Solo Health Collective
Plan Document & Plan Summary Description

In partnership with

2026 plan year

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HEALTH BENEFIT PLAN SUMMARY PLAN DESCRIPTION
INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan, as well as with information on a Covered Person's rights and obligations under this Health Benefit Plan Summary Plan Description (the "Plan"). You are a valued Employee, and Your Employer is pleased to sponsor this Plan to provide benefits that can help meet Your healthcare needs. Please read this document carefully and contact the assigned Third-Party Administrator identified on Your medical ID card if You have questions or if You have difficulty translating this document.

The Plan Sponsor and named Plan Administrator for this Plan are identified on the cover page of this document and on page 5 of this document. The Plan Administrator has retained the services of independent Third-Party Administrators to process claims and handle other duties for this self-funded Plan. The Third-Party Administrator for this Plan is VAULT ADMIN SERVICES, hereinafter "VAULT" for medical claims.

The Plan is governed by ERISA, and the structure and administration of this Plan are intended to align with the spirit and intent of Title I of ERISA. This Plan is a self-insured medical plan intended to meet the requirements of Sections 105(b), 105(h) and 106 of the Code so that the portion of the cost of coverage paid by the Plan Sponsor, and any benefits received by a covered individual through this Plan, are not taxable income to the covered individual. The specific tax treatment of any covered individual will depend on the individual's personal circumstances; the Plan does not guarantee any particular tax treatment. Covered individuals are solely responsible for any and all federal, state, and local taxes attributable to their participation in this Plan, and the Plan expressly disclaims any liability for such taxes.

This Plan is "self-insured" which means benefits are paid from the Plan Sponsor's general assets and are not guaranteed by an insurance company. The Plan Sponsor has contracted with the Third-Party Administrator to perform certain administrative services related to this Plan.

The Employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the Employer and there is no separate fund that is used to pay promised benefits.

Some of the terms used in this document begin with capital letters, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each individual covered under this Plan will be receiving an identification card that they may present to providers whenever they receive services. On the back of this card are phone numbers to call in case of questions or problems.

This document contains information on the benefits and limitations of the Plan and will serve as both the Summary Plan Description and Plan document. Therefore, it will be referred to as both the SPD and the Plan document.

Note for Plan Participants

- Capitalized terms have specific meanings when used in this document. The meanings of these capitalized terms are in the Defined Terms section of this document.
- This SPD describes the circumstances when this Plan pays for health care. All decisions regarding health care remain with the Plan Participant and his or her Physician. There may be circumstances when a Plan Participant and his or her Physician determine that health care not covered by this Plan is appropriate. The Plan Sponsor neither provides nor ensures quality of care.
- Changes in the Plan may occur in any or all parts of the Plan including, but not limited to, benefit coverage, Deductibles, maximums, Copays, exclusions, limitations, definitions and eligibility, and general provisions.
- The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.
- If the Plan is terminated, or amended, or benefits are eliminated, the rights of Plan Participants are limited to covered charges incurred before such termination, amendment or elimination.

Purpose

This document is a Summary Plan Description of an employee group health and welfare plan.

- The Plan described is designed to protect Plan Participants against certain health expenses.
- The Plan Sponsor established this Plan to provide for the payment or reimbursement of covered health expenses incurred by Plan Participants.
- The Plan is not to be construed as a contract for or a guarantee of employment. Nothing in this Plan shall be deemed to:
    - affect the right of the Employer to discipline or discharge any Employee at any time;
    - affect the right of any Employee to terminate his or her employment at any time;
    - give the Employer the right to require any Employee to remain in its employ; or
    - give any Employee the right to be retained in the employ of the Employer.

Exclusive Benefit

- This Plan is established and shall be maintained for the exclusive benefit of eligible Plan Participants.
- The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage begins or after coverage is terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.
- Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.
- No clerical errors made in keeping records pertaining to this coverage, or delays in making entries in such records, will invalidate coverage otherwise validly in force, or continue coverage otherwise validly terminated. Upon discovery of an error, an adjustment of any benefits paid will be made.

Compliance / Limitation

- This Plan is established and shall be maintained with the intention of meeting the requirements of all pertinent laws. No oral interpretations can change this Plan.
- No action at law or in equity shall be brought to recover any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.
- No action at law or in equity can be brought to recover after the expiration of two (2) years after the time when written proof of loss is required to be furnished to the Third-Party Administrator.
- Failure to follow the eligibility or enrollment requirements, including timely application for coverage by this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, the timeliness of COBRA elections, utilization review or other health management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.
- Should any part of this Summary Plan Description for any reason be declared invalid, such decision shall not affect the validity of the remaining portion, which remaining portion shall remain in effect as if this Summary Plan Description has been executed with the invalid portion thereof eliminated.

Document Sections

This Summary Plan Description (SPD) is organized into the following sections:

1. **Introduction**
   Overview of the Plan, its purpose, and important general information for participants.
2. **Plan Information**
   Key identifying details about the Plan, Plan Sponsor, Plan Administrator, and other administrative information.
3. **Medical Schedule of Benefits**
   Outline of covered benefits, Deductibles, Copays, out-of-pocket maximums, and plan limits.
4. **Out-of-Pocket Expenses and Maximums**
   Explanation of Deductibles, plan participation, and annual out-of-pocket maximums.
5. **Rescission of Coverage**
   Circumstances under which coverage may be retroactively canceled or terminated.
6. **Notice of Prior Authorization and/or Precertification Requirements**
   Information about services that require prior approval and the process for obtaining it.
7. **Eligibility Requirements**
   Rules for Employee and Dependent eligibility, including special enrollment and extended coverage.
8. **Termination**
   Events that cause coverage to end for Employees and Dependents, and information about reinstatement.
9. **Allowable Expenses or Usual and Customary**
   How the Plan determines the amount payable for covered services.
10. **Review of Claims**
    Procedures for independent review of high-cost claims and related privacy practices.
11. **Provider Network**
    Explanation of Network and non-Network providers, and how provider status affects benefits.
12. **Covered Medical Benefits**
    Detailed description of medical services and supplies covered by the Plan.
13. **Transplant Benefits**
    Special provisions, requirements, and coverage for organ and tissue transplants.
14. **Prescription Drug Benefits**
    Coverage details, limitations, exclusions, and procedures for prescription medications.
15. **Mental Health Benefits**
    Coverage for mental health disorders, including Inpatient, Outpatient, and Residential Treatment.
16. **Substance Use Disorder and Chemical Dependency Benefits**
    Coverage for substance use disorder and chemical dependency treatment.
17. **Utilization Management and Prior Authorization**
    Utilization review process, medical necessity determinations, and prior authorization requirements.
18. **Coordination of Benefits**
    How the Plan coordinates with other health coverage, including Medicare and other group plans.

19. **Right of Subrogation, Reimbursement, and Offset**
    The Plan's rights to recover payments from third parties responsible for a Participant's Injury or illness.
20. **General Exclusions**
    List of services, supplies, and situations not covered by the Plan.
21. **Claims and Appeal Procedures**
    How to file claims, timelines for processing, and the process for appealing denied claims.
22. **Fraud**
    Provisions regarding fraudulent activity and the consequences for participants.
23. **Other Federal Provisions**
    Compliance with federal laws such as COBRA, HIPAA, the Newborns' and Mothers' Health Protection Act, and others.
24. **HIPAA Administrative Simplification Medical Privacy and Security Provision**
    How the Plan uses and protects participants' protected health information (PHI).
25. **Glossary of Terms**
    Definitions of capitalized terms and other important terminology used throughout the SPD.

PLAN INFORMATION

Plan Name	<<Legal Entity Name>> GROUP HEALTH BENEFIT PLAN
Name And Address of "Employer"	<<Legal Entity Name>> <<Street Address >> <<City>>, <<State>>, <<Zip>>
Name, Address, and Phone Number of Named Fiduciary, Plan Administrator, and Second Level Appeals Fiduciary	<<Legal Entity Name>> <<Street Address >> <<City>>, <<State>>, <<Zip>>
Level I Claims Administrator for Medical Claims	Vault Admin Services, LLC. 4022 E. Greenway, Ste. 11-12 Phoenix, Arizona 85022
Employer Identification Number Assigned by the IRS	<<EIN>>
Type of Benefit Plan Provided	Self-funded health and welfare plan providing group health benefits.
Type of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. The initial claims appeal administrator provides administrative services such as claim payments for medical and pharmacy claims.
Name And Address of Agent for Service of Legal Process	Vault Admin Services, LLC. 4022 E. Greenway, Ste. 11-12 Phoenix, Arizona 85022
Funding of the Plan	Employer and Employee Contributions Benefits are provided by a benefit Plan maintained on a self-insured basis by Your

	Employer. The Plan pays benefits and administration expenses directly from the Employer's general assets. Employee contributions are applied to Plan costs and expended immediately. Employee contributions are deducted as authorized and begin when coverage starts (including for special enrollees).
Benefit Plan Year	Benefits begin on the Effective Date (on the first page of this document), and end on the following December 31.
ERISA And Other Federal Compliance	It is intended that this Plan comply with spirit of applicable requirements of ERISA and other federal regulations.
Discretionary Authority	The Plan Administrator will perform its duties as the Plan Administrator and, in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third-Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third-Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third-Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third-Party Administrators at the time they made the

decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third-Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law. If, due to a drafting error, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, the provision will be treated as ambiguous and interpreted in a manner consistent with the Plan's intent, as determined by the Plan Administrator in its sole discretion. The Plan may be amended retroactively to cure any such ambiguity or drafting error.

MEDICAL SCHEDULE OF BENEFITS

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Copays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Benefits listed in this Schedule of Benefits are subject to all provisions of this Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details. In the event of a conflict or inconsistency between the Schedule of Benefits and any other section of this Summary Plan Description (SPD), the terms and provisions set forth in the detailed sections of the SPD shall control.

Important: Prior Authorization may be required before benefits will be considered for payment. Failure to obtain Prior Authorization may result in a penalty or increased out-of-pocket costs. If there is an "*" next to a listed benefit, it requires prior-authorization. Contact the Third-Party Administrator for assistance securing a prior-authorization. Some benefits may require a second-opinion and/or the use of a designated facility, please contact the Third-Party administrator for no-cost to You, programs.

Medical and Rx Summary of Benefits	
Third-Party Administrator:	Vault Admin Services, LLC
Website:	allthingsvault.com
Customer Service Phone Number:	888.211.2707
Email	clientservices@allthingsvault.com
Hours of Operation	8:00 AM - 5:00 PM CST

Coverage Overview	Plan Benefits	Plan Limits
Annual Deductible: Individual:	See cover page of SPD	
Family	Two Times Individual	
Note: Embedded Deductible Means if You Have Family Coverage Any Combination of Covered Family Members May Help Meet The Maximum Family Deductible; However, No One Person Will Pay More Than Their Embedded Individual Deductible Amount.		
Annual Total Out-of-Pocket Maximum: Individual:	See cover page of SPD	
Family:	Two Times Individual	
Note: Embedded Out-Of-Pocket Maximum Means That if You Have Family Coverage, Any Combination of the Covered Family Members May Help Meet the Family Out-Of-Pocket Maximum; However, No One Person Will Pay More Than Their Embedded Individual Out-Of-Pocket Maximum Amount.		

If there is an * by the service it requires a prior-authorization.

Preventive Services	Plan Benefits	Plan Limits
Preventive/Routine Care Benefits. See Glossary of Terms for Definition.	100% deductible waived	
Preventive/Routine Physical Exams (age appropriate)	100% deductible waived	
Preventive Immunizations	100% deductible waived	
Preventive/Routine Diagnostic Tests, Lab and X-Rays (age appropriate)	100% deductible waived	
Preventative/Routine Mammograms and Breast Exams	100% deductible waived	
Preventative/Routine Pelvic Exam and Pap Test	100% deductible waived	
Preventative/Routine PSA Test and Prostate Exam (age appropriate)	100% deductible waived	
Pediatric Preventative/Routine Hearing Exams (age appropriate per ACA)	100% deductible waived	
Pediatric Preventative/Routine Eye Exams (age appropriate per ACA)	100% deductible waived	
Well-Woman Visits	100% deductible waived	

Flu and Pneumonia Immunizations	100% deductible waived		
Pediatric Immunizations	100% deductible waived		
Regular Well-Baby and Well-Child Visits	100% deductible waived		
Mammograms (Age Appropriate)	100% deductible waived		
Colonoscopies (Age Appropriate)	100% deductible waived		
Contraceptive Methods and Contraceptive Counseling Approved by the FDA for Men and Women	100% deductible waived		
Breast Pumps	100% deductible waived		One pump per delivery; reimbursement is capped at $150 per pump

Ambulance Transportation (Ground or Air) - Prior Authorization required for non-emergency inter-facility transportation; no Prior Authorization required for Emergency transport.	**Plan Benefits**		**Plan Limits**
Ground Ambulance	After Deductible, plan pays 100%		
Emergency Air Ambulance	After Deductible, plan pays 100%		$15,000 Maximum Benefit per flight
Non-Emergency Air Ambulance	After Deductible, plan pays 100%		$15,000 Maximum Benefit per flight

Physician Office Visit	**Plan Benefits**		**Plan Limits**
Primary Care Physician Visit	After Deductible, plan pays 100%		
Specialist Visit	After Deductible, plan pays 100%		
Services Performed in a Physician Office	After Deductible, plan pays 100%		
Pediatric Office Visits	After Deductible, plan pays 100%		
OBGYN	After Deductible, plan pays 100%		
Injections*	After Deductible, plan pays 100%		

Urgent Care/Emergency Services	**Plan Benefits**		**Plan Limits**
Urgent Care	After Deductible, plan pays 100%		
Walk-In Retail Health Clinics	After Deductible, plan pays 100%		
Emergency Room Only	After Deductible, plan pays 100%		
Emergency Physicians Only	After Deductible, plan pays 100%		

Facility Based Services	**Plan Benefits**	**Plan Limits**

Pre-Admission Testing	After Deductible, plan pays 100%		
Inpatient Admissions/Inpatient Physician Charges	After Deductible, plan pays 100%		
Inpatient Surgery*	After Deductible, plan pays 100%		
Outpatient Services/Outpatient Physician Charges	After Deductible, plan pays 100%		
Outpatient Surgery/Facility*	After Deductible, plan pays 100%		
Outpatient Surgery/Professional Services	After Deductible, plan pays 100%		
Physician Clinic Visits in an Outpatient Hospital Setting	After Deductible, plan pays 100%		
Cardiac Implants	After Deductible, plan pays 100%		
LVAD/RVAD Implants	After Deductible, plan pays 100%		
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent or Subacute Facility	After Deductible, plan pays 100%		
Inpatient/Outpatient Orthopedic Services	After Deductible, plan pays 100%		
Anesthesia*	After Deductible, plan pays 100%		
Inpatient Diagnostic Lab/X-Ray*	After Deductible, plan pays 100%		
Organ Transplant*	After Deductible, plan pays 100%		$10,000 per transplant

Maternity Services	**Plan Benefits**		**Plan Limits**
Routine Prenatal Services	After Deductible, plan pays 100%		
Non-Routine Prenatal Services	After Deductible, plan pays 100%		
Postnatal Care	After Deductible, plan pays 100%		
Delivery in a Facility	After Deductible, plan pays 100%		

Mental Health, Substance Use Disorder and Chemical Dependency	**Plan Benefits**		**Plan Limits**
Therapy Services	After Deductible, plan pays 100%		40 visits per Calendar Year
Preventative/Routine Counseling for Alcohol or Substance Use Disorder, Tobacco/Nicotine Use, Obesity, Diet and Nutrition *	After Deductible, plan pays 100%		
Inpatient Services*	After Deductible, plan pays 100%		
Residential Treatment	After Deductible, plan pays 100%		
Outpatient or Partial Hospitalization Services and Physician Charges	After Deductible, plan pays 100%		

Imaging Services	**Plan Benefits**	**Plan Limits**

3D Mammograms for Diagnosis/Treatment of a Covered Medical Benefit*	After Deductible, plan pays 100%	
Pediatric/Routine Diagnostic Tests, Labs, X-Rays	After Deductible, plan pays 100%	
Routine/Diagnostic Tests in a Physician Office Labs, X-Rays	After Deductible, plan pays 100%	
Advanced Imaging in a Facility (CT/PET Scans, MRIs)*	After Deductible, plan pays 100%	
Outpatient Lab and X-Ray in a Facility	After Deductible, plan pays 100%	

Assisted Living/Hospice Care	**Plan Benefits**	**Plan Limits**
Hospice Services*	After Deductible, plan pays 100%	One benefit period not to exceed 6 months
Bereavement Counseling	After Deductible, plan pays 100%	Immediate family only max 3 visits
Home Health Care Benefits*	After Deductible, plan pays 100%	40 visits per Calendar Year
Skilled Nursing Facility Services*	After Deductible, plan pays 100%	
Physician Services in a Skill Nursing Facility*	After Deductible, plan pays 100%	
Home IV Therapy*	After Deductible, plan pays 100%	

	Plan Benefits	**Plan Limits**
Chiropractic	After Deductible, plan pays 100%	40 Visits per Calendar Year
Physical Therapy	After Deductible, plan pays 100%	40 Visits per Calendar Year
Orthopedic Implants*	After Deductible, plan pays 100%	
Telehealth Visits	Plan Pays 100%	
Custom Molded Foot Orthotics	After Deductible, plan pays 100%	1 pair
Durable Medical Equipment*	After Deductible, plan pays 100%	Lifetime Maximum Benefit $5,000
Outpatient Habilitative Services	After Deductible, plan pays 100%	40 visits per Calendar Year
Chemo Therapy*	After Deductible, plan pays 100%	
Radiation Therapy*	After Deductible, plan pays 100%	
Dialysis*	After Deductible, plan pays 100%	
Sleep Study*	After Deductible, plan pays 100%	
Prosthetics*	After Deductible, plan pays 100%	
Medical Rehabilitation Center*	After Deductible, plan pays 100%	

Genetic Counseling*	After Deductible, plan pays 100%
Genetic Testing*	After Deductible, plan pays 100%

Heart, Spine, Cancer, Transplant and Knee and Hip Replacements	Plan Benefits	Plan Limits
Heart Surgery	Plan Pays 100%	Limited to Vault Cares Network Centers of Excellence unless granted an exception by the Vault Cares Network
Spine Surgery	Plan Pays 100%	Limited to Vault Cares Network Centers of Excellence unless granted an exception by the Vault Cares Network
Cancer Surgery and Treatment	Plan Pays 100%	Limited to Vault Cares Network Centers of Excellence unless granted an exception by the Vault Cares Network
Knee and Hip Replacements	Plan Pays 100%	Limited to Vault Cares Network Centers of Excellence unless granted an exception by the Vault Cares Network
Transplant Services	Plan Pays 100%	Limited to Vault Cares Network Centers of Excellence unless granted an exception by the Vault Cares Network
Travel, lodging and food coverage for Heart, Spine, Cancer, Transplant, Knee and Hip Replacement services listed in this section	Plan Pays 100% for travel and lodging costs (coach seat for travel by air or train, or mileage at IRS level for travel by car) for Covered Person plus one companion. A $75 food per diem per day will be provided for a Covered Person or $150 per day for a Covered Person plus one companion.	Limited to travel, lodging and food coverage as a result of the use and services of the Vault Cares Network Centers of Excellence

Note: Covered Persons are responsible for the federal minimum regulatory amounts of Copays and Coinsurance which are required by the IRS for HSA-complaint plans.

Prescription Drugs	Retail (30 day)	Mail Order (90 day)
Tier 1. Preventative	$0 copay	$0 copay
Tier 2. Preferred Generics	$15 copay after deductible	$30 copay after deductible
Tier 3. Preferred Brand & Non-Preferred Generics	$50 copay after deductible	$100 copay after deductible
Tier 4. Non-Preferred Brand	$100 copay after deductible	$200 copay after deductible
Tier 5. Specialty Rx	Covered up to $1,000 per RX	
Tier 6. Non-Formulary & Excluded Drugs	Not Covered	

Note: Copays and Coinsurance are applicable after Deductible and maximum out-of-pocket have been satisfied

Important Contacts	
Pharmacy Benefit Manager	
Name:	Fairos RX
Contact:	833-464-9600
Website:	www.FairosRx.com

OUT-OF-POCKET EXPENSES AND MAXIMUMS

DEDUCTIBLES

A Deductible is an amount of money paid once per Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits. Generally, the applicable Deductible must be met before any benefits will be paid under this Plan. However, certain covered benefits may be paid first dollar.

The Deductible amounts that the Covered Person incurs for Covered Expenses, including covered Pharmacy expenses, as well as any amounts paid as Copays or Coinsurance, will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at all benefit levels (whether Incurred at an in Network or non-Network provider) will be used to satisfy the applicable benefit level's total individual and family Deductible.

PLAN PARTICIPATION

Plan Participation is the percentage of Covered Expenses that the Covered Person is responsible for paying after the Deductible is met. The Covered Person pays this percentage until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is the most the Covered Person pays each year for Covered Expenses. Annual out-of-pocket maximums are shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). If the Covered Person's out-of-pocket expenses in a Plan Year exceed the annual out-of-pocket maximum, the Plan pays 100% of the Covered Expenses through the end of the Plan Year. Certain Preventive Services are covered at 100% with no Deductible or Coinsurance.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Any amounts over the Recognized Amount, Usual and Customary amount, Negotiated Rate, or established fee schedule that this Plan pays.

- Employee contributions.
- COBRA monthly payments.
- Expenses for excluded services, charges above the Maximum Allowable Charge, or penalties for failure to obtain Prior Authorization.
- Pharmacy ancillary fees for Brand-name medication when a generic is available

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Copays, or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses may not be waived by a provider under any "fee forgiveness," "not out-of-pocket," or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied, and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that they paid the out-of-pocket expenses under the terms of this Plan.

The Covered Person's ability to contribute to a HSA on a tax favored basis may be affected by any arrangement that waives this Plan's Deductible.

RESCISSION OF COVERAGE

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Plan Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Plan Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Plan Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Plan Participants being canceled, and such cancellation may be retroactive.

A determination by the Plan that a Rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Plan Participant whose coverage is being rescinded will be provided a 30-day notice period as described under the Patient Protection and Affordable Care Act (PPACA) and applicable regulatory guidance. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan

NOTICE OF PRIOR AUTHORIZATION AND/OR PRECERTIFICATION REQUIREMENTS

IMPORTANT NOTICE
Certain medical services require Prior Authorization/Precertification.

Prior Authorization/Precertification* is the process of collecting certain information before elective Inpatient admissions and/or selected ambulatory procedures and services take place. Not all medical services are covered under the Plan. When Prior Authorization/Precertification is required, failure to follow the process as described herein in advance of a procedure or service may result in significant penalties as defined in this SPD, including non-coverage. Requests for Prior Authorization/Precertification and notification must be received before receipt of a service or procedure. Failure to contact VAULT for Prior Authorization/Precertification will relieve VAULT from any financial liability for the applicable service(s) or product(s), unless otherwise stated in this SPD.

*Precertification means the utilization review process to determine whether the requested service, procedure, Prescription Drug, or medical device meets the clinical criteria for coverage.

ELIGIBILITY REQUIREMENTS

An **eligible Dependent** includes:

- Your legal spouse, provided they are not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides, nor does it include a partner to whom You are joined by civil union or similar relationship, even if recognized by any state or jurisdiction. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

- A Dependent Child until the Child reaches their 26th birthday. The term "**Child**" includes the following Dependents:

    - A natural biological Child;
    - A stepchild;
    - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
    - A Child under Your (or Your spouse's) Legal Guardianship as ordered by a court;
    - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO).

- A Dependent does not include the following:

    - A foster Child;
    - A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship;
    - A grandchild;
    - A Domestic Partner;
    - A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
    - Any other relative or individual unless explicitly covered by this Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

Totally Disabled Dependent Child: To be an eligible Totally Disabled Dependent Child, the following conditions must all be met:

- A Totally Disabled Dependent Child age 26 or over must be dependent upon the Employee for more than 50 percent of their support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the Employee's divorce or separation decree.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Human Resources Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

The Dependent Child must also fit the following category:

If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may, for three years, ask for additional proof at any time, after which the Plan may ask for proof not more than once per year. Coverage may continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable); and
- The Employee must still be covered under this Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of the following dates:

- The date Your coverage under the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 30 calendar days of acquiring the Dependent; or
- The date set forth under the Special Enrollment Provision if Your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within 30 calendar days following the event; or
- The date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent if an additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Employees will be able to make changes in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- The Employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and

- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and

- The Effective Date of coverage will be January 1 following the annual open enrollment period.

TERMINATION

For information about continuing coverage, refer to the COBRA Continuation of Coverage section of this SPD.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the Employer except as follows:
    - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave~~,~~ provided the applicable Employee contribution is paid when.
    - If You are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends; or

- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or

- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or

- If Your Dependent Child qualifies for extended Dependent coverage because they are Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment section; or

- The date Dependent coverage is no longer offered under this Plan; or

- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment, or at annual open enrollment periods; or

- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent submits a false claim or is involved in any other fraudulent act related to this Plan or any other group plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect;
- it is attributable to non-payment of premiums or contributions; or
- it is initiated by You or Your personal representative.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 13-week period, You will be treated

as a new hire and will be required to meet all the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions or contact Your Human Resources or Personnel office.

ALLOWABLE EXPENSES or USUAL and CUSTOMARY

The Plan pays benefits-based covered charges, not actual charges. covered charges cannot exceed the Usual and Customary Rates of a Covered Service, as determined by the Plan. The Plan determines Usual and Customary Rates based on a multiple of the currently published Medicare Reimbursement Schedules, along with other sources of publicly available and proprietary data. If a Provider charges more than the Usual and Customary Rates (as determined by the Plan), the covered individual is responsible for the amount in excess of the Usual and Customary Rates. This excess amount is considered outside the scope of the Plan, It is not counted toward satisfaction of the Deductible and it is not paid by the Plan even after satisfaction of the Deductible.

"Usual and Customary Rate" may be less than what a Provider actually charges a covered individual for a service or supply. The Third-Party Administrator determines the Usual and Customary Rate for any procedure, service, or supply in the exercise of its discretion under the Plan.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, You are not responsible, and a Physician may not bill You, for amounts in excess of Your applicable Copay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For Emergency health care services provided by a provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and a provider may not bill You, for amounts in excess of Your applicable Copay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill You, for amounts in excess of Your Copay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a Network provider and on the Recognized Amount as defined in this SPD.

After the Plan has issued payment for covered health care services, the Plan may be required to pay the provider an additional amount or discount to resolve and settle the provider's balance bill.

REVIEW OF CLAIMS

To assist Participants, their covered family members, and the Plan in reducing healthcare costs, an independent claim review of any claim over $10,000, to avoid costly errors and overpayments (or to recover already-made overpayments), may be conducted. The purpose of the claim review is to identify charges billed in error or that exceed the Maximum Allowable Charge, or services that are not Medically Necessary, and may include an examination of the Participant's medical and billing records and/or medical charts. Upon completion of a claim review, the Plan Administrator has the discretionary authority to reduce the Maximum Allowable Charge, in accordance with the terms of this SPD.

All claim reviews will follow the privacy practices set forth in the SPD **OR** the Notice of Privacy Practices, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. The SPD **OR** the Notice describes how the Plan uses and discloses Your personal health information (PHI), and also describes certain rights You have regarding this information.

Protecting privacy and PHI. In some instances, the claim review reveals the possibility of lowered costs for the Participant as the result of qualification for financial assistance or due to other applicable state or federal laws governing the claim. In some cases, savings for the Plan and/or the Participant may require the Participant to apply for financial assistance. In those instances, a Plan representative will contact the affected Participant. In some instances, incentives may be offered for applying for financial assistance. Incentives may be classified as taxable income. Failure to participate may result in a reduction or denial of coverage, **OR** participation in this program is voluntary, and You will not be penalized if You ignore outreach from the Plan regarding potential lower costs. **OR**

NOTE: ***Failure to participate when asked in the reduction of high-cost Hospital claims may result in such claims being denied by the Plan for non-observance of required claim procedures.***

DEFINITIONS

"Amount Generally Billed" ("AGB") is the maximum amount a Hospital can collect from a patient who is eligible for financial assistance under the applicable Financial Assistance Policy ("FAP") and is the Maximum Allowable Charge the Plan will pay for Participants who are eligible for financial assistance. This is true for all eligible costs, even for Participants who have not yet sought, applied for, or been awarded financial assistance, as long as they would qualify under the terms of the relevant FAP if an application was made. The Plan will accept the AGB as determined by the Hospital, as long as the amount is determined in accordance with 26 CFR § 1.501(r)-5.

"HCMC" is a claim or a set of aggregate claims for medical goods or services that exceeds $10,000.

"Maximum Allowable Charge" shall mean the amount payable for a specific covered item, service or supply under this Plan. The Maximum Allowable Charge will be a Negotiation Rate if one exists, subject to the exceptions set forth below and the exception for Participants eligible for financial assistance. If no Negotiation Rate exists, the Maximum Allowable Charge will be

determined by the Plan to be the lesser of the AGB by that Provider or Facility or it will be tied to Medicare reimbursement rates, except for claims subject to the No Suprises Act ("NSA"), in which case the Maximum Allowable Charge will be the Qualifying Payment Amount ("QPA"), or an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If no Negotiation Rate, AGB or Medicare reimbursement rate is available for a given item of service or supply not subject to the NSA, the Maximum Allowable Charge will be calculated using the prices established by the Center for Medicaid and Medicare Services ("CMS") either utilizing standard Medicare Payment methods and/or based upon (a) supplemental Medicare or Medicaid pricing data for items Medicare doesn't cover based on data from CMS; (b) prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained Providers of care; or (c) items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained Providers of care in traditional settings.

QPA for 2026 and beyond means the median of the contracted rates recognized by the Plan as of January 31, 2026, or recognized by all plans serviced by the Plan's TPA (if calculated by the TPA), for the same or a similar item or services delivered by a Provider in the same or similar specialty in the same geographic region, adjusted for inflation. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law. In all cases the QPA will be calculated in accordance with the NSA and any guidance or rules issued by the Department of Labor regarding its application.

Exclusions and Limitations
Coverage is excluded from the Plan for charges arising from care, supplies, treatment, and/or services:

Covered by Financial Assistance. That are for the cost of care for which a Hospital ordinarily charges a fee, but which is provided free or at a reduced rate to patients who qualify, in accordance with the Hospital's financial assistance policy.

Self-pay. That are for costs of care for any Participant who chooses to opt out of the coverage provided under this Plan and pay out of pocket for medical care. Any patient who opts out of the Plan cannot submit claims for covered medical services or supplies. Members may opt out of the Plan for an episode of care and remain covered under the Plan for all other covered medical services or supplies.

Unreasonable due to excessive or hidden fees. That are based on charges that are not reasonable as required by the Employee Retirement Income Security Act of 1974(ERISA). Costs that exceed the Maximum Allowable Charge are unreasonable. Undisclosed fees or fees included with claim costs without distinguishing them are presumptively unreasonable.

Limitations on Maximum Allowable Charge.
The Maximum Allowable Charge is limited to an amount which, in the Plan Administrator's discretion is charged for services or supplies that are not unreasonably caused by the treating

Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The Maximum Allowable Charge shall not include:

- Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.
- Charges for billing errors including, but not limited to, upcoding, duplicate charges, and charges for services not performed.
- Charges relating to clearly identifiable errors in medical care.
- Charges which the Plan cannot identify or understand the item(s) being billed.
- Charges identified based upon a medical record review and/or an audit which finds that a different treatment or different quantity of a drug or supply was provided.
- Charges that are unreasonable because they exceed the applicable QPA, AGB, the median charges billed by the provider, usual customary and reasonable charges (UCR), or exceed the Negotiation Rate agreed to with the Network.
- Charges incurred at any medical visit for which the patient opted out of the Plan and chose to proceed as self-pay.
- Charges that exceed the AGB at non-profit hospitals or other hospitals that provide financial assistance to qualified individuals for patients that qualify for financial assistance under the Hospital's FAP.

PROVIDER NETWORK

The word **"Network"** means an organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the Negotiated Rates as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Plan Participation amounts, or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the Network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs will help a Covered Person determine how much they will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons should receive services from In-Network providers. However, this Plan does not limit a Covered Person's right to choose their own provider of medical care at their own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

The Plan may make benefit provider Network(s) or provider agreements available to Participants to facilitate establishing and maintaining provider/patient relationships and to enhance provider access.

Your Plan has contracted with Fairos for repricing services for non-Network facility claims, and with Multiplan (PHCS Physicians Network) for non-Network non-facility claims.

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the In-Network benefit level by the prior claims administrator, but that are not considered at the In-Network benefit level by the current Claims Administrator, may be paid at the applicable In-Network benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous preferred provider organization but who is not a member of the Plan's current providers that are In-Network. In order to ensure continuity of care for certain medical conditions already under treatment, the In-Network medical plan benefit level may continue for 90 after the Plan's effective date with the current Claims Administrator for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplants for patients under active treatment (e.g., seeing a Physician on a regular basis, being on a transplant waiting list, or being ready at any time for a transplant).
- Being an Inpatient in a Hospital on the Covered Person's Effective Date.
- Post-acute Injury or surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral health (any previous treatment).

You or Your Dependent must call Vault Admin Services within 30 days prior to Your Effective Date or within 30 days after Your Effective Date to see if You or Your Dependent is eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, treatment for minor Illnesses, and elective surgical procedures will not be covered by transitional level benefits.

CONTINUITY OF CARE

You or Your Dependents have the option of requesting extended care from Your current health care provider or facility if the provider or facility is no longer working with Your health Plan and is no longer considered In-Network. Retiree-only plans are not subject to the Continuity of Care requirements.

The In-Network benefit level may continue for up to 90 days or until You no longer meet the criteria below, whichever is earlier, despite the fact that these expenses are no longer considered In-Network due to provider or facility termination from the Network. In order to be eligible, You or Your Dependents must have been, and must continue to be, under a treatment plan by a provider or facility who was a member of the participating Network. You must also be one of the following:

- An individual undergoing a course of treatment for a serious and complex condition that is either:
  - An acute Illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm.
  - A chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.
- An individual undergoing Inpatient or institutional care.
- An individual scheduled for non-elective surgical care, including necessary postoperative care.
- An individual who is pregnant and being treated.
- An individual who is terminally ill and receiving treatment for such Illness by a provider or facility.

PROTECTION FROM BALANCE BILLING

This section is to be interpreted in accordance with the No Surprises Act, as amended. Covered health care services that are subject to the No Surprises Act requirements will be reimbursed according to this section.

Emergency health care services provided by a non-Network provider will be reimbursed as set forth under Allowed Amounts below.

Covered health care services provided at certain Network facilities by non-Network Physicians, when not Emergency health care services, will be reimbursed as set forth under Allowed Amounts below. For these covered health care services, the term "certain Network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

ALLOWED AMOUNTS

For covered health care services that are Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians, You are not responsible, and the non-Network provider may not bill You, for amounts in excess of Your Copay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria, or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, You are not responsible, and the non-Network provider may not bill You, for amounts in excess of Your Copay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are Emergency health care services provided by a non-Network provider, You are not responsible, and the non-Network provider may not bill You, for amounts in excess of Your applicable Copay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD. Note: You may receive balance bills for post-stabilization services after an Emergency if Your attending Emergency Physician or treating provider determines that You can travel to an In-Network facility using non-medical or non-Emergency transportation but You choose to stay at the non-Network facility, if the notice and consent requirements have been satisfied and the provider or facility acts in compliance with applicable state laws.

Allowed Amounts for Air Ambulance Services

- Non-Network Air Ambulance (Emergency): If covered, benefits are subject to the Plan's Maximum Benefit per flight. The member's cost sharing is based on the Recognized Amount determined in accordance with federal law (in order of application: applicable All-Payer Model Agreement; applicable state law; otherwise the

lesser of the Qualifying Payment Amount or the billed charge). The Plan may negotiate an alternative payment or pursue IDR.

- Non-Network Air Ambulance (Non-Emergency): If covered, benefits are subject to the Plan's Maximum Benefit per flight and are paid based on the lesser of: (a) the Plan's repriced amount using its Usual and Customary or reference-based pricing methodology (including a multiple of Medicare when applicable), (b) a negotiated amount, or (c) applicable law.
- Network Air Ambulance: Paid per Network contract, up to the Maximum Benefit per flight.
- Third-party "broker" or coordination fees unrelated to medically necessary transport are not included in the Allowed Amount.

For covered Emergency air ambulance services provided by non-Network air ambulance provider, You are not responsible, and the non-Network provider may not balance bill You, for amounts in excess of applicable in-Network cost sharing (Deductible, Copay, or Coinsurance) calculated using the Recognized Amount, as determined under the No Surprises Act (the lesser of the Qualifying Payment Amount or the billed charge, unless an applicable All Payer Model Agreement or state law applies). The Plan's payment will be determined in accordance with federal law, including negotiation and, if necessary, the Independent Dispute Resolution (IDR) process. Any additional amounts paid by the Plan through negotiation or IDR above the Recognized Amount do not affect Your cost sharing.

Allowed amounts are determined in accordance with the claims administrator's reimbursement policy guidelines or as required by law, as described in this SPD. The amount paid by the Plan to the provider or facility will be determined in accordance with the requirements of the No Surprises Act.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

Important: Prior Authorization may be required before benefits will be considered for payment. Failure to obtain Prior Authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management and Preauthorization section of this SPD for a description of these services and prior authorization procedures.

1. **3D Mammograms,** for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care benefits.

2. **Abortions:** If a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term or if the pregnancy was the result of incest or rape.

3. **Allergy Treatment,** including injections and sublingual drops, testing and serum.

4. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically appropriate Hospital. Medically Necessary Ambulance Transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport is to the nearest facility able to provide appropriate medical care.

5. **Anesthetics and Their Administration.**

6. **Aquatic Therapy.** (See Therapy Services below.)

7. **Augmentation Communication Devices** and related instruction or therapy.

8. **Autism Spectrum Disorders (ASD) Treatment.**

ASD treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.

Treatment is subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services).

Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, Custodial Care, nutritional or dietary supplements, or educational services that should be provided through a school district).

9. **Breast Pumps** and related supplies. Benefits for breast pumps include the lesser cost of purchasing or renting one breast pump per pregnancy in conjunction with childbirth.

10. **Breast Reductions** if Medically Necessary.

11. **Breastfeeding Support, Supplies, and Counseling** in conjunction with each birth. The Plan also covers comprehensive lactation support and counseling by a trained provider during pregnancy and in the postpartum period.

12. **Cardiac and LVAD / RVAD Implants**, as shown in the Schedule of Benefits of this SPD

13. **Cardiac Pulmonary Rehabilitation** when Medically Necessary when needed as a result of an
Illness or Injury.

14. **Cardiac Rehabilitation** programs are covered when Medically Necessary, if referred by a Physician, for patients who have certain cardiac conditions.

    Covered services include:

    - Phase I cardiac rehabilitation, while the Covered Person is an Inpatient.
    - Phase II cardiac rehabilitation, while the Covered Person is in a Physician-supervised Outpatient, monitored, low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure, and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

15. **Cataract or Aphakia Surgery** as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.

16. **Circumcision** and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

17. **Cleft Palate and Cleft Lip,** benefits will be provided for initial and staged reconstruction of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

18. **Contraceptives and Counseling:** All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling.

    The following contraceptives will be processed under the medical Plan:

    - Contraceptive injections (such as Depo-Provera) and their administration regardless of purpose.
    - Contraceptive devices such as IUDs and implants, including their insertion and removal regardless of purpose.

    The following contraceptives will be processed under the Prescription Drug Benefits section of this SPD:

    - Contraceptive patches, oral tablets, or self-insertable vaginal devices containing contraceptive hormones (e.g., Nuva ring).

19. **Cornea Transplants** are payable as provided on the Schedule of Benefits.

20. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self management education programs, diabetic shoes and nutritional counseling.

21. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Coverage also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same as for any other Illness.

22. **Durable Medical Equipment,** subject to all of the following:

    - The equipment must meet the definition of Durable Medical Equipment in the Glossary of Terms. Examples include, but are not limited to, crutches, wheelchairs, Hospital-type beds, and oxygen equipment.
    - The equipment must be prescribed by a Physician.
    - The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
    - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to the growth of the

person or if changes to the person's medical condition require a different product, as determined by the Plan.

- If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries, or replacement only if required:
  - due to the growth or development of a Dependent Child;
  - because of a change in the Covered Person's physical condition; or
  - because of deterioration caused from normal wear and tear.

  The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered, and replacement is subject to prior approval by the Plan.
- This Plan covers taxes and shipping and handling charges for Durable Medical Equipment.

23. **Emergency Room Hospital and Physician Services,** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

24. **Extended Care Facility Services** for both mental and physical health diagnoses. Charges will be paid under the applicable diagnostic code. The following services are covered:

- Room and board.
- Miscellaneous services, supplies, and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

25. **Eye Refractions** if related to a covered medical condition.

26. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

- Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.
- Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
- Physician office visit for diagnosis of bunions. The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed.

27. **Genetic Testing or Genetic Counseling in relation to Genetic Testing** based on Medical Necessity.

Genetic testing MUST meet the following requirements:

The test must not be considered Experimental, Investigational, or Unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person.

Genetic testing must also meet at least one of the following:

- The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
- Conventional diagnostic procedures are inconclusive.
- The patient has risk factors or a particular family history that indicates a genetic cause.
- The patient meets defined criteria that place them at high genetic risk for the condition.

28. **Hearing Services** include:

    - Exams, tests, services, and supplies to diagnose and treat a medical condition.
    - Purchase or fitting of hearing aids.
    - Implantable hearing devices, including semi-implantable hearing devices when the Covered Person has craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid or hearing loss severe enough that it would not be remedied by a wearable hearing aid.

29. **Home Health Care Services:** (Refer to the Home Health Care Benefits section of this SPD.)

30. **Hospice Care Services:** Treatment given at a Hospice Care facility must be in place of a stay in a Hospital or Extended Care Facility, and may include:

    - **Assessment,** which includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care required to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and parttime Home Health Care services.
    - **Outpatient Care,** which provides or arranges for other services related to the Terminal Illness, including the services of a Physician or Qualified physical or occupational therapist or nutrition counseling services provided by or under the supervision of a Qualified dietician.
    - **Respite Care** to provide temporary relief to the family or other caregivers in the case of an Emergency or to provide temporary relief from the daily demands of caring for a terminally ill person.
    - **Bereavement Counseling** services that are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and the charges for which are bundled with other hospice charges. Counseling services must be provided by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable. The services must be furnished within six months of death.

    The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. However, services are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

31. **Hospital Services (Including Inpatient Services, Surgical Centers, and Inpatient Birthing Centers).** The following services are covered:

- Semi-private and private room and board services:
  - For Network charges, this rate is based on the Network agreement. Semi-private rate reductions may apply.
  - For non-Network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to the Protection from Balance Billing allowed amount, Usual and Customary charges, or Negotiated Rate, whichever is applicable.
- Intensive care unit room and board.
- Miscellaneous and Ancillary Services.
- Blood, blood plasma, and plasma expanders, when not available without charge.

Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

32. **Hospital Services (Outpatient).**

Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

33. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

34. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition of, alleviates the symptoms of, slows the harm to, or maintains the current health status of the Covered Person. Once the patient is receiving fertility treatment to achieve pregnancy, diagnostic tests and treatments are then considered part of the infertility benefit.

Infertility Treatment does not include genetic testing. (See General Exclusions for details.)

35. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits. Charges by a pathologist for interpretation of computer-generated automated laboratory test reports are not covered by the Plan.

36. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

37. **Maternity Benefits** for Covered Persons include:

- Hospital or Birthing Center room and board.
- Vaginal delivery or Cesarean section.
- Non-routine prenatal care.
- Postnatal care.
- Diagnostic testing.
- Abdominal operation for intrauterine pregnancy or miscarriage.
- Outpatient Birthing Centers.
- Midwives.

38. **Medical and/or Routine Services Provided in a Foreign Country,** except that no coverage is provided if the sole purpose of travel to that country is to obtain medical services and/or supplies.

39. **Mental Health Treatment.** (Refer to the Mental Health Benefits section of this SPD.)

40. **Morbid Obesity Treatment** includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.

- Bariatric surgery, including, but not limited to:
  - Gastric or intestinal bypasses (Roux-en-Y, biliopancreatic bypass, and biliopancreatic diversion with duodenal switch).
  - Stomach stapling (vertical banded gastroplasty, gastric banding, and gastric stapling).
  - Lap band (laparoscopic adjustable gastric banding).
  - Gastric sleeve procedure (laparoscopic vertical gastrectomy and laparoscopic sleeve gastrectomy).
- Physician-supervised weight loss programs at a medical facility.
- Charges for diagnostic services.
- Nutritional counseling by registered dieticians or other Qualified Providers.

This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions section of this SPD.

41. **Nursery and Newborn Expenses, Including Circumcision,** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

42. **Nutritional Counseling.**

43. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** that are prescribed by a Physician and administered through a tube, provided they are the sole source of nutrition or are part of a chemotherapy regimen. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer

enteral feedings), provided the feedings are prescribed by a Physician and are the sole source of nutrition or are part of a chemotherapy regimen.

44. **Occupational Therapy.** (See Therapy Services below.)

45. **Oral Surgery** includes:

- Excision of partially or completely impacted teeth.
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examinations.
- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
- Reduction of fractures and dislocations of the jaw.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands, or ducts.
- Frenectomy (the cutting of the tissue in the midline of the tongue).
- Excision of exostosis of jaws and hard palate.

46. **Orthopedic Implants**, as shown in the Schedule of Benefits of this SPD**.**

47. **Orthognathic, Prognathic, and Maxillofacial Surgery** when Medically Necessary.

48. **Orthotic Appliances, Devices, and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic appliances and devices include custom molded shoe orthotics supports, trusses, elastic compression stockings, and braces.

49. **Oxygen and Its Administration.**

50. **Pharmacological Medical Case Management** (medication management and lab charges).

51. **Physical Therapy.** (See Therapy Services below.)

52. **Physician Services** for covered benefits.

53. **Pre-Admission Testing** if necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

54. **Prescription Medications** that are administered or dispensed as take-home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility, or Skilled Nursing Facility) and that require a Physician's Prescription. Coverage does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

55. **Preventive / Routine Care** as listed under the Schedule of Benefits.

The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility, or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes, and include the following as required under applicable law:

- 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
- Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Well-women Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-women visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

    - Screening for gestational diabetes;
    - Human papillomavirus (HPV) DNA testing;
    - Counseling for sexually transmitted infections;
    - Counseling and screening for human immune-deficiency virus;
    - Screening and counseling for interpersonal and domestic violence; and
    - Breast cancer genetic test counseling (BRCA) for women at high risk.

    Please visit the following links for additional information:

    https://www.healthcare.gov/preventive-care-benefits/
    https://www.healthcare.gov/preventive-care-children/
    https://www.healthcare.gov/preventive-care-women/

56. **Private Duty Nursing Services** when Outpatient care is required and Medically Necessary. Coverage does not include Inpatient private duty nursing services.

57. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) that replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

- Due to the growth or development of a Dependent Child; or
- When necessary, because of a change in the Covered Person's physical condition; or,
- Because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

58. **Qualifying Clinical Trials** as defined below, including routine patient care costs Incurred during participation in a Qualifying Clinical Trial for the treatment of:

- Cancer or other Life-Threatening Disease or Condition. For purposes of this benefit, a Life Threatening Disease or Condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a Qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for Qualifying Clinical Trials may include:

- Covered health services (e.g., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Diseases or Conditions, a "Qualifying Clinical Trial" is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

- National Institutes of Health (NIH), including the National Cancer Institute (NCI);
- Centers for Disease Control and Prevention (CDC);
- Agency for Healthcare Research and Quality (AHRQ);
- Centers for Medicare and Medicaid Services (CMS);
- A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or Veterans Administration (VA);

- A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or
- The Department of Veterans Affairs, the DOD, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
  - It is comparable to the system of peer review of studies and investigations used by the NIH; and
  - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (*IRBs*) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

59. **Radiation Therapy and Chemotherapy** when Medically Necessary.

60. **Radiology and Interpretation Charges.**

61. **Reconstructive Surgery** includes:

- Surgery following a mastectomy under the Women's Health and Cancer Rights Act (WHCRA). Under the WHCRA, the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments that include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
- Surgery to restore a bodily function that has been impaired by a congenital Illness or anomaly, or by an Accident, or from an infection or other disease of the involved part.

62. **Respiratory Therapy.** (See Therapy Services below.)

63. **Second Surgical Opinion** if given by a board-certified Specialist in the medical field related to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

64. **Sleep Disorders** if Medically Necessary.

65. **Sleep Studies.**

66. **Speech Therapy.** (See Therapy Services below.)

67. **Sterilizations.**

68. **Substance Use Disorder Services.** (Refer to the Substance Use Disorder and Chemical Dependency Benefits section of this SPD.)

69. **Surgery and Assistant Surgeon Services.**

- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the allowance for the primary procedure performed. For in-Network providers, the assistant surgeon's allowable amount will be determined per the Network contract.
- If bilateral or Multiple Surgical Procedures are performed by one surgeon, benefits will be determined based on the allowance for the primary procedure; and a percentage of the allowance for the subsequent procedure(s). If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the allowance for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the allowable amount for that procedure.

70. **Telehealth.** Consultations made by a Covered Person to a Physician.

71. **Temporomandibular Joint Disorder (TMJ) Services** include:

- Diagnostic services.
- Surgical treatment.
- Non-surgical treatment (including intraoral devices or any other non-surgical method to alter occlusion and/or vertical dimension).

Coverage does not include orthodontic services.

72. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

- **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.

- **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
- **Respiratory therapy** by a Qualified respiratory therapist (RT) or other Qualified Provider, if applicable.
- **Aquatic therapy** by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if applicable.
- **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or Autism Spectrum Disorder.

73. **Tobacco Addiction:** Preventive / Routine Care as required by applicable law.

74. **Transplant Services.** as shown in the Schedule of Benefits of this SPD.

75. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

76. **Walk-In Retail Health Clinics:** Charges associated with medical services provided at Walk-In Retail Health Clinics.

77. **Wigs (Cranial Prostheses), Toupees, and Hairpieces** for hair loss due to cancer treatment or alopecia related to a medical condition.

TRANSPLANT BENEFITS

Refer to the Utilization Management and Prior Authorization section of this SPD for Prior Authorization Requirements

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing, and Ancillary Services.

Organ and Tissue Acquisition / Procurement means the harvesting, preparation, transportation, and storage of human organ and tissue that is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells and may include chimeric antigen receptor T-cell therapy (CAR-T).

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Center of Excellence due to an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary charge, or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain Prior Authorization for all transplant-related services. If Prior Authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be an individual Plan exclusion.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Center of Excellence for Organ and Tissue Acquisition / Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including a bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition / Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not

provide coverage for Organ and Tissue Acquisition / Procurement. Coverage includes the cost of donor testing, blood typing, and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor-related complications during the transplant period, per the transplant contract, if the recipient is a Covered Person under this Plan.

Benefits are payable for the following transplant types:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by care management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous), which may include chimeric antigen receptor T-cell therapy (CAR-T) for certain conditions.
- Small bowel.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.

- Expenses for Organ and Tissue Acquisition / Procurement and storage of cord blood, stem cells, or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.

- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.

- Transplants considered Experimental, Investigational, or Unproven unless covered under a Qualifying Clinical Trial.

- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.

- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG BENEFITS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and home delivery service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Benefits.

Prescription Drug Benefit Highlights

Prescription Drug Benefits will not be coordinated with those of any other health coverage plan.

Identification Card (ID Card)

You must either show Your ID card at the time You obtain Your Prescription Drug at a Network Pharmacy or provide the Network Pharmacy with identifying information that can be verified by FairosRx during regular business hours.

If You do not show Your ID card or provide verifiable information at a Network Pharmacy, You will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

Benefit Levels

Benefits are available for Outpatient Prescription Drugs that are considered a Covered Expense.

The Plan pays benefits at different levels for tier 1, tier 2, and, if applicable, tier 3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug may change periodically, as frequently as monthly, based on the Formulary Management Committee's periodic tiering decisions. When that occurs, You may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, for the most current information, You can visit www.FairosRx.com, or call FairosRx Member Services at 833-464-9600.

Each tier is assigned a Copay or Participation, which is the amount You pay when You visit the pharmacy or order Your medications through home delivery. Your Copay or Participation will also depend on whether or not You visit the pharmacy or use the home delivery service; see the Prescription Schedule of Benefits for further details. Here is how the tier system works:

Tier 1 is usually Your lowest Copay or Participation option. For the lowest out-of-pocket expense, You should consider tier 1 drugs if You and Your Physician decide they are appropriate for Your treatment.

Tier 2 is Your middle Copay or Participation option. Consider a tier 2 drug if no tier 1 drug is available to treat Your condition.

Tier 3, if applicable, is Your highest Copay or Participation option. The drugs in tier 3 are usually more costly. Sometimes there are alternatives available in tier 1 or tier 2.

For Prescription Drugs at a retail Network Pharmacy, You are responsible for paying the lower of:

- The applicable Copay, Participation, or Deductible amount;
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- The Prescription Drug Charge that FairosRx agreed to pay the Network Pharmacy.

For Prescription Drugs from a home delivery Network Pharmacy, You are responsible for paying the lower of:

- The applicable Copay, Participation, or Deductible amount; or
- The Prescription Drug Charge for that particular Prescription Drug.

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by visiting www.FairosRx.com, and navigating to the Pharmacy section, or call FairosRx Member Services at 833-464-9600.

To obtain Your Prescription from a retail pharmacy, simply present Your ID card and pay the Copay, Participation or Deductible amount. The Plan pays benefits for certain covered Prescription Drugs as written by a Physician and in accordance with the Plan.

Note: Pharmacy benefits apply only if Your Prescription is for a Covered Expense, and not for Experimental, Investigational, or Unproven Services. Otherwise, You are responsible for paying 100% of the cost.

Home Delivery

The home delivery service may allow You to purchase up to a 90-day supply of a covered maintenance drug through the mail. Maintenance drugs help in the treatment of chronic Illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the home delivery service, all You need to do is complete a patient profile and enclose Your Prescription order. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after Your order is received. If You need a patient profile form, or if You have any questions, You can contact FairosRx Member Services at 833-464-6900.

The Plan pays home delivery benefits for certain covered Prescription Drugs as written by a Physician and in accordance with the Plan.

You may be required to fill an initial Prescription Drug order and obtain one or more refills through a retail pharmacy prior to using a home delivery Network Pharmacy.

Note: To maximize Your benefit, ask Your Physician to write Your Prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a home delivery Copay, Participation, or Deductible amount for any Prescription order or refill if You use the home delivery service, regardless of the number of days' supply that is written on the order. Be sure Your Physician writes Your home delivery or refill for a 90-day supply, not a 30-day supply with three refills.

Designated Pharmacy

If You require certain Prescription Drugs, FairosRx may direct You to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Please see the Definitions in this section for the definition of Designated Pharmacy.

Want to lower Your out-of-pocket Prescription Drug costs?

Consider tier 1 Prescription Drugs, if You and Your Physician decide they are appropriate.

Assigning Prescription Drugs to the PDL

FairosRx Pharmacy and Therapeutics (P&T) Committee and Formulary Management Committee make the final approval of Prescription Drug placement in tiers. In their evaluation of each Prescription Drug, the Committees take into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- Evaluations of the place in therapy;
- Relative safety and efficacy; and
- Whether supply limits or prior authorization requirements should apply.

Economic factors may include:

- The acquisition cost of the Prescription Drug;
- The net cost of the Prescription Drug; and
- Available rebates and assessments on the cost effectiveness of the Prescription Drug.

When considering a Prescription Drug for tier placement, the Committees review clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

The Formulary Management Committee may periodically change the placement of a Prescription Drug among the tiers. These changes may occur as frequently as monthly and may occur without prior notice to You.

Prescription Drug, Prescription Drug List (PDL), and Formulary Management Committee are defined at the end of this section.

Prescription Drug List (PDL)

The PDL is a tool that helps guide You and Your Physician in choosing the medications that allow the most effective and affordable use of Your Prescription Drug benefit.

Prior Authorization Requirements

Before certain Prescription Drugs are dispensed to You, it is the responsibility of Your Physician, Your pharmacist, or You to obtain Prior Authorization. FairosRx will determine if the Prescription Drug, in accordance with Your plan's approved guidelines, is both:

- A Covered Expense as defined by the Plan; and
- Not Experimental, Investigational, or Unproven.

Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or You are responsible for obtaining Prior Authorization from FairosRx.

Non-Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a non-Network Pharmacy, You or Your Physician is responsible for obtaining Prior Authorization from FairosRx as required.

To determine if a Prescription Drug requires Prior Authorization, You can visit www.FairosRx.com , and navigate to the Pharmacy section, or call FairosRx Member Services at 833-464-6900. The Prescription Drugs requiring Prior Authorization are subject to periodic review and modification.

Benefits may not be available for the Prescription Drug after FairosRx reviews the documentation provided and determines that the Prescription Drug is not a covered health service or it is an Experimental, Investigational, or Unproven service.

We may also require Prior Authorization for certain programs that may have specific requirements for participation and/or activation of an enhanced level of benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation, or activation requirements associated with such programs through the Internet at www.FairosRx.com, and navigating to the Pharmacy section, or call FairosRx Member Services at 833-464-6900.

Limitation on Selection of Pharmacies

If FairosRx determines that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Network Pharmacies may be limited. If this happens, You may be required to select a single Network Pharmacy that will provide and

coordinate all future pharmacy services. Benefits will be paid only if You use the designated single Network Pharmacy.

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per Prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit www.FairosRx.com, and navigate to the Pharmacy section, or call FairosRx Member Services at 833-464-6900. Whether or not a Prescription Drug has a supply limit is subject to FairosRx's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan and FairosRx have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the tier placement of the Brand-name drug may change. As a result, Your Copay, Participation, or Deductible amount may change. You will pay the amount applicable for the tier to which the Prescription Drug is assigned.

Special Programs

Vault and FairosRx may have certain programs in which You may receive an enhanced or reduced benefit based on Your actions such as adherence to or compliance with medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.FairosRx.com, and navigating to the Pharmacy section, or call FairosRx Member Services at 833-464-6900.

COVERED BENEFITS - What the Prescription Drug Benefits Section Will Cover

The following are considered Covered Expenses:

- **Prescription products that:**
    - Are necessary for the care and treatment of an Illness or Injury and are prescribed by a duly licensed medical professional; and
    - Can be obtained only by Prescription and are dispensed in a container labeled “Rx only” or with similar language; and
    - Are the following non-Prescription products prescribed by a duly licensed medical professional:
        - Compounded medications of which at least one ingredient is an FDA Prescription Drug;
        - Any other medications that, due to state law, may be dispensed only when prescribed by a duly licensed medical professional; and

- In an amount not to exceed the day's supply outlined in the Prescription Schedule of Benefits.

- **Prescription Drugs lost as a direct result of a natural disaster.** Covered Persons will be given the opportunity to prove that Prescription Drugs otherwise considered Covered Expenses under this Plan were lost due to a natural disaster. Acceptable proof could include, but not necessarily be limited to, proof of other filed claims of loss (homeowner's, property, etc.).

- **Home Delivery Prescriptions.** The Plan will pay for Covered Expenses Incurred by a Covered Person for Prescription products dispensed through the home delivery pharmacy identified by FairosRx. Prescription products may be ordered by mail with a Copay from the Covered Person for each Prescription or refill. The Copay is shown on the Prescription Schedule of Benefits. By law, Prescription products may not be mailed to a Covered Person outside the United States.

- **Diabetic Supplies.** Some diabetic supplies may be covered.

- **Tobacco and Nicotine Cessation.** Some tobacco cessation products may be covered, and may be subject to quantity and age restrictions and prior therapy review.

- **Vaccines.** Some vaccines may be covered, and may have limitations depending on whether the vaccine is administered in a pharmacy or a clinic.

Covered Expenses apply only to certain Prescription Drugs and supplies. You can visit www.FairosRx.com, and navigate to the Pharmacy section, or call FairosRx Member Services at 833-464-6900, for information on which specific Prescription Drugs and supplies are covered.

EXCLUSIONS - What the Prescription Benefits Section of this Plan Will Not Cover

In addition, the following exclusions apply.

When an exclusion applies to only certain Prescription Drugs, You can visit www.FairosRx.com, and navigate to the Pharmacy section, or call FairosRx Member Services at 833-464-6900 for information on which Prescription Drugs are excluded.

Excluded medications are:

- Any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
- Pharmaceutical products for which benefits are provided in the medical (not in the Prescription Drug Benefits) portion of the Plan;
- Available over-the-counter that do not require a Prescription order or refill by federal or state law before being dispensed, unless the Plan has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter

form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan has determined are Therapeutically Equivalent to an over-the-counter drug. The Plan may decide, at any time, to reinstate benefits for a Prescription Drug that was previously excluded under this provision;

- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription order or refill. Compounded drugs that may be available as a similar, commercially available Prescription Drug;
- Compound drugs that contain non-FDA approved bulk ingredients, available as a similar commercial Prescription Drugs, and contain non-covered over-the-counter products;
- Dispensed outside of the United States, except in an Emergency;
- Durable Medical Equipment (prescribed and non-prescribed Outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
- The amount dispensed (days' supply or quantity limit) that exceeds the supply limit;
- The amount dispensed (days' supply or quantity limit) that is less than the minimum supply limit;
- Certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the Formulary Management Committee;
- Prescribed, dispensed, or intended for use during an Inpatient stay;
- Prescription Drugs, including new Prescription Drug products or new dosage forms, that FairosRx and Plan Sponsor determine do not meet the definition of a Covered Expense;
- Used for conditions and/or at dosages determined to be Experimental, Investigational, or Unproven, unless FairosRx and Plan Sponsor have agreed to cover an Experimental, Investigational, or Unproven treatment, as defined in the Glossary of Terms;
- Vitamins, except for the following, which require a Prescription:
  - ➢ Prenatal vitamins;
  - ➢ Vitamins with fluoride; and
  - ➢ Single-entity vitamins.
- Certain Prescription products excluded by formulary design, utilization management programs, or benefit design;
- Certain new Prescription Drugs to market until the Committees have reviewed them for formulary placement;
- Certain Prescription products with over-the-counter products in the same Therapeutic Class.

DEFINITIONS

Brand-name means a Prescription Drug that is either:

- Manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- Identified by FairosRx as a Brand-name drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "Brand-name" by the manufacturer, the pharmacy, or Your Physician may not be classified as Brand-name by FairosRx.

Co-payment (or Copay) means the amount You are required to pay for certain Prescription Drugs.

Committees means FairosRx Pharmacy and Therapeutics Committee and Formulary Management Committee.

Designated Pharmacy means a pharmacy that has entered into an agreement with FairosRx, or with an organization contracting on its behalf, to provide specific Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic means a Prescription Drug that is either:

- Chemically equivalent to a Brand-name drug; or
- Identified by FairosRx as a Generic drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as “Generic" by the manufacturer, the pharmacy, or Your Physician may not be classified as Generic by FairosRx.

Network Pharmacy means a retail or home delivery pharmacy that has:

- Entered into an agreement with FairosRx to dispense Prescription Drugs to Covered Persons;
- Agreed to accept specified reimbursement rates for Prescription Drugs; and
- Been designated by FairosRx as a Network Pharmacy.

Participation means the percentage of the cost You are required to pay for certain Prescription Drugs.

PDL: see Prescription Drug List .

Pharmacy and Therapeutics (P&T) Committee means the Committee at FairosRx that is responsible for the reviews of Prescription Drugs for inclusion on the formulary and creates

criteria, policies, and procedures for such inclusion including, but not limited to, clinically appropriate quantity restrictions, step therapies, and prior authorizations.

Prescription Drug means a medication, product, or device that has been approved by the Food and Drug Administration and that may, under federal or state law, be dispensed only using a Prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs also include:

- Inhalers (with spacers);
- Insulin;
- The following diabetic supplies:
  - Insulin syringes with needles;
  - Blood-testing strips - glucose;
  - Urine-testing strips - glucose;
  - Ketone-testing strips and tablets;
  - Lancets and lancet devices; and
  - Glucose monitors.

Prescription Drug Charge means the rate FairosRx has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) means a list that categorizes into tiers medications, products, or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic review and modification (as frequently as monthly). You may determine to which tier a particular Prescription Drug has been assigned by visiting www.FairosRx.com, and navigating to the Pharmacy section, or calling FairosRx Member Services at 833-464-6900.

Specialty Drug List means the list(s) of Specialty Drugs. The Specialty Drug List is maintained and updated by FairosRx from time to time. The Specialty Drug List(s) applicable to the Plan will be provided to the client upon request.

Specialty Drugs means the Prescription Drugs that include at least one or more of the following:

- Biotechnology drugs;
- Typically high-cost drugs;
- Drugs administered by oral or injectable routes, including infusions in any Outpatient setting;
- Drugs requiring ongoing frequent patient management or monitoring or focused, in-depth member education;
- Drugs that require specialized coordination, handling, and distribution services for appropriate medication administration;
- Infusion or injectable drugs professionally administered by a health care professional or in a health care setting (but excluding supplies or the cost of administration);
- Therapy requiring management and/or care coordination by a health care provider specializing in the member's condition; or

- Drugs as determined by FairosRx to be indicated for a specialty condition in which other Specialty Drugs are categorized.

Specialty Pharmacy means a facility that is duly licensed to operate as a pharmacy and to dispense Specialty Drugs. Specialty Pharmacies include pharmacies that FairosRx or its affiliates own or operate.

Therapeutic Class means a group or category of Prescription Drug with similar uses and/or actions.

Therapeutically Equivalent means when Prescription Drugs have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge, also known as the retail price, means the amount charged to customers who have no health coverage for Prescription Drugs.

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Copays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

All financial requirements and treatment limitations for Mental Health Disorders will be applied in a manner no more restrictive than those applied to medical/surgical benefits, in compliance with the Mental Health Parity and Addiction Equity Act.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent DSM for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.

- Services provided for conflict between the Covered Person and society that is solely related to criminal activity.

- Conditions listed in the most recent DSM or the ICD-CM in the following categories:

    - Personality disorders; or
    - Sexual/gender identity disorders; or
    - Behavior and impulse control disorders; or
    - "Z" codes (including marriage counseling).

- Services for biofeedback.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Copays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate, as applicable and consistent with the application of such terms to medical/surgical benefits.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual diagnosis facility for the treatment of substance use disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance-related disorders. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes.)

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for the change. Such records must include the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent DSM for the new diagnosis.

SUBSTANCE USE DISORDER EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for the following:

- Treatment or care considered inappropriate or substandard as determined by the Plan.

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

UTILIZATION MANAGEMENT AND PRIOR AUTHORIZATION

Utilization Management

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and are appropriate level of care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons are responsible for ensuring the provider calls the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

Prior Authorization is the process of obtaining advance approval from the Third-Party Administrator before certain medical services are provided. Prior Authorization ensures that specific services are reviewed and approved as necessary before they are rendered. Although Your medical provider typically submits the required information to request Prior Authorization on Your behalf, it is important to confirm with Your provider that Prior Authorization has been obtained prior to receiving the service. The responsibility to secure Prior Authorization ultimately rests with the Participant. For assistance, please refer to the Prior Authorization phone number located on the back of Your Participant Identification Card.

Special Note: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. Covered Persons who have received care on this basis are responsible for ensuring the provider contacts the Utilization Review Organization (see below) as soon as possible by phone or fax within 24 hours, or by the next business day if on a weekend or holiday, from the time coverage information is known. If notice is provided past the timeframe shown above, the extenuating circumstances must be communicated. The Utilization Review Organization will then review the services provided.

This Plan complies with the Newborns' and Mothers' Health Protection Act. Prior Authorization is not required for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

DEFINITIONS

The following terms are used for the purpose of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Prior Authorization is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for drugs, supplies, tests, procedures, and other services that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay.

Utilization Management is the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits Plan. This management is sometimes called "utilization review." Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization **before** receiving services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over $1,500 or Durable Medical Equipment rentals over $500 per month.
- Qualifying Clinical Trials.
- Chemotherapy (cancer diagnosis).
- Dialysis.
- Medical Specialty Drug Program. To encourage safe and cost-effective medication use, Prior Authorization may be required for some Specialty Drugs. Please visit https://FairosRx.com for a list of Medical Specialty Drugs that may require Prior Authorization, including Site of Care when applicable (including select gene therapy drugs, orphan drugs, and CAR-T drugs). To request a copy of the Medical Specialty Drug list, call the toll-free number on the back of Your member identification card and the list will be provided free of charge. **Prior Authorization does not guarantee benefit payment**. This Plan may exclude specific drugs on this list from coverage. Refer to the General Exclusions section of this SPD for possible Medical Specialty Drug exclusions.
- Bariatric surgeries.
- Non-Emergency interfacility air transport.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject

to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization.

Medical Director Oversight. A medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case-to-case management for review. Opportunities are identified by using a system integrated, automated and manual trigger lists during the Prior Authorization review process. Other trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals.

Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted upon request and a determination will be issued within the required timeframe of the request, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures and a final determination will be made no later than 30 days after the request for review.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (which is the "Primary Plan").

The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A "Secondary Plan" pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Copays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Foreign health care coverage.
- Medical care components of group long-term care contracts, such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies (including no-fault policies). See the order of benefit determination rules (below).
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

However, this Plan does not coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a Network contract requiring otherwise, covered charges will not include any amount that is not payable under the Primary Plan as a result of a contract between the Primary Plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply:

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan will always be considered secondary regardless of the individual's election under Personal Injury Protection (PIP) coverage with the auto carrier.

- If an individual is covered under one plan as a dependent and another plan as an employee, member, or subscriber, the plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) is considered primary. This does not apply to COBRA participants. See continuation coverage below. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan.

- The plan that covers a person as a dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent. See continuation coverage below. Also see the section on Medicare, below, for exceptions.

- If an individual is covered under a spouse's plan and also under their parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.

- If one or more plans cover the same person as a Dependent child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

    If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or Plan Years starting after the plan is given notice of the court decree.

- If the parents are not married and reside separately, or are divorced or legally separated (whether or not they have ever been married), the order of benefits is:

    a. The plan of the custodial parent;
    b. The plan of the spouse of the custodial parent;
    c. The plan of the non-custodial parent; and then
    d. The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or dependent of an active employee), and is also covered under another plan as a retired or laid-off employee (or Dependent of a retired or laid-off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See the exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that has covered the person as an employee, member, subscriber, or retiree the longest is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including through Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Copays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance.

When Medicare is primary to this Plan and a Covered Person has not elected Medicare, this Plan will coordinate benefits using an estimate of what Medicare would have paid.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:
  - You continue to be actively employed by the Employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
  - You continue to be actively employed by the Employer, Your covered spouse becomes eligible for and enrolls in Medicare, and Your spouse is also covered under a retiree plan through their former employer. In this case, this Plan pays first for You and Your covered spouse, Medicare pays second, and the retiree plan pays last.
  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
  - You are no longer actively employed by an employer; and
  - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also has COBRA continuation coverage through the Plan; or
  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first; however, COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or
  - You or Your covered spouse has retiree coverage plus Medicare coverage; or
  - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability **before** being diagnosed with ESRD and Medicare was previously paying as the Primary Plan, the person may continue to receive Medicare benefits on a primary basis).
- Medicare is the secondary payer when no-fault insurance, Workers' Compensation, or liability insurance is available as the primary payer.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's health insurance plan.

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive. You must reimburse the Plan 100% of the benefits it paid from any recovery You receive from a third party, insurer, or other source, regardless of whether the recovery is characterized as payment for medical expenses, lost wages, pain and suffering, or any other damages. Reimbursement to the Plan must be made in the amount of benefits actually paid by the Plan, which will be based on the Plan's re-priced (or allowed) amount, not the provider's billed charges. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing. The Plan has an equitable lien on any such proceeds and may seek other equitable remedies against any person or entity holding such proceeds, including Your attorney. The Plan's reimbursement and subrogation rights supersede the 'make whole' doctrine and the 'common fund' doctrine. The Plan is not required to wait until You are fully compensated for Your losses, and the Plan is not required to contribute to attorney fees or costs You incur in obtaining a recovery.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.

- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.

- The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.

- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.

- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.

- Any person or entity that is liable for payment to You on any equitable or legal theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

    - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or Injuries.
    - Making court appearances.
    - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
    - Complying with the terms of this section

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, punitive, and any other alleged damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:

  - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own negligence.

- By participating in and accepting benefits from the Plan, You agree to assign to the Plan any benefits, claims, or rights of recovery You have under any automobile policy (including no-fault benefits, PIP benefits, and/or medical payment benefits), under other coverage, or against any third party, to the full extent of the benefits the Plan has paid for the Illness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, You acknowledge and recognize the Plan's right to assert, pursue, and recover on any such claim, whether or not You choose to pursue the claim, and You agree to this assignment voluntarily.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.

Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval. The Plan may take legal action in Your name, may require approval of any settlement, and may apply these rights to wrongful death claims and claims involving minors. You may not allocate settlement proceeds in a manner that evades the Plan's reimbursement rights.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2)

make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

- In the case of occupational Illness or Injury, the Plan's recovery rights will apply to all sums recovered, regardless of whether the Illness or Injury is deemed compensable under any Workers' Compensation or other coverage. Any award or compromise Workers' Compensation settlement, including any lump-sum settlement, will be deemed to include the Plan's interest and the Plan will be reimbursed in first priority from any such award or settlement.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items, are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below or as otherwise required to be covered by the No Surprises Act. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of an Injury if the Plan has information that the Injury is due to a medical condition (including physical and mental health conditions and Emergencies) or domestic violence.

1. **3D Mammograms,** unless covered elsewhere in this SPD.

2. **Abdominoplasty.**

3. **Abortions:** Unless a Physician states in writing that the mother's life would be in danger if the fetus were carried to term, or unless the pregnancy is the result of incest or rape.

4. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

5. **Acupuncture Treatment.**

6. **Alternative / Complementary Treatment** including treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.

7. **Appointment Missed:** An appointment the Covered Person did not attend.

8. **Assistance With Activities of Daily Living.**

9. **Assistant Surgeon, Co-Surgeons, or Surgical Team Services,** unless determined to be Medically Necessary by the Plan.

10. **Auto Excess:** Illness or bodily Injury from a Motor Vehicle Collision for which there is a medical payment or expense provided or that is payable under any automobile coverage.

11. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins or after coverage ends under this Plan.

12. **Biofeedback Services**.

13. **Blood:** Blood donor expenses.

14. **Blood Pressure Cuffs / Monitors,** unless covered elsewhere in this SPD.

15. **Breast Pumps,** unless covered elsewhere in this SPD.

16. **Cardiac Rehabilitation** beyond Phase II, including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

17. **Cell and Gene Therapy**: Treatment, services, supplies or Prescription Drugs designed to diagnose, treat, alter, impact, or differentiate a Participant's cell or genetic make-up or cell or genetic predisposition, including but not limited to cell or genetic therapy.

18. **Claims** received later than 12 months from the date of service.

19. **Contraceptive Products and Counseling,** unless covered elsewhere in this SPD.

20. **Cosmetic Treatment, Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

21. **Court-Ordered:** Any treatment or therapy that is court-ordered, or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving-while intoxicated conviction or other classes ordered by the court.

22. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) for which the individual is charged or a felony for which the individual is charged.

23. **Custodial Care** as defined in the Glossary of Terms of this SPD.

24. **Dental Services,** unless covered elsewhere in this SPD.

25. **Developmental Delays:** Medical charges and occupational, physical, or speech therapy services related to Developmental Delays, intellectual disability, or behavioral therapy.

26. **Duplicate Services and Charges or Inappropriate Billing,** including the preparation of medical reports and itemized bills.

27. **Education:** Charges for education, special education, job training, music therapy, and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

28. **Environmental Devices:** Environmental items such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices.

29. **Examinations:** Examinations for employment, insurance, licensing, or litigation purposes.

30. **Excess Charges:** Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, the Negotiated Rate, or the fee schedule. This exclusion does not apply to payments that may be required under the No Surprises Act.

31. **Experimental, Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment. This exclusion does not apply to Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD.

32. **Extended Care:** Any Extended Care Facility services that exceed the appropriate level of skill required for treatment as determined by the Plan.

33. **Family Planning:** Consultations for family planning.

34. **Financial Counseling.**

35. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment, and health club memberships, or other utilization of services, supplies, equipment, or facilities in connection with weight control or bodybuilding.

36. **Foot Care (Podiatry):** Routine foot care.

37. **Gender Transition:** Treatment, drugs, medicines, services, and supplies for, or leading to and including, gender transition surgery.

38. **Genetic Testing or Genetic Counseling,** unless covered elsewhere in this SPD.

39. **Growth Hormones.**

40. **Home Births** and associated costs.

41. **Home Modifications:** Modifications to Your home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, or ramps.

42. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

43. **Infertility Treatment:**

- Fertility tests.
- Surgical reversal of a sterilized state that was a result of a previous surgery.
- Direct attempts to cause pregnancy by any means, including, but not limited to, hormone therapy or drugs.
- Artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT).
- Embryo transfer.
- Freezing or storage of embryo, eggs, or semen.
- Genetic testing.

This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition of, slow the harm to, alleviate the symptoms of, or maintain the current health status of the Covered Person.

44. **Intraocular Lenses Other Than Conventional Intraocular Cataract Lenses.**

45. **Lamaze Classes** or other childbirth classes.

46. **Learning Disability:** Non-medical treatment, including, but not limited to, special education, remedial reading, school system testing, and other habilitation (such as therapies)/rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

47. **Liposuction,** unless covered elsewhere in this SPD.

48. **Maintenance Therapy** if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve a condition, or if clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

49. **Mammoplasty or Breast Augmentation,** unless covered elsewhere in this SPD.

50. **Marriage Counseling.**

51. **Massage Therapy.**

52. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

53. **Military:** A military-related Illness of or Injury to a Covered Person on active military duty, unless payment is legally required.

54. **Never Events**. Treatment or services for unintended Injury or Illness resulting from an adverse consequence of care that could reasonably have been prevented, including but not limited to: foreign object left in body after surgery, surgery performed on wrong body part,

air embolism, blood incompatibility, etc. For more information see **http://www.cms.gov/HospitalAcqCond/06_HospitalAcquired_Conditions.asp#TopOfPage .**

55. **Nocturnal Enuresis Alarm** (Bed wetting).

56. **Non-Custom-Molded Shoe Inserts.**

57. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of their license.

58. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities, or equipment that reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy above.

59. **Nursery and Newborn Expenses** for a grandchild of a covered Employee or spouse.

60. **Nutrition Counseling,** unless covered elsewhere in this SPD.

61. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** unless covered elsewhere in this SPD.

62. **Over-the-Counter Medication, Products, Supplies, or Devices,** unless covered elsewhere in this SPD.

63. **Palliative Foot Care.**

64. **Panniculectomy,** unless determined by the Plan to be Medically Necessary.

65. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as, but not limited to, private rooms, televisions, telephones, and guest trays.

66. **Pharmacy Consultations.** Charges for or related to consultative information provided by a pharmacist regarding a Prescription order, including, but not limited to, information related to dosage instruction, drug interactions, side effects, and the like.

67. **Prescription Medication Written by a Physician:** A Covered Person with a written Physician's Prescription who obtains medication from a should refer to the Prescription Drug Benefits section of this SPD for coverage.

68. **Preventive / Routine Care Services,** unless covered elsewhere in this SPD.

69. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

70. **Return to Work / School:** Telephone or Internet consultations, or the completion of claim forms or forms necessary for a return to work or school.

71. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization, unless covered by the Plan in connection with Infertility Treatment.

72. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

73. **Self-Administered Services** or procedures, including self-administered or self-infused medications, that can be performed by the Covered Person without the presence of medical supervision. This exclusion does not apply to medications that, due to their characteristics (as determined by the Claims Administrator), must typically be administered or directly supervised by a Qualified Provider or licensed/certified health professional in an Outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to members for self-infusion.

74. **Services at No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

75. **Services Provided By a Close Relative.** See the Glossary of Terms section of this SPD for a definition of Close Relative.

76. **Services Provided By a School.**

77. **Sex Therapy.**

78. **Sexual Function:** Diagnostic service, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Drug Benefits section of this SPD) in connection with treatment for male or female impotence.

79. **Standby Surgeon Charges.**

80. **Subrogation.** Charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Right of Subrogation, Reimbursement, and Offset section. See the Right of Subrogation, Reimbursement, and Offset section for more information.

81. **Surrogate Parenting and Gestational Carrier Services:** Any services or supplies provided in connection with a surrogate parent, not including pregnancy and maternity charges Incurred by a covered Employee or covered spouse acting as a surrogate parent.

82. **Taxes:** Sales taxes and shipping and handling charges, unless covered elsewhere in this SPD.

83. **Telehealth.** Consultations made by a Covered Person's treating Physician to another Physician.

84. **Tobacco Addiction:** Diagnoses, services, treatment, or supplies related to addiction to or dependency on nicotine, unless covered elsewhere in this SPD.

85. **Transportation:** Transportation services that are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

86. **Travel:** Travel costs, unless covered elsewhere in this SPD.

87. **Vision Care,** unless covered elsewhere in this SPD.

88. **Vitamins, Minerals, and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

89. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning, and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

90. **Weekend Admissions** to Hospital confinement (admissions taking place after 3:00 pm on Fridays or before noon on Sundays) unless the admission is deemed an Emergency or is for care related to pregnancy that is expected to result in childbirth.

91. **Weight Control:** Treatment, services, or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling. This exclusion does not apply to specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.

92. **Wigs (Cranial Prostheses), Toupees, Hairpieces, Hair Implants or Transplants, or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss, unless covered elsewhere in this SPD.

93. **Workers' Compensation:** An Illness or Injury arising out of, or in the course of, any employment for wage or profit not including self-employment, for which the Covered Person was entitled to benefits under any Workers' Compensation, U.S. Longshoremen and Harbor Workers' or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force. If You are an Employee with a second job

or if You are covered as a Dependent under this Plan and You are self-employed or employed by an employer that does not provide health benefits, Your claims may not be covered by the health plan. You will need to have other medical benefits to provide for Your medical care in the event that You are hurt on the job. In most cases, Workers' Compensation insurance will cover Your costs, but if You do not have such coverage You may end up with no coverage at all.

94. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

The Plan does not limit a Covered Person's right to choose their own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures ensure that claim determinations are made in accordance with the Plan documents. Plan provisions will be applied consistently to similarly situated individuals.

Pre-Determination

A Pre-Determination is a benefit decision made by the Claims Administrator, on the Plan's behalf, before services are provided. Pre-Determinations are not required, but a Covered Person or provider may request one. A Pre-Determination informs individuals if, and under what circumstances, a procedure or service is generally covered. Requesting a Pre-Determination before incurring medical expenses is optional. A Pre-Determination is not a claim and cannot be appealed. A Pre-Determination does not guarantee payment; all Plan terms and conditions will still apply when the claim is submitted.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim:** A claim for benefits requiring Prior Authorization as stated in the Plan and this SPD. Covered Persons or providers must obtain Plan approval before certain medical care. Calls to check coverage are not Pre-Service Claims unless Prior Authorization is required. Prior Authorization does not guarantee payment.

  Note: The Plan does not require Prior Authorization for urgent or Emergency care claims, but notification may be required after stabilization. Urgent or Emergency care is a sudden, serious condition where a Prudent Layperson would expect the patient's life is at risk, the patient would suffer severe pain, or serious impairment of bodily functions would result without immediate care. Examples include, but are not limited to: chest pain, hemorrhaging, syncope, fever ≥103° F, foreign body in the throat/eye/internal cavity, or severe allergic reaction.

- **Post-Service Claim**: A claim for payment of health care already provided.

- **Concurrent Care Claim:** A claim for ongoing treatment previously approved by the Plan.

PERSONAL REPRESENTATIVE

A "Personal Representative" is a person or provider authorized to contact the Plan on the Covered Person's behalf regarding claims, appeals, or benefits. A minor Dependent must have a parent or Legal Guardian's signature to appoint a third-party Personal Representative.

To appoint a Personal Representative, the Covered Person must submit documentation to the Plan stating: the name, appointment duration, and any other pertinent details. The Covered Person must also agree to grant access to their PHI. Contact the Claim Administrator for the proper forms. All forms must be signed by the Covered Person.

ASSIGNMENT OF BENEFITS

The Plan may, in its sole discretion, make payment directly to a provider for Covered Expenses. Any such payment will discharge the Plan's obligation to the extent of the payment. Except as required by a Qualified Medical Child Support Order, a Covered Person may not assign, pledge, or transfer any right to benefits or payment under this Plan, and any purported assignment shall be void and unenforceable. The Plan may offset any overpayments or other amounts owed to the Plan against future benefit payments.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers coordinate payment directly with the Plan. If not, the Covered Person must submit the claim within the timelines below to receive reimbursement. Medical claim submission addresses are on the back of the group health ID card. For Prescription benefits, a claim is filed when submitted per Pharmacy benefit terms in this SPD. Contact information for Prescription claims is on the ID card. If a Pharmacy refuses to fill a Prescription, call the number on the card for instructions.

For services outside the U.S., the Covered Person is responsible for payment if the provider does not coordinate with the Plan. Submit the claim to the Plan for reimbursement in U.S. currency, based on the exchange rate on the payment or service date.

A complete claim must include:

- Covered Person's/patient's ID number, name, sex, date of birth, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services, or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient's account number (if applicable)
- Total billed charges
- Provider's billing name, address, and telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto Accident, or another Accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons must submit complete claims to the Third-Party Administrator as soon as possible, but no later than 12 months from the date of service. If Medicare/Medicaid paid as primary in error, the deadline extends to three years. A Veterans Administration Hospital has six years. Prescription claim forms are available at FairosRx.com or by calling the number on the card. A claim is complete when all necessary information is provided. Claims received after the deadline will not be paid.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative does not properly follow the Plan's prior authorization procedures, the Plan will notify them and explain the correct process within five calendar days of receiving the request. Notice is usually oral unless written notice is requested.

HOW HEALTH BENEFITS ARE CALCULATED

When Vault Admin Services receives a claim, it determines if the service is covered. If not, the claim is denied, and the Covered Person is responsible for payment. If covered, Vault Admin Services calculates the allowable payment per this SPD.

Covered benefits are paid based on billed charges, a Negotiated Rate, the Protection from Balance Billing amount, or Usual and Customary amounts, minus any Deductible, Plan Participation, Copays, or penalties. See the Protection from Balance Billing section for details.

Negotiated Rate: Sometimes, Vault Admin Services negotiates payment rates for specific services. The Plan pays the Negotiated Rate minus Copays, Deductibles, Plan Participation, or penalties owed by the Covered Person. If a Network contract exists, it determines the Negotiated Rate.

Modifiers: When multiple services are performed on the same day, Network providers are paid per contract; non-Network providers are paid the Usual and Customary fee for the primary procedure and a percentage for secondary procedures, per Plan provisions. Global package services are not billed separately.

Reimbursement for non-Network providers is based on:

- Fee(s) that are negotiated with the Physician or facility; or
- The amount that is usually accepted by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or materials; or
- Current publicly available data reflecting the costs for health care providers providing the same or similar services, treatment, or materials adjusted for geographical differences plus a margin factor; or
- A multiple of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

- A gap methodology may be utilized when CMS does not have rates published for certain procedural codes; or
- 50 percent of the provider's billed charges when unable to obtain a rate published by CMS and/or gap methodology does not apply.

The repriced amount for non-Network claims may be determined using proprietary data sources and methodologies, which are considered confidential and are not subject to disclosure. The Plan and its administrators will not provide the exact repricing calculation or underlying proprietary data used in determining the allowable amount.

When covered health services are received from a non-Network provider as a result of an Emergency or as arranged by Your Plan Administrator, eligible expenses are amounts negotiated by Your Claims Administrator or amounts permitted by law. Refer to the Protection from Balance Billing section of this SPD for more information. Please contact Your Plan Administrator if You are billed for amounts in excess of Your applicable Plan Participation, Copays, or Deductibles. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

See "Surgery and Assistant Surgeon Services" in the Covered Medical Benefits section for exceptions related to multiple procedures. A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

Non-Network providers charge their normal rates for services, so Covered Persons may need to pay more. Covered Persons are responsible for paying the balance of these claims after the Plan pays its portion, if any.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is not fully covered, the Covered Person will receive an Explanation of Benefits (EOB) showing the Plan's payment and the Covered Person's responsibility. Check each EOB for accuracy. For questions, call the number on the EOB or ID card. Providers receive a similar form.

For Prescription benefits, an EOB is sent when a claim is filed directly with FairosRx.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

Vault Admin Services will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

- Pre-Service Claims: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may have an extra 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.

- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the treatment ending or being reduced.
- Emergency and/or Urgent Care claims as defined by the Affordable Care Act: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan and deference will be made to the treating Physician.

A claim is considered to be filed when the claim for benefits has been submitted to Vault Admin Services for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person’s loss of eligibility for coverage under the health Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group health Plan.
- Termination of the group health Plan.
- The Employee, Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Protection from Balance Billing allowed amount, the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered Experimental, Investigational, or Unproven.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is denied in whole or in part and the Covered Person owes any amount, an Explanation of Benefits (EOB) will be provided within the timelines described above. The EOB will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person may take to submit the claim for appeal (review).

If an internal rule, guideline, or Medical Necessity determination was used, the Plan will inform the Covered Person, who may request a copy of the rule/guideline or clinical criteria free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with a claim denial or rescission, they or their Personal Representative may request a review by submitting a written appeal. Appeals filed by providers are only valid if the provider is a Personal Representative. The claimant has 180 days from the initial Adverse Benefit Determination to file a first level appeal.

(a) Full and Fair Review of All Claims. In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The Plan provides for three levels of appeal following an Adverse Benefit Determination (two levels of appeals and the opportunity to initiate arbitration). The claimant has 4 months following an Adverse Benefit Determination in connection with the first level appeal to file a second level appeal of that determination, and 60 days following a second Adverse Benefit Determination to file a third level appeal of that determination. The appeal process will provide the claimant with a reasonable opportunity for a full and fair review of the claim and Adverse Benefit Determination and will include the following:

(i) Receipt of written request by the TPA from the claimant, or an Authorized Representative of the claimant, in the proper form for review of Adverse Benefit Determination, which initiates the appeal process.

(ii) The claimant will have the opportunity to submit written comments, documents,

records, and other information relating to the claim.

(iii) The claimant will have the opportunity to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

(iv) The claimant will be provided, free of charge and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale.

(v) The claimant will be provided, on request and free of charge: (i) reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim in possession of the Plan Administrator, the Claims Delegate or the TPA; (ii) information regarding any rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination; (iii) information regarding any voluntary appeals procedures offered by the Plan; (iv) information regarding the claimant's right to an external review process; and (v) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances.

(vi) The review of the Adverse Benefit Determination will take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

(vii) No deference will be afforded to the previous Adverse Benefit Determination.

(viii) The party reviewing the appeal, which shall be conducted or supervised by an appropriate named fiduciary of the Plan, may be neither the party who made the prior Adverse Benefit Determination, nor a subordinate of the party who made the prior Adverse Benefit Determination.

(ix) In deciding an appeal on which the Adverse Benefit Determination was based in whole or in part on a medical judgment, including whether a particular medical care is experimental, investigational, or not Medically Necessary or appropriate, the TPA, the Claims Delegate or the Plan Administrator, as appropriate depending on the level of appeal, will consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment. The health care professional consulted for the appeal will not be the health care professional or a subordinate of the health care professional consulted in connection with the Adverse Benefit Determination that is the subject of the appeal.

(x) Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be identified, even if the Plan did not rely upon their advice.

The Plan has allocated, delegated and granted to the Claims Administrator primary responsibility and authority for all first level appeals of Adverse Benefit Determinations for claims ("Claim Level I Appeals").

(b) Requirements for First Level Appeal.

The claimant has 180 days from the initial Adverse Benefit Determination to file a first level appeal. All Claim Level I Appeals of Adverse Benefit Determinations on any claim must be sent to the Claims Administrator, and must be addressed as follows:

Vault Admin Services
Attention: Level I Appeals
4022 E. Greenway, Ste. 11-12
Phoenix, Arizona 85022
Phone: (877) 424-2366

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

(i) The name of the Participant;
(ii) The Participant's unique identifier;
(iii) The group name or identification number;
(iv) All facts and theories supporting the claim for benefits;
(v) A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
(vi) Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

(c) Second Appeal Process: External Review. A claimant may request external review of the Plan's Adverse Benefit Determination following the first appeal. To do so, the claimant must file a request for external review ("Claim Level II Appeal") within four (4) months after receiving notice of the Plan's Adverse Benefit Determination on the first appeal. All Claim Level II Appeals must be sent to the Claims Administrator and must be addressed as follows:

Vault Admin Services
Attention: External Review
4022 E. Greenway, Ste. 11-12
Phoenix, Arizona 85022
Phone: (877) 424-2366

(i) Standard External Review. Within 5 business days following the date of receipt of the external review request, a preliminary review of the request will be performed to determine whether the claim is eligible for external review. Claims eligible for external review are only those that involve (a) medical judgment (excluding those that involve

only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer; or (b) rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time). Furthermore, a claim is not eligible for external review if:

- the claimant is (or was) not covered under the Plan at the time the health care item or service is (or was) requested or, in the case of a retrospective review, the claimant was not covered under the Plan at the time the health care item or service was provided;
- the Adverse Benefit Determination is based on the fact that the claimant was not eligible for coverage under the Plan (except where the claim relates to medical judgment or a rescission of coverage);
- the claimant has not exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); or
- the claimant has not provided all the information and forms required to process an external review.

The claimant will be notified of the results of the preliminary review within one business day after completion of the preliminary review. If the request is incomplete, the notice must describe the information, materials, etc. needed to complete the request, and set forth the time limit for the claimant to provide the additional information needed (the longer of the initial four-month period within which to request an external review or, if later, 48 hours (or such longer period specifically identified in the notice) after the receipt of the notice).

If the claim is eligible for external review, an Independent Review Organization (IRO) will be assigned by the Claims Administrator to conduct the external review.

(ii) Expedited External Review. Expedited external review may be requested when:

- an Adverse Benefit Determination involves a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the claimant's life, health, or ability to regain maximum function, and a request for an expedited internal appeal has been filed; or
- a final internal Adverse Benefit Determination involves (a) a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the claimant's life, health, or ability to regain maximum function; or (b) an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility

The request for an expedited external review must be made in writing to the Plan Administrator at the address indicated above. Immediately upon receipt of the request for an expedited external review, a determination will be made as to whether the request meets the requirements described above for a standard external review, the claimant will be notified of the determination, and, if the request meets the requirements, an IRO will be assigned as described above for a standard external review.

(iii) External Review by IRO.

(A) Providing Information to IRO. The Company will timely (in the case of an expedited external review, expeditiously) provide to the IRO documents and any information considered in making the Adverse Benefit Determination. The claimant may submit additional information in writing to the IRO within 10 business days of the IRO's notification that it has been assigned the request for external review.

(B) IRO Review. The IRO will review all of the information and documents timely received. In making its decision, the IRO is not bound by the Plan's prior determination. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

- the claimant's medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and other documents submitted by the Plan, the claimant, or the claimant's treating health care provider;
- the terms of the claimant's summary plan description;
- evidence-based practice guidelines;
- any applicable clinical review criteria developed and used by the Plan; and
- the opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

(C) Notification of IRO Decision. The IRO will provide written notice of the final external review decision to the claimant and the Plan within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision. To the extent the final external review decision reverses the Plan's decision (as was reflected in the notice of Adverse Benefit Determination), the Plan shall follow the final external review decision of the IRO (but may initiate judicial review as described below).

(d) Third and Final Level of Appeal – Binding Arbitration through AAA.

(i) Right to Arbitration. If the claimant is dissatisfied with the Claim Level II Appeal determination, the claimant may request a final and binding appeal through the American Arbitration Association (AAA) (such appeal, a "Claim Level III Appeal"). This request must be submitted in writing within sixty (60) days after receipt of the Claim Level II Appeal decision.

(ii) Administration. The arbitration shall be administered by the AAA in accordance with its Employment Arbitration Rules and Mediation Procedures or other applicable rules governing benefit disputes, as modified herein. The arbitration shall be conducted virtually by a single neutral arbitrator selected in accordance with AAA procedures.

(iii) Scope of Review. The arbitrator shall have authority to review the claim de novo and to interpret and apply the terms of the Plan, ERISA, the Affordable Care Act, and any other applicable law. The arbitrator shall have authority to order the payment of benefits due under the Plan and any other relief permissible under ERISA § 502(a).

(iv) Binding Effect. The arbitrator shall have authority to review the claim de novo and to interpret and apply the terms of the Plan, ERISA, the Affordable Care Act, and any other applicable law. The arbitrator shall have authority to order the payment of benefits due under the Plan and any other relief permissible under ERISA § 502(a).

(v) Costs. The Plan shall bear the administrative costs and arbitrator's fees of the arbitration, except that each party shall be responsible for its own attorneys' fees, unless otherwise awarded by the arbitrator pursuant to ERISA § 502(g).

(vi) Exhaustion of Remedies. Submission to AAA arbitration shall constitute the final level of internal appeals under the Plan's internal claims and appeals procedure. A claimant shall be deemed to have exhausted the Plan's administrative remedies upon completion of arbitration, after which the claimant may pursue judicial remedies, if available, under ERISA or other applicable law.

(e) Appointment of Authorized Representative. A claimant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of an Adverse Benefit Determination; provided, however, that an Assignment of Benefits by a claimant to a Hospital or Physician of the medical care will not constitute appointment of that Hospital or Physician of the medical care as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Claims Delegate or the TPA. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Participant's medical condition to act as the Participant's authorized representative without completion of this form. In the event a claimant designates an authorized representative, all future communications from the Plan concerning that claim will be with the representative, rather than the claimant, unless the claimant directs the Claims Delegate or the Plan Administrator, in writing, to the contrary.

(f) Service Appeal Rights. As noted above, while a claimant may appoint the Hospital or Physician of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied claim, an Assignment of Benefits by a claimant to a Hospital or Physician of service will not constitute appointment of that Hospital or Physician as an Authorized Representative. However, in an effort to facilitate a full and fair review of the denied claim, the Plan will consider an appeal received from the Hospital or Physician as a claimant's appeal, and will respond to the Hospital or Physician (and the claimant) with the results of the review accordingly. Any such appeal must be made within the time limits and under the conditions for filing an appeal specified under the section, "Appeal Process," above. Any Hospital or Physician that accepts Assignment of Benefits, in accordance with this Plan, has agreed to accept and is deemed for all purposes to have

accepted such Assignment of Benefits as consideration in full for services rendered, and has agreed to and shall be bound by the rules and provisions set forth within the terms of this document. Similarly, **Hospitals or Physicians filing an appeal of an Adverse Benefit Determination under the Plan, other than as a formally appointed Authorized Representative, must agree, and by filing an appeal shall be deemed to agree: (i) to pursue reimbursement for medical care covered under the Plan directly from the Plan, further waiving any right to recover such expenses from the claimant, and (ii) to comply with the conditions of the section "Requirements for Appeal" above. The claimant is specifically intended to be and shall be a third-party beneficiary of the agreements referenced in (i) and (ii) above.** Any Hospital or Physician filing an appeal of an Adverse Benefit Determination under the Plan that then pursues recovery from the claimant, on any legal or equitable theory, shall be acting in violation of this Plan and shall be required to immediately refund in full any and all amounts paid to or for the benefit of such Hospital or Physician by or on behalf of the Plan in connection with the claim in question.

For purposes of this section, the Hospital's or Physician's waiver to pursue medical care covered under the Plan does not include the following amounts, which will remain the responsibility of the claimant:

(i) Deductibles;
(ii) Copayments;
(iii) Coinsurance;
(iv) Penalties for failure to comply with the terms of the Plan; and
(v) Charges for medical care which is not included for coverage under the Plan.

Note: This does not apply to amounts found to be in excess of the Maximum Allowable Charge, as defined in the section, "Review of Claims The claimant should not be held responsible for any amounts found to be in excess of the Maximum Allowable Charge.

Contact the Third-Party Administrator or the Plan Administrator for additional information regarding Hospital or Physician of service appeals.

LEGAL ACTIONS FOLLOWING APPEALS

You must complete all required internal appeal levels (which includes Claim Level I Appeals, Claim Level II Appeals, and Claim Level III Appeals) before initiating any legal or equitable action regarding a claim for benefits under this Plan. No action may be commenced or maintained unless and until You have fully exhausted the internal claims and appeals procedures and received a final adverse determination. **No action may be filed against the Plan or Plan Sponsor later than two (2) years from the date of the final internal adverse determination.**

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

LOST DISTRIBUTEES

If a Covered Person cannot be located after reasonable efforts, benefits may be forfeited. If a timely claim is later made, benefits will be reinstated in accordance with the Plan's claim filing rules.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else, such as the Covered Person's spouse or another family member, files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on their knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under their identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. They should answer all questions to the best of their knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the Participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for a 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).

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- Americans With Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Employee Retirement Income Security Act regarding coverage of Dependent Children in cases of adoption or Placement for Adoption.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- Genetic Information Non-discrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not Use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees, or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Human Resources

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy, and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate ("BA") in relationship to a Covered Entity ("CE") means a person to whom the CE Discloses PHI so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, third-party administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Claims Delegate means a person or entity selected by the Third-Party Administrator.

Covered Entity is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical records, billing records, enrollment

records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information ("Electronic PHI") is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or there is reasonable basis to believe the information can be used to identify the Covered Person.

Participant means any Employee or Dependent who is eligible for benefits under the Plan as defined in the Eligibility Requirements provision of this document and is enrolled in the Plan.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

Plan Sponsor means Your Employer.

Plan Year means the 12-month period commencing and ending on the dates indicated on the General Plan Information page in this document.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

GLOSSARY OF TERMS

ABA / IBI / Autism Spectrum Disorder Therapy means intensive behavioral therapy programs used to treat Autism Spectrum Disorder. These programs are often referred to as Intensive Behavioral Intervention (IBI), Early Intensive Behavioral Intervention (EIBI), or Applied Behavior Analysis (ABA). These interventions aim to reduce problem behaviors and develop alternative behaviors and skills in those with Autism Spectrum Disorder. In a typical therapy session, the Child is directed to perform an action. Successful performance of the task is rewarded with a positive reinforcer, while noncompliance or no response receives a neutral reaction from the therapist. For Children with maladaptive behaviors, plans are created to utilize the use of reinforcers to decrease problem behavior and increase more appropriate responses. Although once a component of the original Lovaas methodology, aversive consequences are no longer used. Parental involvement is considered essential to long-term treatment success; parents are taught to continue behavioral modification training when the Child is at home, and may sometimes act as the primary therapist.

Accident means an unexpected, unforeseen, and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, or to treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Advanced Imaging means the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology such as MRA, MRI, CT, or PET scans and nuclear medicine.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation, or when deemed Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Refer to the Protection from Balance Billing section of this SPD for the No Surprises Act requirements specific to air ambulance.

Ancillary Services means services rendered in connection with care provided to treat a medical condition whether scheduled or unscheduled, including, but not limited to: surgery, anesthesia, diagnostic testing, and imaging or therapy services. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency. With respect to the Protection from Balance Billing section, Ancillary Services means items and services provided by non-Network Physicians at Network facilities that are related to Emergency medicine, anesthesiology, pathology, radiology, neonatology, laboratory services, or diagnostic services; provided by assistant surgeons, hospitalists, and intensivists; or provided by a non-Network Physician when a Network Physician is not available.

Birthing Center means a legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse’s Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes the Employee, spouse, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, stepchildren, and grandchildren.

Center(s) of Excellence mean those centers, facilities or providers as determined by the Vault Cares Network.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to qualifying events.

Copay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

Common-Law Marriage means a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

Cosmetic Treatment means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expense means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan. Details regarding Covered Expenses that are health care services subject to the federal No Surprises Act protections are provided in the Protection from Balance Billing section of this SPD.

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

Custodial Care means non-medical care given to a Covered Person, such as administering medication and assisting with personal hygiene or other Activities of Daily Living, rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve the condition of a Covered Person.

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see the Eligibility and Enrollment section of this SPD.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills. Developmental Delay may not necessarily have a history of birth trauma or other Illness that could be causing the impairment, such as a hearing problem, mental Illness, or other neurological symptoms or Illness.

Domestic Partner / Domestic Partnership means an unmarried person of the same or opposite sex with whom the covered Employee shares a committed relationship, who is jointly responsible for the other's welfare and financial obligations, who is at least 18 years of age, who is not related by blood, who maintains the same residence, and who is not married to or legally separated from anyone else.

Durable Medical Equipment means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It is generally not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

A cochlear implant is not considered Durable Medical Equipment.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as their Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency means a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the first day of the Waiting Period.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and applicable regulations.

Experimental, Investigational, or Unproven means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™, or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility means a facility including, but not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: provide 24-hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; require compensation from its patients; admit patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintain adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provide the services to which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Gender Dysphoria means a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Health Savings Account (HSA) (May not apply to all plan designs) means a tax-exempt account administered by a Qualified HSA trustee or custodian, established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a QHDHP, has no other impermissible coverage under IRS rules, is not entitled to benefits under Medicare, and is not claimed as a Dependent on another person's tax return. See Qualified High Deductible Health Plan.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Home Health Care means a formal program of care and intermittent treatment that is: performed in the home; prescribed by a Physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care

Facility stay; organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician that is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours per day, 7 days per week; is certified by Medicare as a Hospice Care Agency; and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services, medical social worker services, psychological and dietary counseling, Physician services, physical or occupational therapy, home health aide services, pharmacy services, and Durable Medical Equipment.

Hospital means a facility that:

- Is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, the term "Hospital" also includes Surgical Centers and Birthing Centers licensed by the states in which they operate.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the Employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the Employer who is not an Employee or an officer of the Employer, and who retains control over how work is completed. The Employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital. A person is not Inpatient on any day on which they are on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas, including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Manipulation means the act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

Maximum Benefit means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

Medical Specialty Medications (including gene therapy and CAR-T therapy) means Prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Medical Specialty Medications often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, substance use disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, disease, or symptoms; and
- Clinical factors used when reviewing Medical Necessity for Specialty Drugs may include review of the progress in use or therapy as compared to other similar products or services, Site of Care, relative safety or effectiveness of Specialty Drugs, and any applicable prior authorization requirements.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available,

observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within our sole discretion.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Mental Health Disorder means a syndrome that is present in an individual and that involves clinically significant disturbance in behavior, emotion regulation, or cognitive functioning. These disturbances are thought to reflect a dysfunction in biological, psychological, or developmental processes that are necessary for mental functioning.

Morbid Obesity means a condition in which an individual 18 years of age or older has a body mass index of 40 or more, or 35 or more if experiencing health conditions directly related to their weight, such as high blood pressure, diabetes, sleep apnea, etc.

Motor Vehicle Collision means an Accident that occurs when a motor vehicle strikes or collides with another vehicle, a stationary object, a pedestrian, or an animal with no implied determination of fault.

Multiple Surgical Procedures means that more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Network Pharmacy means a licensed entity, acting within the scope of its license in the state in which it dispenses, that has entered into a written agreement with FairosRx and has agreed to provide services to covered individuals for the fees negotiated in the agreement.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliance means a brace, splint, cast, or other appliance that is used to support or restrain a weak or deformed part of the body, that is designed for repeated use, that is intended to treat or stabilize a Covered Person's Illness or Injury or improve function, and that is generally not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services, or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who performs services payable under this Plan: a doctor of medicine (MD); doctor of medical dentistry, including an oral surgeon (DMD); doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); doctor of optometry (OPT). Subject to the limitations below, the term "Physician" also includes the following practitioner types:
physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which they practice, the services being provided are within their scope of practice, and the services are payable under this Plan.

Placed for Adoption / Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the Health Benefit Plan sponsored and maintained by the Plan Sponsor.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom it is prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by

applicable law. Benefits included as Preventive / Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive / Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive / Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

> **(May not apply to all plan designs)** For a Qualified High Deductible Health Plan (QHDHP), Preventive / Routine Care means care consistent with IRS Code §223(c)(2)(c) and as listed in the Schedule of Benefits, that may be paid by a QHDHP without the Covered Person satisfying the minimum Deductible under the Plan.

Primary Care Physician means a Physician engaged in family practice, general practice, nonspecialized internal medicine (i.e., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology, or the treatment of mental health/substance use disorders, or a Physician assistant / nurse practitioner regardless of specialty or practice type. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat Children.

Private Duty Nursing (PDN) means continuous and skilled care by a registered nurse (RN) or licensed practical nurse (LPN) under the direction of a Qualified practitioner for a medical condition that requires more than four continuous hours of skilled care that can be provided safely outside of an institution. It does not include care provided while confined at a Hospital, Extended Care Facility, or other Inpatient facility; care to help with Activities of Daily Living, including, but not limited to, dressing, feeding, bathing, or transferring from a bed to a chair; or Custodial Care.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified High Deductible Health Plan (QHDHP) (May not apply to all plan designs) means a health plan that meets the IRS requirements of a High Deductible Health Plan with respect to Deductibles and out-of-pocket amounts for the purpose of being able to contribute to a HSA. See Health Savings Account.

Qualified Provider (or Provider) means a provider duly licensed, registered, and/or certified by the state in which they are practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

Recognized Amount means, in the Plan's determination of the allowed amount payable for covered services subject to Protection from Balance Bills, the amount on which Copays, Plan Participation, and applicable Deductibles are based for the below covered health services when provided by non-Network providers:

- Non-Network Emergency health services.
- Non-Emergency covered health services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, the term "certain network facility" is limited to a Hospital (as defined in section 1861(e) of the Social Security Act), a Hospital Outpatient department, a critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act), and any other facility specified by the Secretary of Health and Human Services.

The amount is based on either:

- an All Payer Model Agreement if adopted,
- state law, or
- the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

Note: Covered health services that use the Recognized Amount to determine Your cost-sharing may be higher or lower than if cost-sharing for these covered health services was determined based upon a Covered Expense.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

Site of Care means the treatment location where services are rendered, for example, Outpatient Hospital, community office, ambulatory infusion site, or home-based settings.

Specialist means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians who are not considered Specialists include, but are not limited to, those specified in the definition of Primary Care Physician above.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide

Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.

Telemedicine means the clinical services provided to patients through electronic communications utilizing a vendor.

Temporomandibular Joint Disorder (TMJ) means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third-Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means, as determined by the Plan in its sole discretion:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is qualified by education, training, or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Diagnosis of one or more of the following conditions is not considered proof of total disability. Conditions are listed in the most recent DSM or the most recent revision of the International Classification of Diseases - Clinical Modification manual in the following categories:

- Personality disorders; or
- Sexual/gender identity disorders; or
- Behavior and impulse control disorders; or
- "Z" codes.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often

Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

Waiting Period means the period of time that must pass before coverage becomes effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan. Refer to the Eligibility and Enrollment section of this Plan to determine if a Waiting Period applies.

Walk-In Retail Health Clinics means health clinics located in retail stores, supermarkets, or pharmacies that provide a limited scope of preventive and/or clinical services to treat routine family Illnesses. Such a clinic must be operating under applicable state and local regulations and overseen by a Physician where required by law.

You / Your means the Employee.