment under the LTD Program. This definition applies to the LTD Program.

Regular Care — Regular care means you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and you are receiving the most appropriate treatment and care that conforms with generally accepted medical standards, for your disabling condition(s) from a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards. This definition applies to the STD and LTD Programs.

Regular Occupation — The occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location. This definition applies to the LTD Program.

Self-Insured — A plan under which the plan sponsor — not an insurance company — and/or participants provide the money to pay claims.

Self-Reported Symptoms — The manifestations of your condition that you tell your physician, that are not verifiable using tests, procedures, or clinical examinations standardly accepted in the practice of medicine. Examples of self-reported symptoms include headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness, and loss of energy. This definition applies to the LTD Program.

Serious Mental Illness — The following psychiatric illnesses defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Bipolar disorders (hypomanic, manic, depressive, and mixed)
- Depression in childhood and adolescence
- Major depressive disorders (single episode or recurrent)
- Obsessive-compulsive disorders
- Paranoid and other psychotic disorders
- Schizo-affective disorders (bipolar or depressive)
- Schizophrenia

Inpatient treatment of serious mental illness requires precertification.

Sickness — An illness or disease. To be a Sickness under the LTD Program, the disability must begin while you are covered under that Program. This definition applies to the LTD Program.

Treatment-Free — You have not received medical treatment, consultation, care, or services including diagnostic measures, or taken prescribed drugs or medicines for the Pre-Existing Condition. This definition applies to the LTD Program.

TRICARE — The managed health care program established by the Department of Defense under 10 U.S.C. §1097.