Summary Plan Description

Genuine Parts Company

Medical Plan

Effective January 1, 2020

Medical Plan

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Highlights

The Genuine Parts Company (GPC) Medical Plan (the "Plan" or "Medical Plan") helps employees and their covered family members afford a wide array of medical services, including preventive care, doctor visits, inpatient and outpatient treatment, mental health and chemical dependency benefits and prescription drugs.

This booklet, along with the *Administrative Information* Summary Description and, where applicable, any information provided by an insurance carrier, such as a certificate of coverage, summary booklet or the insurance contract, together form your Summary Plan Description or "SPD." This SPD describes the key features of the Medical Plan.

Because GPC has a large number of employees located throughout the United States, the Company offers several different types of medical options administered by different third party administrators (referred to throughout as "Claims Administrators") with whom GPC has contracted to provide administrative services. Some of these benefits are funded through the purchase of insurance, but most of the benefits offered under this Plan are self-funded by the Company. Generally, the medical benefits offered to employees within the contiguous United States, Alaska and Puerto Rico are self-funded by the Company. The Claims Administrator for your medical option can be found on your medical ID card. Except for employees located in Hawaii, your prescription drug benefits for all medical options are administered by Express Scripts. For Hawaii employees your prescription drug benefits are administered by Hawaii Medical Service Association or Kaiser.

The medical coverage options currently offered by GPC are:

- Health Savings Plan
- Traditional Health Plan

Important Information About the GPC Medical Plan: The GPC Medical Plan is a cost-sharing mechanism for covered medical expenses incurred by you and your Eligible Dependents. Under the Health Savings Plan and the Traditional Health Plan, benefits may be paid at a higher level if certain network health care providers are used.

The GPC Medical Plan helps defray the costs of medical care covered by the Plan. However, neither GPC nor the GPC Medical Plan can make medical decisions for you. The GPC Medical Plan can only determine whether or not it will pay for the services your physician recommends. The decision on whether to receive such services is between you and your physician. The terms and conditions of payment are governed in this Summary Plan Description (the "SPD").

All physicians and other health care providers that participate in network arrangements are independent contractors. In all cases, the health care network manager (and not GPC or its benefits plan) is responsible for selecting and contracting with the health care providers.

GPC is not responsible for the efficiency, quality or integrity of the services delivered by health care providers. In addition, GPC and its benefits plan are not liable in any way for:

- the effect or delivery of health care services and supplies,
- the results of actions taken as a result of a health care service or supply being limited or not covered by a medical option, or
- any limitations imposed on the cost-sharing responsibility by a medical option.

Certain health care providers or suppliers allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of the Plan, and this Plan will retain any resulting payments. All claims submitted will have copayment and deductible amounts calculated according to the provider's charge for covered expenses without regard to discounts, allowances or incentives.

Eligibility

GPC's benefit plans are designed for Eligible Employees, and their Eligible Dependents, of participating GPC companies. If you are an employee, this Plan will not provide benefits during the time in which you are classified as an Ineligible Employee (as further explained below). If you are later reclassified and become eligible to participate in this Plan, you will become a participant after you meet the eligibility requirements.

Nonresident aliens who do not earn income in the United States, and individuals classified by GPC as independent contractors, temporary employees or leased employees (as defined by GPC) are not eligible to participate in this Plan (regardless of whether these individuals meet the definition for such classifications established by the Internal Revenue Service). Employees covered by union contracts are only eligible if the collective bargaining agreement provides for participation in GPC's benefit plans.

Employees within the Automotive Parts Group at company-owned jobbing stores, as classified by GPC, will not be eligible unless and until benefit enrollment is offered at these locations.

Special eligibility rules will affect those employees absent from their jobs due to illness, injury or approved leave of absence (including leave for the purpose of military service). Please contact your Human Resources Department or the GPC Employee Service Center prior to beginning your absence (or as soon after as possible) to determine how your absence may impact your employee benefits.

Employee Coverage

Full-Time Employees: If you are classified by GPC as a full-time employee, you are eligible to participate in GPC's Medical Plan on your 61st day of continuous employment. If you are an ineligible part-time employee, and are subsequently reclassified as a full-time employee, you will be eligible to participate on the 61st day of continuous employment following your reclassification.

Part-Time Regular Employees: You may also be eligible to participate in GPC's Medical Plan if you meet certain hours worked requirements as described below.

Initial Measurement Period
Part-time employees become eligible for benefits under the Plan on the first day of the first month after 12 months of employment (beginning from your most recent date of hire) provided that you have worked at least 1,560 hours during that 12-month period. This length of time is called the **Initial Measurement Period** and consists of the work hours accumulated during the first 12 months of your employment through the payroll period that includes your one-year anniversary date.

Initial Stability Period
If you meet the 1,560 hours threshold for benefits eligibility during your Initial Measurement Period, you will be eligible to participate in the GPC Medical Plan for a 12-month period beginning on the first day of the first month after completion of your Initial Measurement Period. This 12-month period (365 days) of continuous benefits coverage is called the **Initial Stability Period**.

Ongoing Measurement Period
After completion of your Initial Measurement Period, you must work 1,560 hours during a designated subsequent 12-month period to be eligible for coverage in this benefit plan.

This length of time is called the **Ongoing Measurement Period** and occurs annually from October 16 of the current year through October 15 of the following year. The Ongoing Measurement Period consists of the work hours accumulated during this 12-month period and will include hours worked within the payroll periods including these dates.

Ongoing Stability Period
If you meet the 1,560 hours threshold for benefits eligibility during an Ongoing Measurement Period, you will be eligible to participate in the GPC Medical Plan for a 12-month period beginning the January 1 after completion of the Ongoing Measurement Period. This 12-month period (365 days) of continuous benefits coverage is called the **Ongoing Stability Period**.

Coverage Continuation
If you met the 1,560 hours threshold for benefits eligibility during your Initial Measurement Period or a subsequent Ongoing Measurement Period and continue to meet the 1,560 hours threshold during each Ongoing Measurement Period, you are eligible for continuous benefits coverage.

Eligibility End Date
If you are enrolled in benefits coverage during your Initial Stability Period, but do not meet the 1,560 hours threshold during the subsequent Ongoing Measurement Period, your benefits eligibility will end on the last day of your Initial Stability Period.

If you are enrolled in benefits coverage during an Ongoing Stability Period, but do not meet the 1,560 hours threshold during a subsequent Ongoing Measurement Period, your benefits eligibility will end on the last day of your current Ongoing Stability Period.

Annual Enrollment
If Annual Enrollment occurs during your Initial Stability Period or the Ongoing Stability Period, you will be eligible to participate in Annual Enrollment and make changes to your elected coverage.

Reclassified Employees (Full-time to Part-time):
There is a special rule for existing full-time employees of GPC who are subsequently reclassified as part-time regular. For GPC employees who are reclassified as part-time and participating in this benefit plan, they will be able to continue participation until the end of their part-time employee Initial Measurement Period which begins on the date they are reclassified to part-time. Effective the date of the reclassification to part-time, coverage for the GPC Medical Plan can be continued for the employee and eligible children only. Spouses will no longer be eligible for medical coverage. Covered legal spouses will be eligible for COBRA at that time. Employees will be eligible to continue participation after their Initial Measurement Period if they meet the 1,560 hours threshold during their Initial Measurement Period. Following their Initial Measurement Period, the Ongoing Measurement Period and Ongoing Stability Period rules described previously will apply.

Dependent Coverage

If you are a full-time employee, you may also enroll your Eligible Dependents in the Medical Plan. Eligible Dependents include:

- the employee's legal spouse (a "Spouse") *, and
- eligible children from birth to age 26 (i.e., their 26th birthday) regardless of marital, student or tax-dependent status.

* *Common-law Spouses are recognized provided their marriage was formed in a state that permits the formation of common law marriages, and at a time when such state permitted the formation of common law marriages. If your spouse is your legal spouse under the common law of the state in which you reside, you will be required to provide evidence of the state's law on common law marriages and evidence that you meet such legal requirements.*

If you are a part-time benefits eligible employee you may also enroll your eligible children in the GPC Medical Plan, but you may not enroll a legal spouse.
Eligible children include:

- natural children,
- stepchildren,
- children you have legally adopted (or who have been placed with you for adoption) and
- children for whom you are a legal guardian or have legal custody.

If you have a mentally or physically handicapped child that is covered under the Plan when they turn age 26, coverage may be continued after age 26 if the child is incapable of earning a living and totally dependent on you for support and maintenance (you will be asked to provide proof of the child's incapacity beyond age 26. The failure to provide proof may result in the termination of the Dependent medical coverage.).

The Plan Administrator, or its designee, will require proof of dependent status as a condition of enrolling an Eligible Dependent in the Plan. In addition, you may be required to provide certain information deemed necessary by the Plan Administrator as a condition of eligibility for you and/or your dependents. For example, you generally must provide a Social Security number (SSN), or other satisfactory documentation where a SSN is not available, for each dependent you wish to enroll in the Plan to satisfy federal reporting requirements. Proof of dependent status may also be periodically requested as a condition of continued dependent coverage. Failure to provide satisfactory proof of dependency status may result in termination of dependent coverage, and you may be required to reimburse the Medical Plan for any benefits paid for an otherwise Ineligible Dependent's expenses if it is determined that the enrollment was due to fraud or intentional misrepresentation. Regardless, termination of coverage for failing to provide the appropriate documentation does not give rise to COBRA continuation coverage.

Important Note: In addition, it is your obligation to ensure that no claims are submitted under this Plan for an ineligible individual. If you knowingly submit a claim for an individual who you know is ineligible or you have reason to believe that a claim will be submitted for an ineligible individual and you fail to alert the Plan Administrator or Claims Administrator, you may be deemed to have committed fraud or intentional misrepresentation against the Plan, which may result in the retroactive loss of coverage.

Qualified Medical Child Support Orders

The Medical Plan will comply with the terms of a Qualified Medical Child Support Order (QMCSO) to the extent that the QMCSO does not require the Medical Plan to provide coverage it does not otherwise provide. A medical child support order is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or an administrative process established under state law which has the force and effect of law or a judgment from a state court directing a plan administrator to cover a child under a company's group health plan, and which the Plan Administrator determines in its discretion is a Qualified Medical Child Support Order.

Federal law requires that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child covered by the order will be notified of the procedure to determine if the order is valid. If you have any questions or would like to receive a copy of the written procedures for determining whether a medical child support order is a QMCSO, you may request a copy of the procedures from the GPC Employee Service Center at any time and without charge.

Generally, if GPC receives an order that is a QMCSO, coverage for the Eligible Dependent child that is the subject of the QMCSO will become effective on the specific date specified in the QMCSO, or at a later date as specified in the Plan's QMCSO procedures.

Enrolling in the GPC Medical Plan

Medical coverage is not automatic — you must enroll to receive this coverage. Enrollment occurs when you first become eligible ("Initial Enrollment"), at any time during the Plan Year if you experience an event described in the "Changing Your Benefits" section that permits you to enroll, and again every fall ("Annual Enrollment") to allow you to make changes to your elections.

Initial Enrollment:

For full-time employees, you must complete your enrollment prior to your 61st day of continuous employment.

For eligible part-time employees, you must complete your enrollment within 31 days from the date your Initial Stability Period begins.

If you do not enroll during your Initial Enrollment period, you must wait until the next Annual Enrollment period (held every year), unless you experience a Qualified Status Change, as described in the following "Changing Your Benefits" section, enables you to enroll.

You may be required to complete your benefits enrollment during Initial or Annual Enrollment, or through the status change process if you experience a Qualified Status Change event.

Annual Enrollment: Annual Enrollment for the Medical Plan is held annually (every calendar year) and gives you the opportunity to reconsider your medical coverage. During Annual Enrollment, you can enroll, add dependents not previously covered, disenroll dependents or cancel coverage. Once you enroll, you may not cancel or change your elections until the next Annual Enrollment period, unless you experience a Qualified Status Change as described in the "Changing Your Benefits" section of this SPD that enables you to make a change. Likewise, if you drop coverage during Annual Enrollment, you cannot re-elect coverage until the next Annual Enrollment period unless you experience a Qualified Status Change.

The medical options available to you will offer a variety of coverage levels. If you are a full-time employee, you can choose to cover either yourself alone, or yourself and your

Eligible Dependents. If you are a part-time benefits eligible employee, you can choose to cover either yourself alone or yourself and your eligible children. Or, you may choose to decline coverage altogether. If you enroll in medical coverage and do not enroll in the GPC Vision Plan, you will be eligible to receive vision discounts for certain vision services. If you enroll in the GPC Medical Plan and the GPC Vision Plan you will receive vision discounts only through the GPC Vision Plan (see the *Vision Plan* Summary Plan Description).

If You and Your Spouse Work for GPC

If both you and your spouse work for GPC in a full-time capacity, you may both enroll for coverage as employees. One spouse who is a full-time employee can cover the other as a dependent, but under no circumstances may you cover each other as dependents. In addition, only one spouse who is a full-time employee may cover dependent children.

If You Decline Coverage

Under most conditions, if you or your Eligible Dependents decline to enroll or participate during an applicable enrollment period you will need to wait until the next Annual Enrollment period. However, if you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in the GPC Medical Plan at a future date if you lose the other coverage that you had. You may even change the type of coverage — for example, Traditional Health Plan to Health Savings Plan, Health Savings Plan to Traditional Health Plan. But, to do this, you must request enrollment within 31 days after your other coverage ends.

Rehires

If you are rehired within the same Plan Year and are eligible for the Medical Plan (or you become eligible again), you may make new elections if you are rehired or become eligible again more than 30 days after your employment terminated or you otherwise lost eligibility. If you are rehired or again become eligible within 30 days, your Medical Plan elections that were in effect when you terminated employment or stopped being eligible will be reinstated and remain in effect for the remainder of the Plan Year, unless you experience a Qualified Status Change as referenced in the following section.

Changing Your Benefits

Generally, you cannot change your election under the Medical Plan during the Plan Year. There are several important exceptions to this general rule. You may change or revoke your previous election during the Plan Year if you experience one of the events described below, provided you file a timely request for the change with the GPC Employee Service Center. Your election will automatically terminate if you terminate employment or lose eligibility under the Medical Plan, except as otherwise provided pursuant to GPC policy or individual arrangement.

You may voluntarily change your medical elections during the Plan Year if you satisfy the following conditions (prescribed by federal law):

- you experience one of the events described in this section; and
- the change you wish to make, if it is a Qualified Status Change, meets the Consistency Rule, described below; or
- you experience a significant cost or coverage change; and
- you complete the status change process and submit any required form(s) or documentation to the GPC Employee Service Center within 31 days of the date you experience the event.

With the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective. In order for elections to be effective, you must complete the status change process and submit any required form(s) or documentation to the GPC Employee Service Center within 31 days of the date of the event. Generally, elections changes are effective the first day of the month following the date the request is made and received by the GPC Employee Service Center. **If you do not complete the status change process and submit any required form(s) or documentation to the GPC Employee Service Center within the 31-day deadline, you will not be permitted to make a change to your benefit elections until the next Annual Enrollment period unless you experience another event described in this section.**

Any expenses incurred by your Eligible Dependents before the date of the event will not be eligible for reimbursement under the Medical Plan.

Qualified Status Changes

Status Changes include:

- *Marital Status*. Your legal marital status changes for reasons such as marriage, divorce, legal separation, annulment or death of a spouse.
- *Change in Number of Dependents.* Your number of Eligible Dependents changes for reasons such as birth, adoption, placement of a child with you for adoption or death of a dependent.
- *Dependent Loses or Gains Coverage under a State Medicaid or State Children's Health Insurance Program (SCHIP) program*. Your Dependent ceases to be eligible for Medicaid or SCHIP program, or becomes eligible for premium assistance under Medicaid or SCHIP.
- *Change in Dependent Eligibility*. Your Eligible Dependent satisfies or ceases to satisfy the eligibility requirements for coverage.
- *Change in Employment Status that Affects Eligibility.* You, or your Eligible Dependent experiences a change in employment status due to one of the following events:
  - Termination or commencement of employment;
  - A strike or lockout;
  - Commencement or return from an unpaid leave of absence;

  - A change in employment status, e.g. unpaid leave, part-time to full-time or full-time to part-time, salaried to hourly;
  - A change in worksite; or
  - Any other change in employment status that affects benefits eligibility.
- *Change in Residence that Affects Eligibility*. You or your Eligible Dependent changes residence and as a result of the change, the individual ceases to be eligible for medical coverage or becomes eligible for medical coverage.

Consistency Rule

You can only change your elections if the requested change is on account of and corresponds with the Qualified Status Change event as determined in the discretion of the Plan Administrator. This is called the Consistency Rule.

Because of the Consistency Rule, you may experience a Status Change that does not let you change your benefit elections, as described by the examples below.

Generally, to make a change to your benefits elections, the Qualified Status Change has to affect your or your Eligible Dependent's eligibility for medical coverage. A Status Change affects eligibility for medical coverage if it results in an increase or decrease in the number of dependents who may benefit under the Medical Plan. In addition, you must satisfy the following specific requirements in order to alter your election based on a Qualified Status Change:

- *Loss of Dependent Eligibility.* If the event is divorce, legal separation, annulment, death of a spouse or dependent or a dependent ceasing to satisfy the eligibility requirements and you are enrolled in medical coverage, you may only cancel the coverage for the spouse or dependent. Coverage may not be cancelled for you or any other covered family member, unless some other permitted election change applies.

  Example 1: Pat is married and has two children. Pat elects family medical coverage. One of her children turns 26 and therefore losses eligibility for medical coverage. Even though Pat's child has experienced a Status Change, because Pat still has two remaining Eligible Dependents (her spouse and her other eligible child), Pat is not permitted to change her benefit election for family coverage. However, she still must notify the GPC Employee Service Center that her child is no longer eligible for coverage under the Medical Plan.

  Example 2: Don has no spouse and one dependent child. Don's child turns 26 and therefore loses eligibility for medical coverage. Don can change his election to single coverage. Don cannot, however, cancel coverage.

- *Gaining Eligibility Under Another Employer Plan.* For a Qualified Status Change in which you or your spouse or dependent gains eligibility for coverage under another employer's medical plan as a result of a change in marital status or a change in your spouse's or dependent's employment status, an election to cease or decrease coverage for that

individual under the Medical Plan would correspond with that Status Change only if medical coverage for that individual becomes effective or is increased under the other employer's plan.

> ***Example:*** Employee Chris elects employee only medical coverage. Chris marries. Chris's wife elected employee-only medical coverage from her employer's medical plan prior to their marriage. Chris may either cancel medical coverage if he certifies that he and his wife will be covered under her employer's plan, or Chris may add his wife under the Medical Plan. Either change satisfies the Consistency Rule.

Special Consistency Rules

In addition to the above rules, there are additional special Consistency Rules that apply to some of the Status Changes. If you have specific questions regarding a change you wish to make to your benefit elections, contact the GPC Employee Service Center.

Special Enrollment

If you, your spouse and/or a dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your Eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (e.g., due to legal separation, divorce, death, termination of employment, reduction in hours, moving out of an HMO service area, termination of coverage under Medicaid or SCHIP, eligibility for assistance under Medicaid or SCHIP for employer coverage or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your Eligible Dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may also be able to enroll yourself, your spouse and your newly acquired dependents, provided that you make a proper and timely request. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption or placement for adoption of a child, which may be retroactive up to 30 days.

Notwithstanding anything herein to the contrary, employees and/or their dependents seeking special enrollment due to the following events have up to 60 days from the event described in (i) or (ii) to request enrollment in the Plan: (i) termination of coverage under a Medicaid or SCHIP plan or (ii) eligibility for assistance with employer coverage under Medicaid or SCHIP.

Change in Cost of Coverage

If your share of the contributions for medical coverage you elected significantly increases, you may choose either to make an increase in contribution, revoke the election and receive coverage under another option that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost of a medical option significantly decreases, a participant who elected to participate in another option may revoke the election and elect to

receive coverage provided under the option that decreased in cost. In addition, otherwise eligible employees who elected not to participate in the Medical Plan may elect to participate in the option that decreased in cost. For insignificant increases or decreases in the cost of options, however, your contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

Entitlement to or Loss of Entitlement to Medicare, Medicaid or SCHIP

If you or your spouse, or an Eligible Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's coverage. Similarly, if you, your spouse, or an Eligible Dependent that has been entitled to Medicare, Medicaid or SCHIP loses eligibility for such coverage (or becomes eligible for assistance through Medicaid and SCHIP with regard to the Plan), you can elect to begin or increase that person's health coverage. As a general rule, you cannot add or drop other dependents for medical coverage as a result of your experiencing one of these events. See the "Special Enrollment" section for more information about enrollment on account of Medicaid or SCHIP.

Court Ordered Coverage

If you are an eligible employee and you are required by a Qualified Medical Child Support Order ("QMCSO") to provide medical coverage for your Eligible Dependent child, you may change your election to provide coverage for the dependent child identified in the order. If your spouse, former spouse or another individual is required by a QMCSO to provide coverage to a dependent child you have enrolled in the Medical Plan and such coverage is actually provided, you may change your election to revoke coverage for the dependent child.

Change in Coverage

If coverage under an option is significantly curtailed, you may elect to revoke your election and elect coverage under another option that provides similar coverage, if available. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Medical Plan adds or significantly improves an option during the Plan Year, you may revoke your election and elect to receive, on a prospective basis, coverage provided by the newly added or significantly improved option so long as the newly added or significantly improved option provides similar coverage. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

Change Under Another Employer Plan

You may make an election change that is on account of and corresponds with a change made by another employer plan (including another GPC plan), so long as: (a) the other employer plan permits its participants to make an election change permitted under the Treasury Regulations issued under section 125 of the Internal Revenue Code; or (b) the Plan Year for the Medical Plan is different from the Plan Year of the other employer plan.

The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

> ***Example***: Employee Jean is married and has two children. At Annual Enrollment, Jean elects not to participate in the Medical Plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, the cost of the medical coverage provided by Tom's employer significantly increases and there is no other similar benefit package option available to him. As a result, his employer's plan allows him to cancel his family medical coverage. Because Tom has experienced a Status Change under his employer's plan that allows him to drop his family medical coverage, Jean may elect family medical coverage under the Medical Plan.

About Your Cost

You may be required to pay all or a portion of the cost of medical coverage you elect. If you elect (or are automatically provided) coverage, your share of the cost will be deducted from your paycheck before your taxes (federal and certain state and local income taxes) are calculated. This deduction lowers your taxable income, so you pay less tax.

Qualified Medical Child Support Orders

If you are an Eligible Employee, not enrolled in the Medical Plan, and you are required by a QMCSO to provide medical coverage for a child, you will be enrolled in medical coverage as specified in the QMCSO and the entire cost to you for such coverage will be deducted from your pay automatically on a pre-tax basis. Likewise, if you are already enrolled in the Medical Plan, your coverage level will be modified as specified in the QMCSO, and any additional cost for such coverage will be deducted from your pay automatically on a pre-tax basis.

If your spouse, former spouse or another individual is required by a QMCSO to provide coverage to an eligible dependent child you have enrolled in the Medical Plan, coverage for such child will be canceled and the deductions from your pay for the cost of such coverage will automatically be terminated on the date specified in the QMCSO, or at a later date as specified in the Company's QMCSO procedures. However, if the QMCSO simply expires without an express requirement for the other parent to provide coverage, you may not be able to drop the child's coverage until the next Annual Enrollment period if the child remains an Eligible Dependent.

When Coverage Begins

Coverage for you and your Eligible Dependents begins according to the following chart.

If you enroll…	Your (and your eligible dependents') coverage begins…
Full-time Employees Prior to your 61st day of continuous employment	• On the 61st day of continuous employment.
Part-time Employees Within 31 days of first becoming eligible	• On the first day of the first month following your Initial Measurement Period if you meet the 1,560 hours threshold for benefits eligibility during your Initial Measurement Period.
Part-time Employees Within 31 days of becoming eligible through a subsequent Ongoing Measurement Period	• On the January 1st after completion of the Ongoing Measurement Period if you did not meet the 1,560 hours threshold for benefits eligibility during your Initial Measurement Period, but you meet the 1,560 hours threshold during a subsequent Ongoing Measurement Period.
Full-time and Part-time Employees Within 31 days of a Qualified Status Change	• First day of the month following the date the request is made and received by the GPC Employee Service Center. • However, if your Qualified Status Change is the birth, adoption or placement for adoption of a child, coverage will begin on the date of the birth, adoption or placement for adoption provided you add the child to coverage within 31 days of the birth or adoption or placement for adoption.

For all employees, if you are eligible to make benefit elections and/or participate in Annual Enrollment, but do not enroll within these time periods, you will not be able to enroll in medical coverage until a qualified Status Change or the next Annual Enrollment period.

When Coverage Ends

Coverage under the GPC Medical Plan ends on the earliest of the following:

- the date you fail to make the required contribution;
- the date you are no longer an eligible employee;
- the date you or your spouse submit a fraudulent claim or fail to cooperate with the Plan Administrator;
- the date your employment ends, unless you continue coverage under COBRA or meet the requirements and accept medical coverage due to disability;
- for your dependent, the date the dependent is no longer eligible; or
- the date GPC amends or terminates the Plan.

Additional information about how you can continue medical coverage under COBRA can be found in the *Administrative Information* Summary Description.

If your employment ends and you are Medicare eligible, you have access to a variety of fully insured health care plans administered directly by UnitedHealthcare. You are responsible for the total premium of these plans. For additional information, you can contact UnitedHealthcare Medicare Solutions at 877-718-2619 or visit their website at **www.myuhcplans.com/genuineparts**.

Coverage for Disabled Employees

If an illness or injury causes a short-term disability, and if GPC approves a leave of absence due to your short-term disability, you may continue your coverage under the GPC Medical Plan throughout your approved leave of absence, provided you pay the cost of this coverage.

If, at the end of your short-term disability leave of absence, you are still covered under the Medical Plan, and you are determined to be disabled under the Company's Long-Term Disability Plan, you may continue your medical coverage until the earliest of:

- the date you are no longer eligible for benefits under the Long-Term Disability Plan (please see the *Long-Term Disability Summary Plan Description*);
- the date you become eligible for Medicare because of your disability;
- 24 months from the date that you are approved for, and continue to qualify for, long-term disability benefits;
- the date you fail to make the required contribution for the coverage;
- the date you or your spouse submit a fraudulent claim or fail to cooperate with the Plan Administrator; or
- the date GPC amends or terminates the Plan.

If you elect to continue your medical coverage as described above, your election will replace your rights to continue coverage under COBRA. In other words, continued coverage after long-term disability is in lieu of COBRA, not in addition to.

At the end of your short term disability leave of absence, if your claim for long term disability benefits is denied, or if the Long Term Disability Plan claims administrator has not issued a determination on your application for long term disability benefits, then you may be eligible for COBRA coverage. Refer to the *Administrative Information* Summary Description for additional details on COBRA coverage.

Your dependents who were enrolled at the time that you started your disability leave (and Eligible Dependents acquired after that time) may be able to continue to participate in the GPC Medical Plan while you are receiving GPC's long-term disability benefits and are covered under this Plan. As long as you participate in this Plan:

- your children may continue their medical coverage for as long as they are Eligible Dependents; and
- your spouse, if eligible for coverage, may continue coverage until becoming eligible for Medicare, or until he or she has access to coverage under another group plan.

If You Work Past Age 65

If you work past age 65, you can continue your coverage in the GPC Medical Plan or enroll in Medicare. If you remain in the GPC Medical Plan and enroll in Medicare Parts A, B or D, your medical benefits will not change, but Medicare will act as your secondary insurance. That means Medicare will pay benefits after the GPC Medical Plan pays its share of your medical expenses. This may reduce your out-of-pocket costs. Please note that you should consult with a Medicare representative when you are eligible to elect Medicare coverage as the failure to elect Medicare when eligible could result in a Medicare penalty.

Medicare benefits will be primary to the extent permitted under applicable law. Thus, for example, patients with end-stage renal disease (after 30 months of Medicare coverage) and individuals who receive GPC Medical Plan coverage other than by virtue of current employment status (individuals continuing coverage under COBRA and certain others) will receive benefits after taking into account any benefits paid or payable by Medicare. Even if you do not elect Medicare Part A and B the Plan will still pay benefits as if you had made such elections.

Additional Considerations for Health Savings Plan Participants

If you enroll in Medicare Parts A or B, you are no longer eligible to contribute to a Health Savings Account (HSA). If you become eligible for Medicare, you are not automatically disqualified from contributing to an HSA until you elect to enroll in Medicare. Therefore, if you are enrolled in the Health Savings Plan and have an HSA, you can continue contributing to the account as long as you are not enrolled in Medicare and you are an HSA "eligible individual", as defined by the IRS.

About the GPC Medical Plan

Preventive Care Benefits

GPC wants you and your family to stay healthy. To help you do this, preventive care benefits for adults and children focus on overall health and wellbeing, and have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease. The GPC Medical Plan covers preventive care services, some of which are covered at 100%. The in-network preventive care services covered at 100% include the following, as set forth by the Department of Health and Human Services for recommended preventive services required under the Patient Protection and Affordable Care Act ("Recommended Preventive Services"):

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

All Recommended Preventive Services under this Plan will be provided in accordance with the guidelines established by the Department of Health and Human Services for "recommended treatment services." Some services are only considered preventive and fully covered for people of a particular gender and/or age and/or based on the person's risk status. There are also limitations on the frequency with which you can obtain benefits for certain preventive care services. Additionally, if the primary purpose of your office visit is not for preventive services, you will be responsible for the office visit copay and/or applicable coinsurance. Services related to the diagnosis or testing of a particular condition as prescribed by a doctor may be considered diagnostic services, as opposed to preventive services. Diagnostic services are not covered at 100%, and you will pay an office visit and/or applicable coinsurance. If you are uncertain whether a specific service is covered under the Plan as preventive care, you should contact your medical plan carrier at the telephone number on your medical ID card before receiving the services.

Second Surgical Opinion

To help you decide if surgery is necessary, or if an alternative treatment is available, a second surgical opinion is covered. You do not have to obtain a second surgical opinion in order to receive maximum benefits under your medical option.

Pre-Certification

In order to receive maximum benefits under the Medical Plan, you must follow the pre-certification program for all inpatient and outpatient procedures. You, your physician or the hospital must obtain this approval from the Claims Administrator by calling the toll-free number on your medical ID card. You — not your provider — are responsible for ensuring that pre-certification is obtained. If you do not obtain required approval for an out-of-network provider, you will be required to pay a $500 penalty.

In emergency situations, such as, for example, a serious automobile accident or a heart attack, it may be impossible to pre-certify hospital admission before the admission occurs. But you are still responsible for calling your health care administrator's medical management center or your primary care physician and getting the admission certified according to the provisions of the Plan in which you are enrolled. This responsibility remains even if you have already been discharged.

In addition to pre-certifying a hospital admission, pre-certification is required for:

- outpatient infusion therapy;
- dialysis services (only available in-network)
- transgender benefits;
- a skilled nursing facility or sub-acute facility; and
- home health care.

Autism Spectrum Disorder

Covered Expenses for Autism Spectrum Disorder include charges made by a Physician or Behavioral Health Provider for the services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits and therapy) of Autism Spectrum Disorder when ordered by a Physician, licensed psychologist, or licensed clinical social worker, as part of a treatment plan; and the covered child is diagnosed with Autism Spectrum Disorder.

Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder is covered. Covered Expenses will include charges made by a Physician or Behavioral Health Provider for ABA when ordered by a Physician, licensed psychologist or licensed clinical social worker, as part of a treatment plan for Autism Spectrum Disorder.

Factors That Affect Your Out-of-Pocket Costs

This section includes important information about the GPC Medical Plan that you should know, such as how deductibles and copayments work, what your maximum annual out-of-pocket expense is and what are Allowable Amounts.

Deductible

In the Health Savings Plan, you will pay for initial expenses out-of-pocket when you receive a medical service or purchase a prescription drug, until you reach the deductible.

In the Traditional Health Plan, when you receive inpatient or outpatient services, you will pay for initial expenses out-of-pocket until you reach the deductible.

For employee-only coverage, the Plan begins paying once individual costs reach the employee-only deductible. For dependent coverage, the Plan begins paying once the total employee-plus-dependent(s) deductible is met. The employee-plus-dependent(s) deductible can be satisfied with covered expenses from one family member or any combination of family members.

Copayment and Coinsurance

For certain services under both the Health Savings Plan and the Traditional Health Plan, you will be responsible for a defined percentage of the bill. This is known as coinsurance.

For certain services under the Traditional Health Plan, you will be responsible for paying a flat dollar amount toward the provider's bill. This is known as a copayment.

Annual Out-of-Pocket Maximums

The annual out-of-pocket maximum limits the amount that you will have to pay for medical care each year.

In the Health Savings Plan, the annual deductible and coinsurance for a covered medical or prescription drug expense will be applied toward your annual out-of-pocket maximum.

In the Traditional Health Plan, the annual deductible, coinsurance and copays for a covered medical or prescription drug expense will be applied toward your annual out-of-pocket maximum.

For employee-only coverage, the Plan begins paying 100% of the cost of covered expenses for the remainder of the calendar year once individual costs reach the employee-only out-of-pocket maximum. For dependent coverage, the Plan begins paying 100% of the cost of covered expenses for the remainder of the calendar year should any family member satisfy the individual out-of-pocket maximum. If the total employee-plus-dependent(s) out-of-pocket maximum is met, the Plan will pay 100% of the cost of covered expenses for the remainder of the calendar year for all family members. The total employee-plus-dependent(s) out-of-pocket maximum can be satisfied with covered expenses from any combination of family members. The annual deductible counts toward satisfying the annual out-of-pocket maximum.

Allowable Amount

When you use an out of network provider, the GPC Medical Plan pays benefits based on the Allowable Amount for the eligible medical services, procedures and supplies you or your covered dependents receive. The Allowable Amount is determined within the sole discretion of the Claims Administrator in accordance with the Claims Administrator's policies and procedures. The Allowable Amount may be based on the Reasonable and Customary charges for the service, procedure or supply, up to the average of the usual and customary amount charged by providers of similar training or experience, within the same geographical area. The Allowable Amount may be a percentage of Medicare reimbursement rates; or be based on a set fee schedule, or other methodology as determined to be appropriate by the Claims Administrator. If the Claims Administrator has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that the Claims Administrator will pay for a service or supply, then the Allowable Amount is the rate established in such agreement. The Claims Administrator may also reduce the Allowable Amount by applying its reimbursement policies. The Claims Administrator's reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service. If a provider's charges exceed the Allowable Amount, you are responsible for that part of the charge that exceeds this limit and no excess amounts are applied to your deductible or out of pocket maximum.

If you take advantage of network benefits under a managed care component of the Plan, you will not be responsible for paying charges in excess of the Allowable Amount. That's because network providers agree to charge a pre-determined fee for the services or care that they provide. However, if you receive care from an out-of-network provider, you are responsible for charges that exceed the Allowable Amount as determined by the Claims Administrator. Prior to receiving services you should always confirm the network status of your providers, even if you are receiving services at an in-network facility.

Medically Necessary

The GPC Medical Plan will only reimburse you for health care expenses that the Claims Administrator determines in its discretion to be medically necessary to treat an illness or injury. Please see the section titled "What's Not Covered" in this SPD.

Health Savings Plan

The Health Savings Plan is a Preferred Provider Organization (PPO) Plan.

Under the Health Savings Plan, you may opt to see an in-network or out-of-network provider; however, you will pay less if you use an in-network provider.

The Health Savings Plan allows, but does not require, the designation of a primary care provider. You have the right to designate any primary care provider who participates in your medical plan carrier's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of participating primary care providers, contact your medical plan carrier. Referrals are not required to see a specialist, including any obstetrical or gynecological physicians.

In addition, the Health Savings Plan is a qualified high-deductible health plan. This means if you enroll in this plan and you meet other eligibility requirements described in IRS Publication 969, you may open a Health Savings Account (HSA) to which you can make pre-tax and/or after-tax contributions to save for future health care expenses. If you enroll in the Health Savings Plan and elect to open an HSA with Optum Bank as part of your benefits enrollment, your HSA contributions can be made through pre-tax payroll deductions. For more information about the HSA, go to GPC Connect at **gpcconnect.com.**

Health Savings Plan Highlights

Health Savings Plan Benefits		In-Network	Out-of-Network
Calendar-Year Deductible: • Employee-Only • Employee-Plus-Dependent(s)		 $1,600 $3,200	 $3,800 $7,600
Annual Out-of-Pocket Maximum[1]: • Employee-Only • Employee-Plus-Dependent(s)		 $4,500 $6,850 Individual/$9,000 total	 $9,000 $15,000
Services		**Plan Pays**	
Preventive Care[2]		100%; no deductible	70% of Allowable Amt[3] after deductible
Primary Care Physician Office Visit		90% after deductible	70% of Allowable Amt after deductible
Virtual Visit		90% after deductible	N/A
Specialist Office Visit		90% after deductible	70% of Allowable Amt after deductible
Chiropractic Care Visit (maximum 20 visits/year)		90% after deductible	70% of Allowable Amt after deductible
Physical, Speech and Occupational Therapy Outpatient Visit (maximum 60 combined visits/year)		90% after deductible	70% of Allowable Amt after deductible
Diagnostic, Lab and X-ray Services		90% after deductible	70% of Allowable Amt after deductible
Durable Medical Equipment		90% after deductible	70% of Allowable Amt after deductible
Hospital: • Inpatient • Outpatient		 90% after deductible 90% after deductible	70% of Allowable Amt after deductible
Maternity Care: • Prenatal visits • Delivery charges		 100%; no deductible 90% after deductible	70% of Allowable Amt after deductible
Urgent Care Visit		90% after deductible	70% of Allowable Amt after deductible
Emergency Care Visit		90% after deductible	90% after deductible
Ambulance		90% after deductible	90% after deductible
Other Covered Medical Care: • Skilled nursing facility (maximum 60 days/year) • Home health care including private duty nursing in the home (maximum 60 visits/year) • Hospice (180-day maximum)		90% after deductible	70% of Allowable Amt after deductible
Mental Health/Substance Abuse: • Inpatient • Outpatient		 90% after deductible 90% after deductible	 70% of Allowable Amt after deductible 70% of Allowable Amt after deductible
Prescription Drugs		**Plan Pays**	
Tier 1	Retail Pharmacy Mail Order Pharmacy	90% after deductible	
Tier 2	Retail Pharmacy Mail Order Pharmacy		
Tier 3	Retail Pharmacy Mail Order Pharmacy		
Tier 4	Retail Pharmacy Mail Order Pharmacy		

[1] *Annual deductibles and coinsurance count toward satisfying the out-of-pocket maximum.*

[2] *Preventive care services that are covered without cost sharing are defined as services performed to prevent disease. Some of these services are only covered for people of a particular age, gender and/or risk status.*

[3] *Out-of-network fees are subject to guidelines surrounding Allowable Amounts. Allowable Amounts are determined by the Claims Administrator. You are responsible for any out-of-network fees above the Allowable Amount. Fees paid above the Allowable Amount do not count toward satisfying the out-of-pocket maximum.*

Traditional Health Plan

The Traditional Health Plan is a Preferred Provider Organization (PPO) Plan.

Under the Traditional Health Plan, you may opt to see an in-network or out-of-network provider; however, you will pay less if you use an in-network provider.

The Traditional Health Plan allows, but does not require, the designation of a primary care provider. You have the right to designate any primary care provider who participates in your medical plan carrier's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of participating primary care providers, contact your medical plan carrier. Referrals are not required to see a specialist, including any obstetrical or gynecological physicians.

Traditional Health Plan Highlights

Traditional Health Plan Benefits		In-Network	Out-of-Network
Calendar-Year Deductible: • Employee-Only • Employee-Plus-Dependent(s)		 $850 $1,700	 $2,000 $4,000
Annual Out-of-Pocket Maximum[1]: • Employee-Only • Employee-Plus-Dependent(s)		 $5,000 $6,850 Individual/$10,000 total	 $9,500 $15,500
Services		**Plan Pays**	
Preventive Care[2]		100%; no deductible	60% of Allowable Amt[3] after deductible
Primary Care Physician Office Visit		100% after $30 copay per visit	60% of Allowable Amt after deductible
Virtual Visit		100% after $30 copay per visit	N/A
Specialist Office Visit		100% after $55 copay per visit	60% of Allowable Amt after deductible
Chiropractic Care Visit (maximum 20 visits/year)		100% after $55 copay per visit	60% of Allowable Amt after deductible
Physical, Speech and Occupational Therapy Outpatient Visit (maximum 60 combined visits/year)		100% after $55 copay per visit	60% of Allowable Amt after deductible
Diagnostic, Lab and X-ray Services		80% after deductible	60% of Allowable Amt after deductible
Durable Medical Equipment		80% after deductible	60% of Allowable Amt after deductible
Hospital: • Inpatient • Outpatient		 80% after deductible 80% after deductible	 60% of Allowable Amt after deductible 60% of Allowable Amt after deductible
Maternity Care: • Prenatal visits • Delivery charges		 100%; no deductible 80% after deductible	 60% of Allowable Amt after deductible
Urgent Care Visit		100% after $60 copay	60% of Allowable Amt after deductible
Emergency Care Visit		100% after $250 copay	100% after $250 copay
Ambulance		80% after deductible	80% after deductible
Other Covered Medical Care: • Skilled nursing facility (maximum 60 days/year) • Home health care including private duty nursing in the home (maximum 60 visits/year) • Hospice (180 day maximum)		80% after deductible	60% of Allowable Amt after deductible
Mental Health/Substance Abuse: • Inpatient • Outpatient		 80% after deductible 100% after $55 copay per visit	 60% of Allowable Amt after deductible 60% of Allowable Amt after deductible
Prescription Drugs		**You Pay**	
Tier 1	Retail Pharmacy Mail Order Pharmacy	$10 copay $20 copay	
Tier 2	Retail Pharmacy Mail Order Pharmacy	20% coinsurance ($30 minimum/$60 maximum) 20% coinsurance ($75 minimum/$150 maximum)	
Tier 3	Retail Pharmacy Mail Order Pharmacy	40% coinsurance ($50 minimum/$85 maximum) 40% coinsurance ($125 minimum/$213 maximum)	
Tier 4	Retail Pharmacy Mail Order Pharmacy	50% coinsurance ($55 minimum/$130 maximum) 50% coinsurance ($138 minimum/$325 maximum)	

[1] *Annual deductibles, coinsurance and copays count toward satisfying the out-of-pocket maximum.*

[2] *Preventive care services that are covered without cost sharing are defined as services performed to prevent disease. Some of these services are only covered for people of a particular age, gender and/or risk status.*

[3] *Out-of-network fees are subject to guidelines surrounding Allowable Amounts. Allowable Amounts are determined by the Claims Administrator. You are responsible for any out-of-network fees above the Allowable Amount. Fees paid above the Allowable Amount do not count toward satisfying the out-of-pocket maximum.*

Emergency Defined: For both the Health Savings Plan and the Traditional Health Plan, an emergency is a sickness or injury that could be life threatening or cause serious harm to your bodily functions, as determined by the Claims Administrator. Typically an emergency requires immediate care and treatment, generally is received within 24 hours of onset, to avoid jeopardy to life or health. Apparent heart attacks, severe bleeding, loss of consciousness, convulsions, fractures, breathing difficulties, and severe or multiple injuries are all examples of medical emergencies. Generally, care that you receive after your condition has stabilized would not be considered Emergency Care.

For the Traditional Health Plan, only those services provided in the Emergency Room (ER) are covered at 100%, after the applicable copay. If you are admitted to the hospital for treatment, the regular hospital inpatient benefits apply, which means that if you are at an out-of-network facility charges will be covered at the out-of-network reimbursement rate and subject to the allowable amounts calculation.

What's Not Covered

The general exclusions listed below apply to the GPC Medical Plan. For fully insured medical options, refer to the certificate of coverage that you receive from your Claims Administrator for a complete list of exclusions, which describe plan benefits more thoroughly. If there are any discrepancies between the list below and the exclusions in the fully insured plan's certificate of coverage or booklet provided by the Claims Administrator, the certificate of coverage will govern, as to those benefits that are fully insured.

The GPC Medical Plan does not cover:

- examinations or tests in connection with premarital, school or similar examinations or tests not medically necessary for the treatment of an illness or injury;
- dialysis services received at an out-of-network renal dialysis facility;
- charges in excess of the Allowable Amounts charges (as determined by the Claims Administrator at its sole discretion) for services and supplies;
- charges for care or treatment that is not medically necessary as determined by the Claims Administrator;
- cosmetic surgery or therapies performed to improve or alter appearance or self-esteem or, except as otherwise expressly covered by the Plan, to treat psychological symptomatology or psychological complaints related to one's appearance;
- non-medical or personal convenience items while you are in the hospital, such as television rentals;
- treatment for injuries or illnesses that are a result of an act of war;
- services you do not have to pay for, or for which you are reimbursed by a third party as the result of legal action or settlement;
- travel and transportation, except for approved ambulance service, and travel and lodging benefits ($10,000 lifetime maximum) for transplant patients who must travel more than 50 miles from home for treatment*;
- expenses in connection with any services rendered or hospital confinement that commences prior to the effective date of your coverage under the GPC Medical Plan;
- with regard to insured coverage options, any other services and/or supplies that are not specifically included in the group insurance plan or that are explicitly excluded in the insurance certificate of coverage;
- treatment for injuries or illnesses that are job-related (coverage for occupational illness and injury is provided by Workers' Compensation);
- dental services, except for care that is necessary as a result of an accidental injury and expenses for hospital room and board and other special hospital services while a registered bed patient; treatment must begin within 12 months of the accidental injury;
- expenses in connection with any treatment or confinement that is not recommended by a qualified physician for the diagnosis or treatment of an injury, illness or symptomatic complaint;
- expenses incurred primarily for the treatment of obesity or weight reduction programs, unless the extent of obesity deems the treatment a medical necessity as determined by the Claims Administrator, in which case limitations will apply;

- expenses in connection with any treatment or confinement resulting from an injury or illness sustained while doing any act or thing pertaining to any occupation or employment for remuneration or profit;
- expenses in connection with any treatment or confinement for which the Claims Administrator determines (in its sole discretion) that a contributing cause was the patient's attempt to commit a crime or involvement in an illegal occupation, act or activity;
- expenses for or related to treatment, education testing, or training related to learning disabilities or developmental delays;
- charges incurred for eye refraction, eyeglasses, contact lenses, hearing aids or the examination or fitting of any of these;
- non-prescription drugs, dietary supplements or substitutes;
- charges for completing claim forms, reports or presentations;
- expenses for the reversal of a sterilization procedure;
- those for or related to artificial insemination, in vitro fertilization or embryo transfer procedures;
- any care in excess of plan limits;
- private duty nursing in the hospital, except when medically necessary as determined by your personal physician and with prior approval of the Claims Administrator, and subject to certain limits;
- custodial, domiciliary or convalescent care;
- short-term, disease-specific, inpatient rehabilitation programs and services when not rendered pursuant to a normal pre-certified or emergency acute inpatient admission;
- any transplant deemed experimental in terms of generally accepted medical standards or which is not approved by the FDA, as determined by the Claims Administrator;
- experimental medical, surgical or psychiatric procedure, and pharmaceutical regimens;
- elective abortion;
- orthomolecular medicine, holistic medicine, naturopathy, acupuncture, cytotoxin testing, hair growth and analysis;
- vocational rehabilitation;
- hypnotherapy;
- immunization for travel abroad;
- long-term (in excess of 60 days) rehabilitation programs (i.e., cardiac rehabilitation, pulmonary rehabilitation, mitral valve prolapse, pain management and PMS);
- Lasik surgery, or any surgical procedure for the improvement of vision when vision care can be made adequate through the use of eyeglasses or contact lenses;
- replacement and/or repair of orthotics, prosthetics or prostheses due to normal wear or damage;
- charges in excess of what this Plan would cover, where coverage exists under two or more plans;
- wigs or prosthetic hair;
- charges in connection with marriage, family, child, career, social adjustment, pastoral or financial counseling;
- equipment and appliances that are not prescribed for the treatment of disease, or that are considered to be for convenience in the home;

- if a transplant donor is not a member, covered services for the donor are limited to those services and supplies directly related to the transplant procedure itself and are covered only to the extent that those services are not covered by other health insurance; and if the recipient is not a member, no donor expenses are covered.

**Donor transportation costs are not covered even when the donor is a member of the Plan. All transplants must be approved in advance by your health care company's medical management center*.

This list is intended as a general summary. For more information regarding covered services, contact your health care company's member services department.

GPC Life Resources

GPC provides an Employee Assistance Program (EAP) and Work/Life Benefit to help you balance your responsibilities at work and in your personal life. The program is available to all employees and their household members. You do not have to enroll for this program and it is provided to you and your eligible dependents at no cost. Coverage begins on your date of hire.

The EAP offers free and confidential assistance with many of the work-life challenges you face each day. GPC Life Resources—your Employee Assistance Program and work/life benefit, administered by Beacon Health Options, provides practical solutions, information, advice and support for a wide range of work-life issues, including but not limited to anxiety, depression, child or senior care, relationship or marital issues, alcohol or substance abuse, finding colleges, bereavement, financial or legal concerns, and parenting challenges.

GPC Life Resources can help you handle problems that affect your physical and mental well-being, as well as your relationships. GPC Life Resources offers confidential access 24 hours a day, 365 days a year to trained professionals who can discuss your question, problem, or concern. Depending on your situation, the GPC Life Resources counselor may do the following:

- Refer you to a licensed network EAP provider in your community for up to three in-person visits at no cost to you.
- Link you to available resources in your community.
- Offer you support over the telephone.

Additionally, if the counselor determines the situation requires it, you may be referred for additional assistance through the mental health or substance abuse coverage offered through the GPC Medical Plan. Any information about your call or treatment is confidential and may only be disclosed as permitted or required by law.

Prescription Drug Program

All participants in the GPC Medical Plan automatically receive prescription drug coverage. Coverage works differently under each medical plan option, but certain guidelines are applicable under both options. The following information applies to both the Health Savings Plan and the Traditional Health Plan.

The Express Scripts prescription drug program allows you to obtain your medications from retail pharmacies or through the Express Scripts mail order pharmacy.

Retail Pharmacies

- If you use a retail pharmacy that accepts the prescription ID card, you can get up to a 30-day supply of medications for the applicable copayment or coinsurance. To determine if a pharmacy is participating in the network go to **www.express-scripts.com** and use the Pharmacy Look up feature or download the Express Scripts mobile app and use the Locate a Pharmacy feature.
- If you use a retail pharmacy that does not participate in the prescription drug program, you must pay for your prescription and file a claim for reimbursement. Your reimbursement will be the amount that would have been charged by a participating retail pharmacy less your copayment or coinsurance.

Express Scripts Mail Order Pharmacy

The Express Scripts mail order pharmacy allows you to obtain up to a 90-day supply of maintenance medications for one payment. Maintenance medications are drugs taken on an ongoing, long-term basis (three months or more).

To use the Express Scripts mail order pharmacy program, you should have your doctor write a prescription for a 90-day supply plus refills. If you need a medication right away, ask your doctor to write a separate prescription for a 14-day supply, so it can be filled at a retail pharmacy. When requesting refills, allow up to 14 days to receive your refill medications. Express Scripts mail order pharmacy order forms are available online at **www.express-scripts.com** or by calling Express Scripts Member Services at 800-849-9076.

Express Scripts Specialty Pharmacy, Accredo

Accredo is the Express Scripts Specialty Pharmacy. A Specialty Pharmacy offers specialized teams that focus on complex diseases. They will work with you and your doctor to help you receive the best possible care. To get started, simply contact an Accredo patient care advocate at 800-803-2523 and they will work with your doctor on the rest. You will have access to a team of specialty-trained pharmacists, nurses and insurance representatives who are experienced in your condition. Accredo will schedule and quickly ship all your specialty medications – even those that need special handling, such as refrigeration. Accredo pharmacists and nurses are available around the clock 24/7 to answer all your questions about your medications and condition. Accredo will contact you

regularly to schedule your next refill and see how your therapy is progressing. For convenience, some specialty medication refills can be ordered online or via the Accredo mobile app.

Retail Refill Allowance for Maintenance Medications

To obtain benefits coverage for maintenance medications, you must use the Express Scripts mail order pharmacy after three fills of a prescription at a retail pharmacy (the original prescription plus two refills).

This means that the first three times you purchase a maintenance medication at a participating retail pharmacy, you'll pay the following:

- If you participate in the Health Savings Plan: the negotiated, discounted price if you haven't met the deductible, 10% coinsurance if you have met the deductible or nothing if you have met the out-of-pocket maximum
- If you participate in the Traditional Health Plan: the retail copay or coinsurance based upon the drug's tier coverage

You will be responsible for paying the entire cost of the medication beginning with the fourth time you purchase a long-term drug at a retail pharmacy.

Generic Medications

Generic drugs help you save money because you will pay less for them than you will pay for brand-name drugs. If you do fill a brand-name drug prescription, here are some things to keep in mind:

- **Generic equivalents automatically dispensed**: If you fill a prescription for a brand-name drug at a retail pharmacy or through the Express Scripts mail order pharmacy when an equivalent generic drug is available, the generic equivalent will automatically be dispensed, unless you or your doctor specify otherwise.
- **Purchasing brand-name drugs when a generic equivalent is available:** If you purchase a brand-name drug when a generic equivalent is available, you will pay the amount of coinsurance up to the tier maximum plus the difference in cost between the brand-name drug and the generic drug. If your doctor specifically directs the pharmacy to "dispense as written," which means that a generic equivalent drug may not be substituted for the brand-name medication, you will not have to pay the price difference.
- **Difference between generic equivalent and generic therapeutic alternative:** A *generic equivalent* is made with the same ingredients at the same dose as a brand-name drug. A *generic therapeutic alternative* is designed to work like a brand-name drug or another generic drug in the same class of medicines, but the ingredients in a generic therapeutic alternative are different. Check with your doctor to see what options work best for you. Even if your brand-name drug has no generic equivalent, it may still have a generic therapeutic alternative.

Clinical Coverage Rules

The following clinical coverage rules apply to certain prescriptions:

- **Prior Authorizations:** Certain prescriptions require prior authorization from Express Scripts before benefits can be paid. All request(s) will be reviewed based on the medical condition and dispensing criteria as developed by Express Scripts. Prior authorization must be received before the medication(s) are dispensed.

  When purchasing a prescription at a participating retail pharmacy, the pharmacist will be automatically notified of the need for a prior authorization. When purchasing a prescription at a non-participating pharmacy, it is your responsibility to obtain a prior authorization. You can do so by contacting Express Scripts Member Services at 800-849-9076.

- **Drug Quantity Management**: Certain prescriptions are subject to quantity limits before benefits can be paid to ensure the prescription is consistent with clinical dosing guidelines. The guidelines are based on manufacturer-recommended guidelines and supporting medical studies. For example, a 30-day supply of a medication that requires one pill, or dose, per day would be 30 pills. The supply would be expected to last until the next 30-day refill.

- **Step Therapy**: Within specific therapy classes, multiple drugs may be available to treat the same condition. Through step therapy, a safe, lower cost prescription drug available to treat a condition is required to be tried first before benefits can be paid. Progression to higher-risk prescriptions occurs only if medically necessary.

- **Mail-order Requirement for Specialty Drugs**. All specialty drug prescriptions must be filled through the Express Scripts specialty mail order pharmacy, Accredo, to receive benefits coverage. If you purchase a specialty drug at a retail pharmacy, you will be responsible for paying the entire cost of the medication.

- **Clinical Days Supply**. The Clinical Days Supply coverage rule limits certain specialty drugs – which are frequently discontinued early due to side effects – to a 30-day supply.

- **Variable Copay Program.** Copays for certain specialty medications may be set to the maximum of the current plan design or any available manufacturer-funded copay assistance.

- **Out-of-pocket Protection Program.** Patient assistance, including manufacturer rebates and discounts, will not be considered as a true out of pocket expense for members and may not apply to the deductible and out of pocket maximums.

Express Scripts changes the list of medications for which a clinical coverage rule applies from time to time. To determine if a clinical coverage rule applies to a medication, go to **www.express-scripts.com** or access the Express Scripts mobile app or contact Express Scripts Member Services at 800-849-9076.

What's a Formulary? A formulary is a list of FDA-approved, preferred brand-name and generic medications that have been reviewed for the Pharmacy Benefit Manager by an independent Pharmacy and Therapeutics Committee made up of physicians and pharmacists. This committee and Express Scripts regularly review, evaluate and update the formulary to ensure choice in all therapeutic categories. The committee reviews drugs based on medical appropriateness, safety and cost effectiveness. The formulary covers an extensive list of drugs used to treat most medical conditions. Neither GPC nor the GPC Medical Plan has any control over which drugs are or are not included in the formulary. The formulary is updated periodically and subject to change. For example:

- A drug may be moved to a higher or lower cost-sharing Formulary tier.
- Additional drugs may be excluded from the Formulary.
- A restriction may be added on coverage for a Formulary-covered drug (e.g. prior authorization).
- A Formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

Health Savings Plan Prescription Drug Plan At-A-Glance

Under the Health Savings Plan, prescription drugs are treated like any other expense. You will pay the full, negotiated price for prescription drugs until you meet the Health Savings Plan deductible. After meeting the deductible, you will pay coinsurance until the annual out-of-pocket maximum is reached. Once you reach the out-of-pocket maximum, the Plan pays 100% of your prescription drug costs.

Retail (up to a 30-day supply)	Express Scripts mail order pharmacy (up to a 90-day supply)
10% coinsurance after deductible 100% covered after meeting out-of-pocket maximum	10% coinsurance after deductible 100% covered after meeting out-of-pocket maximum

Traditional Health Plan Prescription Drug Plan At-A-Glance

The Traditional Health Plan provides prescription drug coverage based on a four-tier structure. Tier 1 drugs are purchased with a copay, and drugs in Tiers 2-4 are purchased with coinsurance and are subject to a minimum and maximum dollar amount. Under this plan, the deductible does not apply to prescription drug expenses. This means that prescription drug benefits begin even if your deductible hasn't been met. Once you reach the out-of-pocket maximum, the Plan pays 100% of your prescription drug expenses.

	Retail (up to a 30-day supply)	Express Scripts mail order pharmacy (up to a 90-day supply)
Tier 1	$10 copay	$20 copay
Tier 2	20% coinsurance ($30 minimum and a $60 maximum)	20% coinsurance ($75 minimum and a $150 maximum)
Tier 3	40% coinsurance ($50 minimum and a $85 maximum)	40% coinsurance ($125 minimum and a $213 maximum)
Tier 4	50% coinsurance ($55 minimum and a $130 maximum)	50% coinsurance ($138 minimum and a $325 maximum)

Under the Traditional Health Plan, prescription drugs are categorized by tiers. Following is a list of prescription drugs included in each tier, as well as some examples for each one.

Tier	Drugs Included in Each Tier		Example
Tier 1	All generic drugs		Azithromycin, Omeprazole
Tier 2	Brand-name drugs* on the National Preferred Formulary® **EXCEPT** for preferred brand name medications in the following categories:	COX-II Inhibitors/NSAIDs for arthritis/pain	Flector®, Zipsor®, Pennsaid®
		Proton Pump Inhibitors for ulcer/heartburn	Nexium® and Dexilant®
Tier 3	Brand-name drugs* NOT on the National Preferred Formulary® plus brand-name drugs in the following category:	Hypnotics for insomnia	Halcion®, Prosom®, Restoril®, Rozerem®, Silenor®
Tier 4	Brand-name drugs* in the following categories are included in this tier:	Brand-name COX-II Inhibitors/NSAIDs* for arthritis/pain	Flector®, Zipsor®, Pennsaid®
		Brand-name Proton Pump Inhibitors* for ulcer/heartburn	Nexium® and Dexilant®
		Brand-name non-sedating antihistamines*	Clarinex®, Xyzal®
		Brand-name "lifestyle drugs"*	Muse®, Edex®, Stendra®Levitra®, Xenical®, Belviq XR®, Contrave®, Qsymia®, Saxenda®, Didrex®, Ionamin®

***** *If you purchase a brand-name drug when a generic equivalent is available, you will pay the amount of coinsurance up to the tier maximum plus the difference in cost between the brand-name drug and the generic drug.*

Minimums and Maximums

Under the Traditional Health Plan, each coinsurance percentage for Tiers 2-4 is subject to a minimum and maximum amount. This means that you will pay a percentage of the cost of the drug and GPC will pay the remaining amount. You will never pay more than the maximum amount for a prescription drug, and you will not pay less than the minimum amount unless the original cost of the drug is less than this minimum amount.

What Is Not Covered Under the Prescription Drug Program

Under Health Savings Plan and the Traditional Health Plan, the Express Scripts prescription drug program does not cover:

- non-federal legend drugs;
- contraceptive medications or devices that are not FDA approved;
- oral contraceptive medications not filled through the Express Scripts mail order pharmacy;
- anabolic steroids;
- Antagon®;
- Cetrotide®;
- Ganirelix®;
- Luveris®;
- Mifeprex®;
- Ostomy Supplies;
- Insulin Pumps;
- allergy serums;
- therapeutic devices or appliances;
- drugs whose sole purpose is to promote or stimulate hair growth or are for cosmetic purposes only;
- drugs labeled “Caution — limited by federal law to investigational use,” or experimental drugs, even though a charge is made to the individual;
- medication for which the cost is recoverable under any Workers’ Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member;
- medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows a facility for dispensing pharmaceuticals to be operated on its premises;
- any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician’s original order;
- charges for the administration or injection of any drug, and
- Medications any portion of which have previously been paid by any other source (not including an individual health care spending account, health reimbursement account or similar);
- any drug not approved by the FDA to be lawfully marketing for the proposed use or not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use or which exceeds the recommended dosage;
- any medicine determined by the Claims Administrator to be not medically necessary;
- nutritional and diet supplements;
- over-the-counter medicines, even if the medicine is also available by prescription (e.g., Tagamet® Claritin®, Zantac® or Monistat®); and

- any drug or medicine considered illegal under the Federal Food, Drug and Cosmetic Act, including but not limited to prescription drugs purchased in foreign countries for importation into the United States.

In rare circumstances, an Express Scripts Pharmacist may decline to fill a prescription requested through the Express Scripts mail order pharmacy program if they reasonably believe that it would violate their professional practice guidelines. In these instances, the prescription will have to be filled at a participating retail pharmacy and you may be responsible for the entire cost of the medication.

Filing Claims

In some cases, you must file a claim form to receive reimbursable benefits under the GPC Medical Plan. Medical Expense Claim Forms can be obtained from your medical plan administrator.

If you use a network provider, you will not have to complete claim forms in most circumstances, your provider should submit the completed claim forms for you. If you use an out-of-network provider, you will be responsible for submitting a Medical Expense Claim Form.

When you or a covered family member incurs an eligible expense, complete the claim form by following the instructions included on the form. Instruct your provider to complete the physician's portion of the form or attach an itemized bill for the expenses.

Your claim form and/or the itemized bill must include the following information:

- service provider and tax ID number,
- patient's name and Social Security number,
- diagnosis and treatment of the medical condition,
- date and charge for each service, and
- employee's name and contract number.

Return the completed claim form and itemized bill to the address listed on the form. Remember to keep a copy of the form and your bill for your records.

All claim forms must be received within 12 months after the date of service. Otherwise, the Plan will not pay any benefits for that eligible expense. This 12-month requirement does not apply if you are legally incapacitated, as determined by the Claims Administrator. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

Group Health Plan Benefit Determinations

Initial Determination of Your Claim

A claim for benefits is any request for a Medical Plan benefit or benefits made by a participant or beneficiary in accordance with the claims procedures in this SPD. Note that eligibility determinations and casual inquiries, including requests for prior approval where the Medical Plan does not require prior authorization, are not claims for benefits subject to the following claims procedures.

With the exception of Urgent Care Claims, a health care provider may only pursue an appeal of an adverse benefit determination on your behalf if you have given the health care provider written authorization to do so. The Plan does not permit a healthcare provider to re-assign claims/appeals to a third party.

Your claim will be reviewed as follows depending on whether your claim is classified as Urgent, Concurrent, Pre-Service or Post-Service.

Urgent Care Claims That Require Immediate Action

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain which cannot be controlled using standard methods. In these situations:

- Your claim will be determined and you will receive notice of the benefit determination verbally, in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- If you receive the notice of denial verbally, a written or electronic confirmation will follow within 72 hours.

All necessary information (including the decision on review) may be transmitted between you and the Claims Administrator by telephone, fax or other method designed to expedite your review. You are not required to submit Urgent Care Claims in writing.

If you filed an Urgent Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You will have 48 hours to provide the requested information.

You will then be notified of a determination no later than 48 hours after the earlier of:

- The Claims Administrator’s receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice (called an Explanation of Benefits or "EOB") will explain the reason for denial and will explain your options regarding appeal of the denial. If the Claims Administrator denies your request for benefits, you must appeal the adverse benefit determination no later than 180 days after receiving the adverse benefit determination. The Claims Administrator must notify you of the appeal decision within 72 hours after receiving the appeal.

Concurrent Care Claims

A Concurrent Care Claim is a claim involving extension or termination of a treatment or course of treatments that have previously been approved and are ongoing. If you are currently receiving treatment and the Plan intends to withdraw approval or stop paying, the Plan will give you prior warning with enough time for you to appeal.

In addition, if an ongoing course of treatment was previously approved for a specific period of time or number of treatments and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim. If your request to extend the treatment involves an Urgent Care Claim as defined previously, your request will be decided within 24 hours. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not an Urgent Care Claim, it will be decided according to the applicable post-service or pre-service timeframes, whichever applies.

Finally, if your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim.

Pre-Service Claims

Pre-Service Claims are those claims for which the Plan requires notification or approval prior to receiving medical care. If your claim is a Pre-Service Claim and is submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of the receipt of the claim. If you filed a Pre-Service Claim improperly, and the Claims Administrator becomes aware of the improper filing, the Claims Administrator will notify you of how to correct the filing within 5 days after becoming aware of the claim. If additional information is needed to process the Pre-Service Claim, the claim will be pended, the Claims Administrator will notify you of the information needed, and you will be given 45 days to provide this information. If you don't provide the needed information within the 45-day period, your claim will be denied, and you will be given the chance to appeal the determination as discussed further in this section.

Additionally, the Claims Administrator may take a one-time extension not longer than 15 days for reasons beyond its control. If the Claims Administrator intends to seek this extension, it will notify you within the initial 15-day claim determination period.

If your claim is denied, a denial notice (EOB) will be sent and will explain the reason for denial as well as your options regarding appeal of the claim (see following discussion).

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after you have already had the medical procedure or care and for which you did not need any pre-authorization. In most cases, you will receive a written decision on your claim from the Claims Administrator within 30 days of receipt. However, the Claims Administrator may take longer if it finds that it needs more information or if more time is needed due to circumstances outside the control of the Plan. If the Plan needs more time, the Claims Administrator will inform you within 30 days of receipt of the claim. If the reason for the extension is that additional information is needed, the claim will be pended, the Claims Administrator will tell you what information is needed, and will give you up to 45 days to supply the information prior to making a decision on your claim. If you don't provide the needed information within the 45-day period, your claim will be denied and you will be able to appeal the determination in accordance with the appeals procedure discussed further in this section.

If your claim is denied, a denial notice (EOB) will be sent and will explain the reason for denial as well as your options regarding appeal of the claim (see following discussion).

If You Receive an Adverse Benefit Determination

When the Claims Administrator notifies you of an adverse benefit determination, the notice will include:

- the specific reasons for the adverse benefit determination;
- information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable);
- the specific plan provisions on which the decision is based, including the denial code and its corresponding meaning, a description of the Plan's standard, if any, used in denying the claim, and in the case of a final adverse determination, a discussion of the decision;
- a description of any additional material or information necessary for the claim to be completed and an explanation of why such material or information is necessary;
- a description of the Plan's internal and external review procedures, information about how to initiate an appeal and the time limits applicable to such procedures, including your right to bring a civil action in federal court following a claims denial on review;
- a description of any internal rules, guidelines, protocols or other similar criteria that were relied upon in the decision-making, OR a statement that the decision was based on the applicable items mentioned above and that copies of the applicable material will be provided upon request, free of charge;
- an explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to your medical circumstances OR a statement that such explanation will be provided upon request, free of charge;
- information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes; and
- for a claims denial involving an urgent care claim, a description of the expedited internal and external review processes applicable to such claims.

If you have any questions about a denied claim, you should contact the Claims Administrator.

Time Frame and Procedures for Appealing an Adverse Benefit Determination

If, after receiving an adverse benefit determination, you feel your claim for benefits was handled or decided incorrectly, you have the right to appeal the decision in conjunction with the procedures outlined in this section. Failure to follow the claims procedure as described in this booklet will result in the denial of your claim and may permanently bar you from bringing a claim in court.

As stated previously, you will be provided with a written notice of an adverse benefit determination — an Explanation of Benefits ("EOB"). The EOB will give the reason for the decision and will explain what steps you must take if you wish to appeal. If you wish to appeal a denied pre-service request for benefits, Post-Service Claim or a rescission of coverage, you must submit your appeal in writing as directed in the EOB within 180 days of the denial. This appeal must be in writing and can be made by you or your authorized representative. You do not need to submit urgent care appeals in writing. Your submission must describe the nature of the claim and the reasons why you feel your claim should be granted. If documentary evidence is available to support your claim, you should submit that evidence with your claim, or if the evidence is not within your possession, you should indicate in your submission where it may be located.

There are two levels of appeal available under the Plan: the initial appeal and the second appeal. You must pursue both levels of appeal before you can bring any legal action. If you do not, you will waive your right to sue in court.

As with the claims, different time periods apply for denial of benefits based on the type of claim presented.

Initial Appeal: The Claims Administrator will determine your initial appeal not later than: (a) 72 hours after the request is received for Urgent Care Claims; (b) 15 days after the request is received for Pre-Service Claims; or (c) 30 days after the request is received for Post-Service Claims. Initial appeals with regard to Concurrent Care Claims will be handled in the same time periods as the benefit most closely resembling that claim. Initial appeals should be mailed to the applicable Claims Administrator at the address in the "About This Plan" section of the SPD.

If your initial appeal is denied, you will be promptly notified. The notification will include the following information:

- the specific reasons for the denial;
- information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable);
- the specific plan provisions on which the decision is based, including the denial code and its corresponding meaning, a description of the Plan's standard, if any, used in denying the claim, and in the case of a final adverse determination, a discussion of the decision;

- a description of any additional material or information necessary for the claim to be completed and an explanation of why such material or information is necessary;
- a description of the Plan's internal and external review procedures, information about how to initiate an appeal, the time limits applicable to such procedures, including your right to bring a civil action in federal court following a claims denial on review;
- a description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, OR a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material will be provided upon request, free of charge;
- an explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to your medical circumstances, OR a statement that such explanation will be provided upon request, free of charge;
- information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes; and
- for a claims denial involving an Urgent Care Claim, a description of the expedited internal and external review processes applicable to such claims.

Second Appeal: If your initial appeal is denied, you may, within 60 days of receipt of written notice of the denial, file a second appeal with the Claims Administrator. The Plan Administrator has granted the Claims Administrator the discretionary authority to interpret the applicable facts and the Plan as necessary to determine the extent to which benefits are payable. You should submit any information at that time that you feel would help the Plan decide the claim in your favor. The second appeal will not be reviewed by the same person or persons who reviewed the initial appeal (nor by anyone who reports to the initial reviewer). The Plan will determine your second appeal within the following time periods: (a) 15 days after receipt of the request if the appeal involves a Pre-Service Claims; or (b) 30 days after the request for Post-Service Claims. There is no second appeal for Urgent Care Claims. Second appeals with regard to Concurrent Care Claims will be handled in the same time periods as the benefit most closely resembling that claim. Appeals should be mailed to the applicable Claims Administrator at the address listed in the "About This Plan" section of this SPD.

If your second level appeal is denied you will be notified. This notification will include the following information:

- the specific reasons for the denial;
- information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable);
- the specific plan provisions on which the decision is based, including the denial code and its corresponding meaning, a description of the Plan's standard, if any, used in denying the claim, and in the case of a final adverse determination, a discussion of the decision;
- a description of any additional material or information necessary for the claim to be completed and an explanation of why such material or information is necessary;

- a description of the Plan's internal and external review procedures, information about how to initiate an appeal, the time limits applicable to such procedures, including your right to bring a civil action in federal court following a claims denial on review;
- a description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, OR a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material will be provided upon request, free of charge; and
- an explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to your medical circumstances, OR a statement that such explanation will be provided upon request, free of charge.

External Review Program: If you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services; or
- as otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge if you have exhausted the appeals process identified previously, you receive a decision that is unfavorable, or your appeal has not been responded to within the timelines stated previously.

You may request an independent review of the adverse benefit determination by contacting the Claims Administrator at the address in the "About This Plan" section of this SPD. Neither you nor your medical plan carrier will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four (4) months from the later of the date you received the adverse benefit determination or the date you received the final appeal determination.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has no material affiliation or interest with your medical plan carrier or Genuine Parts Company. The IRO chosen will be based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO. Request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon in making a decision on the case; and
- all other information or evidence that you or your Physician has already submitted to your medical plan carrier.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and the documents will be forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and the Claims Administrator with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

Claims and Appeals Related to Enrollment / Eligibility

If your denial is related to your enrollment or eligibility in the Plan, then you must make an appeal within 180 days of the denial to GPC as the Plan Administrator (see address in the Contact Information Section). Your claim will be decided by the Plan Administrator within 90 days of receipt (unless special circumstances require an extension of time for which you will be provided written notice of the extensions), and you will be notified in writing of the result of the determination. Exhaustion of the appeals process is mandatory, and you can lose your right to file a suit in court if you fail to complete the full appeals procedure available to you.

Coordination of Benefits

When a person is covered by more than one plan that provides medical benefits, eligible expenses will be shared or coordinated between the two plans. This is known as coordination of benefits (COB) and may mean that the benefits paid under the GPC Medical Plan will be less than what the GPC Plan would normally pay if there was no secondary coverage. The COB provisions ensure that the total benefits paid by the two plans do not exceed 100% of eligible expenses that would be payable under this Plan. If the other plan pays a benefit that is higher than what the GPC Plan would pay, then no further benefits are

payable under the GPC Plan. Additionally, any co-pays or deductibles under the other plan are not subject to reimbursement under the GPC Plan.

The COB provisions affecting your GPC benefits are described more thoroughly in a certificate of coverage for the insured benefits or in the GPC Administrative Information SPD for self-funded benefits. If there is a discrepancy between the coordination of benefits provision of the Summary Plan Description and the applicable certificates or booklets, the certificate or booklet will control.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains provisions that apply to group health plans.

Notice of HIPAA Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the GPC Medical Plan, provided that you request enrollment within 31 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your spouse and your new dependents, provided that you request enrollment within 31 days after marriage, birth, adoption or placement for adoption. Coverage for a new dependent by birth or adoption is effective on the date of the birth or adoption, provided you request enrollment within 31 days of the birth or adoption.

Coverage for a new spouse or dependent by marriage is effective on the first day of the month following the date the request for enrollment is made and received by the GPC Employee Service Center, provided you submit a completed enrollment form within 31 days of the marriage

Newborns' and Mothers' Health Protection Act of 1996

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

Women's Health and Cancer Rights Act

Under the Women's Health and Cancer Rights Act, group health plans that provide coverage for mastectomies must cover reconstructive surgery and prostheses following mastectomies.

The law mandates that a participant or eligible beneficiary receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles, coinsurance and copayment provisions that are otherwise applicable under your Plan.

Premium Assistance Under Medicaid and the State's Children's Health Insurance Program (SCHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**

Family and Medical Leave Act of 1993

The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide eligible employees with unpaid, job-protected leaves of absence for up to 12 weeks during any 12-month period (starting with the date the FMLA leave begins or 26 weeks in a single 12-month period for military caregiver leave) for certain family and medical reasons.

Job Benefits and Protection

You can continue coverage for yourself and your dependents as long as you contribute towards the cost of the coverage. If your contribution is more than 30 days late, GPC will give you written notice, and your coverage will end on the last date for which payment was made.

When returning from FMLA leave, employees must be restored to their original or equivalent position with equivalent pay, employment benefits and terms. If your leave is due to your own serious illness, your health care provider must provide a “fitness for duty” report before you can return to work.

Upon your return to active service following your FMLA leave, any canceled health care coverage or other benefits suspended during the term of your leave will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any pre-existing condition limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Upon request, the Company will give you detailed information about the FMLA and its effect on your benefits.

Coverage Termination

While you are on FMLA leave, coverage will not continue beyond the first of the following dates:

- the date you are required to make any contribution and fail to do so;
- the date Genuine Parts Company terminates your approved leave;
- the date coverage ends for the class of employees to which you belong;
- the date employment would have terminated except for FMLA leave status; or
- the date you fail to return to work from leave.

If you fail to return to work, coverage may be available under another GPC-sponsored plan. Also, if you fail to return to work within 30 days of the expiration of your FMLA leave, you may have to repay GPC for contributions to your group health coverage.

Uniformed Services Employment and Reemployment Rights Act

The Uniformed Services Employment and Reemployment Rights Act (USERRA) contains the following provisions:

- If you leave work temporarily for military duty (30 days or less), you can continue medical coverage for yourself and your dependents, as long as you continue to pay your share of the premiums.
- If you will be on military duty for 31 days or longer and desire to maintain your coverage, you will be required to pay the full premium plus a 2% administration fee. You can continue this coverage for the earlier of 24 months, beginning on the day that your service leave begins or until you are released from military duty and fail to return to work.
- If you are reemployed by Genuine Parts Company when you return, you are entitled to all seniority and other rights and benefits you would have attained were it not for the leave, provided:
  - you provided GPC advance written or verbal notice of your military duty;
  - you were released from the military under honorable conditions;
  - you submit an application for reemployment; and
  - the cumulative length of all your military absences does not exceed five years.

You and your Eligible Dependents will have your coverage reinstated effective on the date of your return to work. There will be no waiting period required. However, the Plan will not cover Injuries or Illnesses (as defined by the Plan) that are attributable to military service; these will be covered by the uniformed service.

Right of Reimbursement and Subrogation

Information about the Medical Plan's right to seek reimbursement of expenses paid by the Plan on behalf of you, your covered spouse or covered dependent if those expenses are related to the acts or omissions of a third party can be found in the *Administrative Information* Summary Description.

Patient Protection Notices

The GPC Medical Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in your medical plan carrier's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your medical plan carrier.

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

You do not need prior authorization from the GPC Medical Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your medical plan carrier'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, 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, contact your medical plan carrier.

Other Things You Should Know

Plan Administrator

Genuine Parts Company, as Plan Administrator, has the exclusive right and discretion to interpret the terms and conditions of the Medical Plan, and to decide all matters arising in its administration and operation, including questions of fact and issues pertaining to eligibility for, and the amount of, benefits to be paid by the Medical Plan. Any such interpretation or decision shall, subject to the claim's procedure described herein, be conclusive and binding on all interested persons, and consistent with the Medical Plan's terms and conditions, be applied in a uniform manner to all similarly situated participants and their covered dependents. The Plan Administrator may delegate certain discretionary authority to one or more committees or other entities. Genuine Parts Company hereby delegates to the Claims Administrators the discretionary authority to decide questions of fact and to interpret the terms of the Plan as necessary to determine the extent to which benefits under the plan are payable.

No Contract of Employment

This document is not intended in any way to create an employment contract. No verbal statements by supervisors or management can alter the benefits described in this document or create an employment contract.

Equal Treatment Policy

The design, development and administration of this benefit plan are consistently operated with a policy of equal treatment for all persons, without regard to sex, race, creed, color, religion, marital status, sexual orientation, citizenship status, national origin, age, pregnancy, disability, military status, status as a veteran, or any other protected characteristic.

Limitation on Legal Action

Except as otherwise set forth in the Certificate of Coverage for fully insured benefits, any legal action to receive Medical Plan benefits must be filed the earlier of:

- six months from the date a final determination is made under the Plan or should have been made in accordance with the Plan's claims review procedures,
- if you pursue an external review with an IRO, within six months of the date the IRO issues, or should have issued, it's determination; or
- three years from the date the service or treatment was provided or the date the claim arose, whichever is earlier.

Your failure to file suit within this time limit results in the loss/waiver of your right to file suit.

About This Document

The GPC Medical Plan is summarized in this section. In some cases, Plan benefits that are insured are described more thoroughly in a certificate of coverage or in a more comprehensive summary booklet provided by the Claims Administrator (the certificate of coverage and/or booklet are collectively referred to herein as "Booklet"). If there is any discrepancy between the provisions of this document and the Booklet, the Booklet will control as to these insured benefits. Thus, for example, if Booklet contains a more comprehensive (or more specific) list of exclusions, the Booklet will control over this document. Notwithstanding anything to the contrary herein, Genuine Parts Company, as Plan Sponsor, reserves the right to terminate, suspend, withdraw, amend or modify the Plan at any time for any reason for any class of participants. If the Plan is terminated or changed in any way, you and other participants may not receive benefits as described in this document.

For More Information

If you have questions about the GPC Medical Plan or are uncertain about the medical plans that are available in your area, contact the GPC Employee Service Center or your Human Resources Department.

About This Plan

Plan Name	Genuine Parts Company Medical Plan, a component benefit of the Group Insurance Plan for Employees of Genuine Parts
Plan Sponsor	Genuine Parts Company
Employer Identification Number	58-0254510
Plan Number	501
Type of Plan	Employee and Dependent Medical Plan
Plan Administrator	Health and Welfare Benefits Committee Genuine Parts Company 2999 Wildwood Parkway Atlanta, GA 30339 678-934-5000

Claims Administrators	BlueCross and BlueShield of Alabama – Claims P.O. Box 995 Birmingham, AL 35298-0001 866-208-4945 BlueCross and BlueShield of Alabama – Appeals Attention: Customer Service Appeals P.O. Box 12185 Birmingham, AL 35202-2185 866-208-4945 Express Scripts – Claims Attention: Commercial Claims P.O. Box 14711 Lexington, KY 40512-4711 800-849-9076 Express Scripts – Appeals Attention: Appeals Department PO Box 66587 St. Louis, MO 63166-6587 800-946-3979 HMSA – Claims Attention: Claims Department P.O. Box 44500 Honolulu, HI 96804-4500 800-776-4672 HMSA – Appeals Attention: Appeals Coordinator P.O. Box 1958 Honolulu, HI 96805-1958 800-776-4672 Kaiser Foundation Health Plan, Inc. Attention: Claims Administration Department P.O. Box 378021 Denver, CO 80237-9998 877-875-3805 UnitedHealthcare Insurance Company - Claims P.O. Box 740800 Atlanta, GA 30374-0800 800-377-5137

	UnitedHealthcare Insurance Company – Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 800-377-5137
Eligible Employers	Eligible employers include: • Altrom, US, • Automotive Parts Group, • Balkamp, Inc., • Genuine Parts Company, • Heavy Vehicle Parts Group, USA, • Motion Industries, • Rayloc, • RMDS, • S.P. Richards Co., and • other designated participating employers as determined by the Plan document.
Plan Funding	Most of the medical options offered under this Plan are self-funded, but there are some benefit options that are fully insured. Generally, the medical benefits offered to employees within the contiguous United States, Alaska and Puerto Rico are self-funded by the Company. If you have questions regarding which benefit options are self-funded or insured, contact the Plan Administrator. The GPC Medical Plan is funded by contributions from GPC and participating employees.
Plan Year	January 1 to December 31
Agent for Service of Legal Process	Sr. Vice President — Corporate Counsel Genuine Parts Company 2999 Wildwood Parkway Atlanta, GA 30339 678-934-5000

ERISA Rights Statement

The GPC Medical Plan is governed under a federal law known as ERISA (the Employee Retirement Income Security Act of 1974, as amended). For the statement of your rights under ERISA, please see the *Administrative Information* Summary Description.