# Summary Plan Description

## Belk Employee Assistance Program (the "EAP")

Effective: January 1, 2017

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## SECTION 1 - WELCOME

**Quick Reference Box**

- Member services: (877) 771-7708;
- Claims submittal address: American Behavioral Benefits Managers, Inc., 2204 Lakeshore Drive, Suite 135, Birmingham, AL 35209; and
- Online assistance: **www.americanbehavioral.com**.

Millions of American workers struggle with personal issues and challenges that sometimes affect their job performance. These include family and marital issues, substance abuse, and financial and medical problems. Belk understands that all associates sometimes deal with personal issues that cause stress and affect our ability to handle day-to-day activities. Indeed, most of us have struggled at one time or another with a relationship problem, an aging parent, a defiant teenager, or another challenging personal issue.

Unfortunately, many people wait until they are in a crisis situation before reaching out for help. In an effort to help associates address any pressing personal problems or issues, Belk offers an Employee Assistance Program ("EAP"). American Behavioral Benefits Manager, Inc. ("American Behavioral"), a full-service behavioral healthcare organization based in Birmingham, Alabama, administers this program. They provide employee assistance program services to major companies throughout the nation.

The Company is pleased to provide you with this Summary Description (SPD), which describes the Benefits available to you and your Dependents under the EAP. It includes summaries of:

- Who is eligible.
- Services for Non-Clinical Services that are covered, called Benefits.
- Services that are not covered, called Clinical Services.
- How Benefits are paid.
- Your rights and responsibilities under the EAP.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for the EAP.

**IMPORTANT**

- This document is intended to serve as both the SPD and the plan document for the EAP.
- Belk intends to continue the EAP, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the EAP, at any time, for any reason, and without prior notice. Belk and the Company shall act through the Chief Human Resources Officer (or his or her delegate) in making decisions with respect to the EAP.
- This SPD is not to be construed as a contract of or for employment.

American Behavioral is a private employee assistance program administrator. Although American Behavioral will assist you in many ways, it does not guarantee any Benefits. The Company is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the EAP works. If you have questions contact Belk Benefits Center or call American Behavioral at (877) 771-7708.

**How To Use This SPD**

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at **www.belkbenefits.com** or request printed copies by contacting Belk Benefits Center.
- Capitalized words in the SPD have special meanings and are defined in Section 7, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 7, *Glossary*.
- Certain affiliates of Belk also participate in the EAP. Belk and the participating affiliates jointly are referred to as the "Company" in the SPD.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

## SECTION 2 - INTRODUCTION

**What this section includes:**

- Who's eligible for coverage under the EAP.
- When coverage begins.

### Eligibility

You are eligible for EAP coverage if you are a regular full-time or regular part-time Associate of the Company. Your eligible Dependents are also covered by the EAP.

**Dependent Definition**:

An eligible Dependent is considered to be:

- Your Spouse, as defined in Section 7, *Glossary*.
- Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for foster care or adoption or a child for whom you or your Spouse are the court appointed legal-appointed legal guardian and children for whom health coverage is required through a Qualified Medical Child Support Order or other court administrative order.

- A child age 26 or over who is or becomes disabled and dependent upon you and who has been continuously disabled by a physical or mental condition that began before age 26.

You may be asked to provide proof of eligibility. Proof of eligibility may include:

- copies of social security cards for spouse and dependents.
- marriage license, in the case of spousal coverage.
- birth certificates and/or tax forms indicating the ages and dependent relationship to you, in the case of qualified dependents.

The Company reserves the right to collect documentation and have you complete an affidavit regarding Dependent status at least annually and as a new hire. Correct and accurate completion of the affidavit and document request is a condition of eligibility. Please understand that the EAP is relying on your representation of eligibility in accepting the enrollment of you and your Dependents. Your failure to correctly complete these materials and to provide required evidence of eligibility is evidence of fraud and material misrepresentation and may result in retroactive disenrollment of an individual.

To be eligible for coverage under the EAP, you and your Dependent must reside and work within the United States.

### Cost of Coverage

Currently, the Company pays the entire cost of the EAP. No Participant contributions are required for coverage. However, Benefits are subject to certain limitations as described in Section 3, *How the Plan Works*. Covered Persons are responsible for paying any Non-Clinical Services that exceed the EAP limitations.

### When Coverage Begins

Coverage for you and your Dependents will begin on your date of hire. [**Design Issue**: Is date of hire correct?] Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Belk Benefits Center within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Belk Benefits Center within 31 days of the birth, adoption, or placement.

## SECTION 3 - HOW THE PLAN WORKS

**What this section includes:**

- Accessing Benefits.
- Description of Benefits.

### Accessing Benefits

Benefits are provided by American Behavioral's network of professionals. Benefits are paid directly by the EAP. Claim forms are only required from the EAP provider. To access Benefits, please call

American Behavioral at 877-771-7708 for information or to schedule an appointment. You may also visit their website www.americanbehavioral.com for a list of providers in your area. The EAP does not cover or pay for services provided by individuals who are not part of American Behavioral's network of providers.

## Description of Benefits

The EAP covers Benefits that are Non-Clinical Services. Covered Persons who require Clinical Services and who are eligible for the Belk Employees' Healthcare Plan will be referred to the Belk Employees' Healthcare Plan for other coverage information.

The EAP provides free and confidential assessment, counseling and referral services to help you address potentially stressful issues including, but not limited to:

- ✓ Family and Marital Relationships
- ✓ Interpersonal Relationship Difficulties
- ✓ Drug and Alcohol Abuse Assessment and Referral
- ✓ Grief and Loss
- ✓ Anxiousness
- ✓ Sadness
- ✓ Coping With Change
- ✓ Stress-related Problems
- ✓ Legal and Financial Concerns
- ✓ Eldercare

EAP services are available 24 hours a day, 365 days a year, including holidays and weekends via telephone (and video) counseling and online resources. When you call the toll-free telephone number, an "intake specialist" will listen to your concerns and help identify an appropriate provider in your area. You can then make a pre-authorized appointment to talk to the provider either in-person or by telephone (or video). The following limits apply to the amount of services provided by the EAP:

- A maximum of four (4) counseling sessions per Covered Person per calendar year
- One (1) free legal consultation with access to discount rates for future service
- One (1) free session with a financial professional

The EAP also provides the "Personal Advantage" website, which offers over 20,000 work/life products on topics such as health and wellness, family life and finances. The website can be accessed directly by visiting https://belk.personaladvantage.com or by clicking the EAP/Personal Advantage link on www.belkbenefits.com.

In addition, you may want to refer to separate EAP written materials such as highlight brochures provided by Belk and American Behavioral for EAP services, copies of which are incorporated by this reference into this SPD.

## SECTION 4 - CLAIMS PROCEDURES

**What this section includes:**
- What to do if your claim is denied, in whole or in part.

### Claim Denials and Appeals

#### *If Your Claim is Denied*

If a claim for Benefits is denied in part or in whole, you may call American Behavioral before requesting a formal appeal. If American Behavioral cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

#### *How to Appeal a Denied Claim*

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- The patient's name.
- The provider's name.
- The date of service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to the Claims Administrator:

American Behavioral Benefits Managers, Inc.
2204 Lakeshore Drive
Suite 135
Birmingham, AL 35209

For urgent care requests for Benefits that have been denied, you or your provider can call American Behavioral at 877-771-7708 to request an appeal.

**Types of claims**
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:
- Urgent care request for Benefits.
- Pre-service request for Benefits.

- Post-service claim.
- Concurrent claim.

***Review of an Appeal***

American Behavioral will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if American Behavioral upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

***Filing a Second Appeal***

Your EAP offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from American Behavioral within 60 days from receipt of the first level appeal determination.

***Note***: Upon written request and free of charge, your or your eligible Dependents (as applicable) may examine documents relevant to their claim and/or appeals and submit opinions and comments. American Behavioral will review all claims in accordance with the rules established by the *U.S. Department of Labor* for a group health plan that is an "excepted benefit" under the Affordable Care Act.

## Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by American Behavioral, or if American Behavioral fails to respond to your appeal in accordance with applicable regulations regarding timing, you will be entitled to request an external review of American Behavioral's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received American Behavioral's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The covered person's name and address.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). American Behavioral has entered into agreements with IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

***Standard External Review***

A standard external review is comprised of all of the following:

- A preliminary review by American Behavioral of the request.
- A referral of the request by American Behavioral to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, American Behavioral will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the EAP at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that American Behavioral may process the request.

After American Behavioral completes the preliminary review, American Behavioral will issue a notification in writing to you. If the request is eligible for external review, American Behavioral will assign an IRO to conduct such review. American Behavioral will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

American Behavioral will provide to the assigned IRO the documents and information considered in making American Behavioral's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by American Behavioral.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and American Behavioral will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by American Behavioral. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and American Behavioral, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing American Behavioral determination, the EAP will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the EAP, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the EAP will not be obligated to provide Benefits for the health care service or procedure.

***Expedited External Review***

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, American Behavioral will determine whether the individual meets both of the following:

- Is or was covered under the EAP at the time the health care service or procedure that is at issue in the request was provided.

- Has provided all the information and forms required so that American Behavioral may process the request.

After American Behavioral completes the review, American Behavioral will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, American Behavioral will assign an IRO in the same manner American Behavioral utilizes to assign standard external reviews to IROs. American Behavioral will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by American Behavioral. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to American Behavioral.

You may contact American Behavioral at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

### *Timing of Appeals Determinations*

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
- Pre-Service request for Benefits - a request for Benefits which the EAP must approve or in which you must notify American Behavioral before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the EAP for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and American Behavioral are required to follow.

| Urgent Care Request for Benefits* | |
|---|---|
| **Type of Request for Benefits or Appeal** | **Timing** |
| If your request for Benefits is incomplete, American Behavioral must notify you within: | **24 hours** |
| You must then provide completed request for Benefits to American Behavioral within: | **48 hours** after receiving notice of additional information required |
| American Behavioral must notify you of the benefit determination within: | **72 hours** |
| If American Behavioral denies your request for Benefits, you must appeal an adverse benefit determination no later than: | **180 days** after receiving the adverse benefit determination |
| American Behavioral must notify you of the appeal decision within: | **72 hours** after receiving the appeal |

*You do not need to submit urgent care appeals in writing. You should call American Behavioral as soon as possible to appeal an urgent care request for Benefits.

| Pre-Service Request for Benefits* | |
|---|---|
| **Type of Request for Benefits or Appeal** | **Timing** |
| If your request for Benefits is filed improperly, American Behavioral must notify you within: | **5 days** |
| If your request for Benefits is incomplete, American Behavioral must notify you within: | **15 days** |
| You must then provide completed request for Benefits information to American Behavioral within: | **45 days** |
| American Behavioral must notify you of the benefit determination: | |
| ■ if the initial request for Benefits is complete, within: | **15 days** |
| ■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within: | **15 days** |
| You must appeal an adverse benefit determination no later than: | **180 days** after receiving the adverse benefit determination |
| American Behavioral must notify you of the first level appeal decision within: | **15 days** after receiving the first level appeal |
| You must appeal the first level appeal (file a second level appeal) within: | **60 days** after receiving the first level appeal decision |

| Pre-Service Request for Benefits* | |
|---|---|
| **Type of Request for Benefits or Appeal** | **Timing** |
| American Behavioral must notify you of the second level appeal decision within: | **15 days** after receiving the second level appeal |

*American Behavioral may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the EAP.

| Post-Service Claims | |
|---|---|
| **Type of Claim or Appeal** | **Timing** |
| If your claim is incomplete, American Behavioral must notify you within: | **30 days** |
| You must then provide completed claim information to American Behavioral within: | **45 days** |
| American Behavioral must notify you of the benefit determination: | |
| ■ if the initial claim is complete, within: | **30 days** |
| ■ after receiving the completed claim (if the initial claim is incomplete), within: | **30 days** |
| You must appeal an adverse benefit determination no later than: | **180 days** after receiving the adverse benefit determination |
| American Behavioral must notify you of the first level appeal decision within: | **30 days** after receiving the first level appeal |
| You must appeal the first level appeal (file a second level appeal) within: | **60 days** after receiving the first level appeal decision |
| American Behavioral must notify you of the second level appeal decision within: | **30 days** after receiving the second level appeal |

### *Concurrent Care Claims*

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. American Behavioral 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 made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going 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 request and decided according to post-service or pre-service timeframes, whichever applies.

### Limitation of Action

You cannot bring any legal action against the Company or the Claims Administrator for any reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Company or the Claims Administrator, you must do so within three years [**Design Issue**: correct?] of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Company or the Claims Administrator.

## SECTION 5 - WHEN COVERAGE ENDS

**What this section includes:**

- Circumstances that cause coverage to end.
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Company will still pay claims for Benefits that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the EAP for you and your eligible Dependents will end on the earliest of:

- The date your employment with the Company ends.
- The date the EAP ends.
- The date you stop making any required contributions.
- The date you are no longer eligible.
- The date your Dependents no longer qualify as eligible Dependents under the EAP.

#### *Other Events Ending Your Coverage*

The EAP will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

***Note***: If American Behavioral and the Company find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, the

Company has the right to demand that you pay back all Benefits the Company paid to you, or paid in your name, during the time you were incorrectly covered under the EAP.

## Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the EAP will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability.
- The child depends mainly on you for support.
- You provide to the Company proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age.
- You provide proof, upon the Company's request, that the child continues to meet these conditions.

The proof might include medical examinations at the Company's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the EAP will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the EAP.

## Continuing Coverage Through COBRA

If you lose your EAP coverage, you may have the right to extend it under COBRA, as defined in Section 7, *Glossary*.

### *Continuation Coverage under Federal Law (COBRA)*

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary means you and your eligible Dependents who were covered under the EAP on the day before a qualifying event.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your eligible Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

| If Coverage Ends Because of the Following Qualifying Events: | You May Elect COBRA: | | |
|---|---|---|---|
| | For Yourself | For Your Spouse | For Your Child(ren) |
| Your work hours are reduced | 18 months | 18 months | 18 months |

| If Coverage Ends Because of the Following Qualifying Events: | You May Elect COBRA: | | |
|---|---|---|---|
| | For Yourself | For Your Spouse | For Your Child(ren) |
| Your employment terminates for any reason (other than gross misconduct) | 18 months | 18 months | 18 months |
| You or your eligible Dependents become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1] | 29 months | 29 months | 29 months |
| You die | N/A | 36 months | 36 months |
| You divorce (or legally separate) | N/A | 36 months | 36 months |
| Your child is no longer an eligible Dependent (e.g., reaches the maximum age limit) | N/A | N/A | 36 months |
| You become entitled to Medicare | N/A | See table below | See table below |
| The Company files for bankruptcy under Title 11, United States Code.[2] | 36 months | 36 months[3] | 36 months[3] |

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a) the determination of the disability, b) the date of the qualifying event, c) the date the Qualified Beneficiary would lose coverage under the EAP, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Participant's death if the Participant dies during the continuation coverage.

### *How Your Medicare Eligibility Affects Dependent COBRA Coverage*

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

| If Dependent Coverage Ends When: | You May Elect COBRA Dependent Coverage For Up To: |
|---|---|
| You become entitled to Medicare and don't experience any additional qualifying events | 18 months |
| You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires | 36 months |
| You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the EAP | 36 months |

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

### *Getting Started*

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your EAP coverage ended.

During the 60-day election period, the EAP will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the EAP under COBRA, you have the right to change your coverage election:

- During Open Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

### *Notification Requirements*

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- The date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent.
- The date your enrolled Dependent would lose coverage under the EAP.

- The date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60-day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

### *Notification Requirements for Disability Determination*

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Belk Benefits Center with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 8, *Administrative Information and ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered associate and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

### *Trade Act of 2002*

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that EAP coverage was lost, but begins on the first day of the special second election period.

### When COBRA Ends

COBRA coverage will end before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare.
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire EAP ends.
- The date coverage would otherwise terminate under the EAP as described in the beginning of this section.

***Note***: If you selected continuation coverage under a prior plan which was then replaced by coverage under this EAP, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

### Leaves of Absence

EAP coverage automatically continues while a Participant is absent from employment due to an authorized leave of absence that qualifies for protection under either the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA) or the Family and Medical Leave Act. For more details, refer to the Company's leave of absence policies or contact Belk Benefits Center.

## SECTION 6 – OTHER IMPORTANT INFORMATION

### Interpretation of Benefits

The Company and American Behavioral have the sole and exclusive discretion to:

- Interpret Benefits under the EAP.
- Interpret the other terms, conditions, limitations and exclusions of the EAP, including this SPD and any Summary of Material Modifications and/or Amendments.
- Make factual determinations related to the EAP and its Benefits.

The Company and American Behavioral may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the EAP. The decisions of the Company, American Behavioral and their delegates shall be final and binding on all participants and other affected persons.

### Workers' Compensation Not Affected

Benefits provided under the EAP do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

### Future of the EAP

Although the Company expects to continue the EAP indefinitely, it reserves the right to discontinue, alter or modify the EAP in whole or in part, at any time and for any reason, at its sole determination.

If this EAP is terminated, Covered Persons will not have the right to any other Benefits from the EAP, other than for those claims incurred prior to the date of termination, or as otherwise provided under the EAP. In addition, if the EAP is amended, you may be subject to altered coverage and Benefits.

### Plan Document

This Summary Plan Description (SPD) also serves as the official plan document. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

## SECTION 7 - GLOSSARY

**What this section includes:**
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the EAP is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the EAP.

**Associate** - a common law employee of the company (other than a person classified as an independent contractor, even if it is later determined that the classification is incorrect and he or she should have been classified as a common-law employee of the Company).

**Belk –** Belk Stores Services, Inc.

**Benefits** - EAP payments for Non-Clinical Services, subject to the terms and conditions of the EAP.

**Claims Administrator** - American Behavioral Benefits Managers, Inc. (also known as American Behavioral) and its affiliates, who provide certain claim administration services for the EAP.

**Clinical Services** - the diagnosis and treatment of (1) mental health or psychiatric diagnostic categories or (2) alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. Clinical Services are not covered by the Plan.

**COBRA** - the Consolidated Omnibus Budget Reconciliation Act of 1985, which is a federal law that provides for the purchase of continued medical coverage in certain circumstances.

**Company** -Belk and the participating affiliates.

**Covered Person** - either the Participant or a Dependent, but this term applies only while the person is eligible for Benefits under the EAP. References to "you" and "your" throughout this SPD are references to a Covered Person.

**Dependent** - an individual who meets the eligibility requirements specified in the EAP, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also a Participant. No one can be a Dependent of more than one Participant.

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

**Non-Clinical Services** - Benefits provided under the EAP that are not Clinical Services. [**Design Issue**: Is there a definition for these non-clinical services?]

**Participant** - an Associate of the Company who meets the eligibility requirements specified in the EAP, as described under *Eligibility* in Section 2, *Introduction*.

**Plan Administrator** - Belk or its designee.

**Plan Sponsor** - Belk.

**Spouse** - an individual to whom you are legally married.

**Urgent Care** - treatment of an unexpected sickness or injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering.

## SECTION 8 - ADMINISTRATIVE INFORMATION AND ERISA

**What this section includes:**
- Administrative information, including your rights under *ERISA*.

This section includes information on the administration of the EAP, as well as information required of all Summary Plan Descriptions. While you may not need this information for your day-to-day participation, it is information you may find important.

### *Plan Sponsor and Administrator*

Belk Stores Services Inc. is the Plan Sponsor and Plan Administrator. You may contact the Plan Administrator at:

Plan Administrator
Belk Stores Services Inc.
2801 West Tyvola Road
Charlotte, NC 28217-4500
(704) 426-8346

### *Participating Affiliates*

In addition to Belk, the following affiliates currently participate in the EAP:

Belk, Inc.

Belk-Simpson Company, Greenville, South Carolina

The Belk Center, Inc.

Belk International, Inc.

Belk Administration Company

Belk Stores of Virginia LLC

Belk Accounts Receivable LLC

Belk Gift Card Company LLC

Belk Merchandising LLC

Belk Department Stores LP

Belk Texas Holdings LLC

Belk Ecommerce LLC

Belk Stores of Mississippi LLC

The participating affiliates may change from time to time. A current list of their names and addresses may be obtained upon written request to the Plan Administrator and is available for examination during the Plan Sponsor's normal business hours.

### *Claims Administrator*

American Behavioral is the EAP's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the EAP's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the EAP. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the EAP.

You may contact the Claims Administrator by calling 877-771-7708, or by writing:

American Behavioral Benefits Managers, Inc.
2204 Lakeshore Drive
Suite 135
Birmingham, AL 35209

### *Agent for Service of Legal Process*

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the EAP. The EAP's Agent of Service is:

General Counsel
Belk Stores Services Inc.
2801 West Tyvola Road
Charlotte, NC 28217-4500

### *Other Administrative Information*

This section of your SPD contains information about how the EAP is administered as required by ERISA.

### *Type of Administration*

The EAP is not insured and is funded from the Company's general assets. Plan administration is provided through contracts with one or more third party administrators.

| | |
|---|---|
| **Plan Name:** | Belk Employee Assistance Program |
| **Plan Number:** | 519 |
| **Employer ID:** | 56-0616731 |
| **Plan Type:** | Welfare benefits plan – group health |
| **Plan Year:** | January 1 - December 31 |
| **Plan Administration:** | contract administration |
| **Source of Plan Contributions:** | Company |
| **Source of Benefits:** | general assets of the Company |

### *Your ERISA Rights*

As a participant in the EAP, you are entitled to certain rights and protections under ERISA. ERISA provides that all EAP participants shall be permitted to:

- Receive information about EAP Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents — including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all EAP documents and other EAP information, including insurance contracts and collective bargaining agreements (if applicable), the latest annual return (Form 5500) and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies. Requests for available plan documents should be sent to the address provided under *How to Appeal a Denied Claim* in Section 4, *Claims Procedures*.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the EAP as a result of a qualifying event. You or your Dependents may have to pay

for such coverage. Review this Summary Plan Description and the EAP documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for EAP participants, *ERISA* imposes duties on the people who are responsible for the operation of the EAP. The people who operate your EAP, who are called "fiduciaries" of the EAP, have a duty to do so prudently and in the interest of you and other EAP participants and beneficiaries. No one, including your Employer, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining an EAP Benefit or exercising your rights under *ERISA*.

If your claim for an EAP Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 4, *Claims Procedures*, for details.

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the EAP, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the EAP, you may timely file suit in a state or federal court. In addition, if you disagree with the EAP's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the EAP's fiduciaries misuse the EAP's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your EAP, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U.S. Department of Labor*, listed in your telephone directory, or write to the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue NW Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publications hotline of the *Employee Benefits Security Administration* at 1-866-444-3272.

Belk, the Plan Administrator, administers the EAP's Benefits. American Behavioral is the Claims Administrator and processes claims for the EAP and provides appeal services; however, American Behavioral and the Company are not responsible for any decision you or your Dependents make regarding whether to receive treatment, services or supplies. American Behavioral and the Company are neither liable nor responsible for the treatment, services or supplies provided by network professionals.