SUMMARY PLAN DESCRIPTION

F&W Transportation, Inc.

Medical and Prescription Drug Benefits Plan
Gravie Copay $6,500 Ded/$8,500 OOPM

Aetna Signature Administrators® PPO Network

Plan Year 2026

This SPD is approved by Employer for use as the final form of the SPD.

BY: Scott Rodgers
Scott Rodgers (May 4, 2026 08:29:03 EDT)

DATE: May 4, 2026

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Welcome to Your Health Plan

On behalf of Gravie, we're excited to welcome you to a new year of your health plan. Whether you're a new Member or continuing your membership, we're proud to partner with your employer to help you navigate your healthcare and benefits with ease and confidence.

Gravie: Your Plan's Claims Administrator

As the designated Claims administrator of your employer's health plan, Gravie is here to ensure your plan is administered accurately and efficiently. Our primary responsibility is to manage the administrative aspects of your benefits, including:

- **Processing Claims:** We handle medical Claims to make sure they are paid based on your plan's coverage.
- **Answering Your Questions:** We help you understand your benefits, explain how your plan works, and answer any questions you may have about your coverage or Claims.
- **Providing Support:** Our team is dedicated to providing friendly and knowledgeable support to help you make the most of your benefits.

What This Means for You

When you receive care, your healthcare providers will typically submit Claims to Gravie. We will review these Claims based on your plan details to determine coverage and process payments accordingly. If you have a question about a bill you've received, the status of a Claim, or how a particular service is covered, please don't hesitate to reach out to us.

This Summary Plan Description (SPD) contains important details about your plan, including eligibility, covered services, exclusions, and how to file a Claim. We encourage you to read it thoroughly to understand your coverage fully.

We are committed to making your benefits experience as simple and transparent as possible. Thank you for choosing Gravie. We're glad to be a part of your healthcare journey.

Sincerely,

The Gravie Team

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Introduction

How to Use This Document

This Summary Plan Description (SPD) is intended to help you understand the health benefits under the self-insured health and welfare plan established by your Employer or the Plan Sponsor, as applicable (the "Plan"). It explains what the Plan covers, how benefits work, and what steps you need to take to receive Benefits.

We encourage you to read this SPD carefully and keep it for future reference. The SPD contains important information about:

- Who is eligible for coverage;
- How to enroll in the Plan;
- What Healthcare Services are covered;
- What Healthcare Services are excluded;
- How to file a Claim and appeal Adverse Benefit Determinations; and
- Your rights and responsibilities under the Plan.

If you have questions about this SPD or your benefits, contact F&W Transportation, Inc. at (706) 796-3342 ext. 209.

Important Information about this Document

This document is intended to serve as the Summary Plan Description (SPD) for the Plan, as required by the Employee Retirement Income Security Act of 1974 (ERISA).

In the event of any ambiguity or conflict within this document, the Plan Administrator (as defined below) has discretionary authority to interpret the Plan and make final decisions regarding eligibility for Benefits, coverage, and the amount of Benefits payable, consistent with applicable law.

The Plan Sponsor (as defined below) reserves the right to amend, modify, or terminate the Plan at any time, in whole or in part, subject to applicable legal requirements.

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Plan Overview

Plan Information

Plan Name: F&W Transportation, Inc. Group Health Plan
Type of Plan: Health and Welfare Benefit Plan
Plan Number: 501
Plan Year: The year beginning on the first day of June and ending on the last day of May
Plan Administrator: F&W Transportation, Inc., located at 4197 Mike Padgett Hwy, Augusta, GA 30906
Plan Sponsor: F&W Transportation, Inc., located at 4197 Mike Padgett Hwy, Augusta, GA 30906
Plan Sponsor and Plan Administrator mailing address: 4197 Mike Padgett Hwy, Augusta, GA 30906
Agent for Service of Legal Process: F&W Transportation, Inc., located at 4197 Mike Padgett Hwy, Augusta, GA 30906
Employer Identification Number (EIN): 52-2051178

About the Plan

The Plan is a self-insured employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). The Plan is intended to meet the requirements of Sections 105(b), 105(h) and 106 of the Internal Revenue Code so that the portion of the cost of coverage paid by the Employer, and any Benefits received by a Member through the Plan, are not taxable income to the Member. The specific tax treatment of any Member will depend on their individual personal circumstances; the Plan does not guarantee any particular tax treatment and Members are solely responsible for any and all federal, state, and local taxes attributable to their participation. The Plan expressly disclaims any liability for such taxes.

Non-Grandfathered Status of Plan

The Plan is a Non-Grandfathered Health Plan under the Affordable Care Act (ACA) and is subject to all applicable ACA requirements, including coverage for Preventive Services without Cost-Sharing, External Review rights, limits on annual Cost-Sharing, and other consumer protections.

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Compliance With Applicable Law

The Plan is designed and intended to comply with all applicable federal and state laws and their corresponding regulations governing employee health benefit plans. This includes, but is not limited to, the Internal Revenue Code (IRC), the Affordable Care Act of 2010 (ACA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity and Addiction Equity Act (MHPAEA), the Newborns' and Mothers' Health Protection Act (NMHPA), the Women's Health and Cancer Rights Act (WHCRA), the Genetic Information Nondiscrimination Act (GINA), and the Uniformed Services Employment and Reemployment Rights Act (USERRA).

This Plan is established and maintained in accordance with the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, and is intended to comply with all applicable ERISA requirements.

The Plan shall be construed, operated, and administered at all times in a manner consistent with these laws and any other applicable legal requirements. In the event of any conflict between any part or provision of the Plan and applicable federal or state law, the provisions of that law shall be deemed controlling. Any conflicting Plan provision shall be superseded to the extent of the conflict.

Plan Funding

The Plan is a self-insured employee welfare benefit plan established by the Plan Sponsor. Benefits are paid directly from the Employer’s general assets and are not guaranteed by an insurance company. No separate trust or fund is established for the payment of Benefits under the Plan.

If required by the Employer, eligible Employees may make contributions toward the cost of coverage. These contributions may be made pre-tax through the Employer's Section 125 Cafeteria Plan (if applicable) or after-tax, as determined by the Employer. All Employee contributions are paid directly to the Employer. The Employer funds and provides contributions for the cost of coverage and will inform Employees of their share of the contribution, if any, which will be used to reimburse the Employer for the cost of coverage it provided.

Claims Administrator

The Employer has contracted with a Claims Administrator to perform certain administrative services related to the Plan. Gravie Administrative Services LLC (“Gravie”) is the Claims

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Administrator and will process Claims, manage the network of Healthcare Providers, and answer medical Benefit and Claims questions. Gravie is not an insurer of Benefits under the Plan, nor does it underwrite the risk or otherwise assume any risk for the payment of Benefits under the Plan.

For assistance with Claims, Benefits, or general inquiries, you may visit Gravie's website at www.gravie.com/member or contact Gravie Care® at 866.863.6232, weekdays, 8 a.m. to 5 p.m. CST.

Gravie's mailing address is:
Gravie Administrative Services LLC
P.O. Box 211543
Eagan, MN 55121

Other Key Partners

To provide seamless benefits on behalf of the Plan, Gravie also utilizes other Service Providers for administrative and support functions, including Claims processing, network access, and specialized member programs. Key partners are detailed below.

Partner	Role & Service Provided	How to Contact/Access
Provider Network	Aetna Signature Administrators® PPO.	Search for providers in your network by visiting: https://www.aetna.com/individuals-families/find-a-doctor.html
Express Scripts® Pharmacy Benefit Services	Express Scripts® is Evernorth's pharmacy benefit services business and manages your pharmacy benefits and prescription drug Claims.	For more information, call 1-877-608-0355 or visit express-scripts.com to create an account. The Plan's Prescription Drug Formulary may be found here: www.expressscripts.com/gravie.
Accredo® Specialty Pharmacy	A Specialty Pharmacy providing services such as scheduled medication delivery and refill reminders.	Phone: 1-877-605-2001, Monday-Friday, 8 AM to 8 PM ET.

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Teladoc Health®	A designated virtual care network that offers telehealth services to Members via phone or video.	For more information, call 1-855-Teladoc (1-855-835-2362) or visit www.teladoc.com
Sword Thrive	Virtual treatment for back, joint, and muscle pain.	For more information, email help@swordhealth.com or call 888-492-1860 (Monday through Friday, 9 AM – 6 PM ET). You may also contact Gravie Care® with questions.
American Health Holding Inc. (AHH)	The Plan's Utilization Administrator. Performs utilization management services including Prior Authorization, Medical Necessity reviews/appeals, and case management for certain services under the medical benefit.	Submit requests to AHH by calling 833-462-0102 or by visiting https://www.getprecert.com/
Zerigo Health	A care delivery program for chronic skin conditions such as eczema or psoriasis. care delivery for chronic skin conditions.	Visit zerigohealth.com/gravie to sign up. You can also call (833) 666-281.
HelpScript	A copay assistance program for certain provider-administered Specialty Medications.	Call 1-833-807-4773 Monday through Friday, 8 AM to 8 PM ET.
SaveOnSP	Administers the Plan's Prescription Drug/Pharmacy Copay Assistance Benefit for certain Specialty Drugs.	Phone: 1-800-683-1074, Monday through Thursday, 8 AM - 10 PM ET, and Friday, 8 AM - 9 PM ET.
Scripta Insights™	A prescription savings benefit offering personalized savings reports with lower-cost prescription drug options and potential savings.	Download the Scripta app or visit members.scriptainsights.com.

Plan Authority, Fiduciary Roles, and Delegation

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Plan Administrator and Named Fiduciary Authority

F&W Transportation, Inc. (“Employer”) serves as the Plan Administrator, Plan Sponsor, and Named Fiduciary under ERISA. In this role, the Plan Administrator acts in good faith and, in its sole discretion, determines how best to fulfill the Plan’s purposes.

The Plan Administrator has exclusive discretionary authority to interpret the Plan and related documents, make factual and eligibility determinations, and decide Benefit entitlements. All such decisions are final and binding, unless shown to be arbitrary, capricious, or an abuse of discretion. Review of any decision is limited to the evidence available at the time the decision was made. By submitting a Claim or accepting Benefits, individuals agree to this standard of review.

Delegation of Limited Functional Fiduciary Authority

The Claims Administrator may engage vendors, such as a Pharmacy Benefit Manager (PBM) or a Utilization Management (UM) Administrator, that require discretion in the execution of their duties related to Claims processing. To the extent any such vendor performs functions requiring the exercise of discretionary authority (e.g., oversight of final decisions regarding benefit coverage), they shall be considered a Functional Fiduciary solely related to such discretionary activities (“Limited Functional Fiduciary”).

The Plan Administrator expressly delegates the necessary discretionary authority to these designated vendors. This delegation is limited solely to the specific duties they perform on behalf of the Plan for which discretion is required.

For all matters and decisions other than those specifically delegated to the Limited Functional Fiduciaries, the Plan Administrator retains final authority over Plan interpretation and administration.

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Eligibility

General Eligibility Provisions

You are eligible to participate in the Plan if you meet the criteria established by the Employer, consistent with the terms of the Plan and applicable law. Eligibility is generally based on your employment status and job classification. For questions about your eligibility, refer to the Employer's internal benefits policies or contact your human resources department.

Employee Eligibility

The following Employees are eligible for coverage under the Plan:

- Employees regularly scheduled to work at least 30 hours per Week are eligible for coverage under the Plan.

Geographic Exclusions: An Employee is not eligible to participate in the Plan if they reside in or are primarily employed in Hawaii, Guam, or the Commonwealth of Puerto Rico.

Affordable Care Act (ACA) Compliance: Solely for the purpose of meeting the ACA's employer shared responsibility provisions (if the Plan Sponsor is an Applicable Large Employer (ALE) for the applicable plan year), and notwithstanding the above, the Employer will determine an Employee's eligibility for coverage based on their Hours of Service, as defined under applicable federal guidelines.

Employees who meet the criteria for eligibility under the ACA, either through the Monthly Measurement Method or the Lookback Measurement Method, will be offered coverage based on their hours worked. Specifically, an Employee will be considered eligible for coverage if they average thirty (30) or more Hours of Service per week or 130 Hours of Service per month, as determined by the Employer's selected and documented method that aligns with the ACA.

In the case of the Lookback Measurement Method, Employees who are determined to be eligible for coverage will continue to be offered coverage during a Stability Period, even if their Hours of Service drop below the eligibility threshold (30 hours per week), as long as they remain employed.

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For purposes of this provision, the terms Hours of Service, Lookback Measurement Method, Monthly Measurement Method, and Stability Period have the same meaning as those terms defined under the ACA's Employer Shared Responsibility provision.

Dependent Eligibility

Eligible Dependents under the Plan include:

- The Employee's legal Spouse.
- The following children until the end of the month in which they turn 26:
    - The Employee's biological child;
    - The Employee's adopted child (including a child placed for adoption with the Employee);
    - The Employee's stepchild;
    - The Employee's foster child (a child placed with the Employee by an authorized placement agency or by court order);
    - A child for whom the Employee has been appointed legal guardian by a court of law;
    - Any child for whom the Employee is required to provide coverage under a Qualified Medical Child Support Order (QMCSO), as determined by the Plan Administrator.
- The Employee's child who otherwise would lose eligibility due to age but qualifies as a Disabled Child

Geographic Exclusions: A Dependent is not eligible to participate in the Plan if they reside in Hawaii, Guam, or the Commonwealth of Puerto Rico.

The Plan reserves the right at any time to request proof that an individual qualifies or continues to qualify as an Eligible Dependent as defined by this Plan.

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Enrollment

Open Enrollment Periods

The Open Enrollment Period is the period prior to the start of a new Plan Year allowing Eligible Employees not currently covered to elect coverage, and Covered Employees to change existing coverage. The Employer will determine and communicate the specific terms and duration of each Open Enrollment Period.

Other Opportunities to Elect Coverage

In addition to the annual Open Enrollment Period, there may be other times during the year when Employees or their Dependents may elect or make changes to coverage under the Plan. These opportunities generally arise due to certain life events as defined by the Plan and special enrollment rights under applicable law. Examples include the loss of other health coverage, the addition of a new Dependent due to marriage, birth, adoption, or placement for adoption, or eligibility for coverage under a state Medicaid or CHIP program.

Specific rules and deadlines apply to these enrollment opportunities. Please refer to the HIPAA Special Enrollments and Midyear Election Changes Due to Section 125 Events provisions below for additional information.

Enrollment Process

An Eligible Employee must enroll for coverage by completing an enrollment application along with the appropriate payroll authorization, if applicable. The Plan may use an electronic enrollment process. If the Employee intends to cover any Dependents, those Dependents must also be affirmatively enrolled.

Timely and Late Enrollment

An enrollment is considered “timely” if it is completed:

- During the Employer’s annual Open Enrollment period;
- Within thirty-one (31) days after the individual first becomes eligible;
- Within thirty-one (31) days of a Section 125 Event (described below);
- Within thirty-one (31) days of a HIPAA Special Enrollment event (described below) related to loss of coverage or acquisition of a new Dependent; or

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- Within sixty (60) days of a HIPAA Special Enrollment event related to changes to Medicaid and/or CHIP eligibility.

An enrollment is considered “late” if it does not meet the criteria outlined above for a timely enrollment. Employees and Dependents with a late enrollment who are not eligible to join the Plan during a Special Enrollment Period or pursuant to an eligible Section 125 Event (as described below) may enroll only during a subsequent Open Enrollment Period.

If an individual loses eligibility for coverage due to termination of employment or a general suspension of coverage under the Plan, and later becomes eligible again (for example, due to resumption of employment or reinstatement of Plan coverage), only the most recent period of eligibility will be considered when determining whether the enrollment is timely or late.

HIPAA Special Enrollments

Eligible Employees and Dependents may enroll outside of the annual Open Enrollment Period if certain events occur. The following events will trigger a HIPAA Special Enrollment opportunity:

Loss of Other Coverage

An Eligible Employee or Dependent who loses eligibility for other group health plan coverage or health insurance may enroll if all the following conditions are met:

1. The individual had other coverage in place when coverage under the Plan was previously offered;
2. If requested by the Plan Administrator, the individual provided written confirmation that the other coverage was the reason for declining Plan coverage;
3. Eligibility for the other coverage was lost due to a Qualifying Reason (as defined) and not due to non-payment or premiums or termination of coverage for cause; and
4. The request for enrollment is submitted within thirty-one (31) days of losing eligibility for the other coverage.

Acquisition of a New Dependent

An Eligible Employee may enroll themselves and/or a new Dependent in the event of:

- Marriage
- Birth
- Adoption or placement for adoption

Enrollment changes must be requested within thirty-one (31) days of the event. Coverage for

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newborns is not automatic. If not enrolled within 31 days, the enrollment for the child may be considered a Late Enrollment, and Claims may not be covered. Additionally, if the Eligible Employee is not enrolled at the time of the event, they must also enroll in order to add a Dependent.

Medicaid or CHIP Eligibility Changes

An Eligible Employee or Dependent may enroll if:

- They lose eligibility for Medicaid or the Children's Health Insurance Program (CHIP); or
- They become eligible for premium assistance under Medicaid or CHIP.

Enrollment must be requested within sixty (60) days of the loss of eligibility or determination of assistance. In addition, if the Eligible Employee is not enrolled at the time, they must enroll to add an Eligible Dependent.

Midyear Election Changes Due to Section 125 Election Change Events

Generally, the elections made during annual Open Enrollment remain in effect for the entire Plan Year. However, if permitted by the Plan Sponsor's Cafeteria Plan, Employees may be allowed to change benefit elections midyear if they experience an event recognized under IRS rules. These changes are commonly referred to as "Midyear Election Changes" and may only be made if the event qualifies as a permissible Section 125 Event and is recognized by the Plan Sponsor's cafeteria plan. Employees may only make a Midyear Election Change if they notify the Plan Administrator in the time period identified in the Plan Sponsor's cafeteria plan.

Examples of Section 125 Events include, but are not limited to, the following:

- **Change in Legal Marital Status:** Marriage, divorce, legal separation, annulment, or death of a Spouse.
- **Change in Number of Dependents:** Birth, adoption, placement for adoption, or death of a Dependent child.
- **Change in Employment Status:** Commencement or termination of employment, change from full-time to part-time status (or vice versa), or commencement or return from an unpaid leave of absence for the Employee, Spouse, or other Dependent.
- **Change in Dependent Eligibility:** A Dependent satisfying or ceasing to satisfy the Plan's eligibility requirements (for example, reaching age limits or loss of student status).
- **Significant Changes in Coverage or Cost:** A significant increase or decrease in the cost of coverage or a significant curtailment or improvement in coverage for the

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Employee, Spouse, or other Dependent's benefit options.

- **Changes Affecting Coverage Under Another Employer Plan:** The Employee or Dependent gains or loses eligibility for coverage under another employer's plan.
- **Change in Residence or Worksite:** A change in the Employees, Spouse's or other Dependent's place of residence or worksite that affects eligibility for coverage under the Plan.
- **Medicare or Medicaid Eligibility:** An Employee, Spouse, or other Dependent becomes (or ceases to be) eligible for Medicare or Medicaid.
- **Judgment, Decree, or Order:** A judgment, decree, or court order (such as a Qualified Medical Child Support Order) requires coverage for a child.

The ability to make a Midyear Election Change is subject to the terms of the Plan Sponsor's Cafeteria Plan document and IRS regulations, including the requirement that any change must be consistent with the Section 125 Event. Individuals must notify the Plan Administrator and complete any required election change forms within the timeframe specified by the Plan.

Mid-year Election Changes must also be consistent with the triggering event. This is commonly known as the "Consistency Rule." For example, if a Member gains a new Dependent due to birth, they may add that child to coverage and make any corresponding changes, such as enrolling themselves if they were not already enrolled or changing from single to family coverage. However, a Member would not be permitted to switch from family to single-only coverage, as that change would not be consistent with the event.

If you believe you have experienced a Section 125 Event that permits a Midyear Election Change, please contact the Plan Administrator promptly for information on eligibility and procedures.

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When Coverage Begins

In General

Coverage under the Plan will generally become effective on the following dates:

- **Annual Open Enrollment:** The first day of the Plan Year, for Employees and Dependents who enroll during the annual Open Enrollment period.
- **New Hires:**
    - On the first of the month following a 0-day waiting period for Employees and their Dependents.
- **HIPAA Special Enrollment - Marriage:** First of the month following receipt of the enrollment request for new Spouses who are enrolling midyear due to marriage, provided the request for special enrollment is received within 31 days of the loss of coverage.
- **HIPAA Special Enrollment - Birth/Adoption:** The date of birth, adoption, or placement for adoption, for newly eligible Dependent children, provided enrollment is completed within 31 days of the date of birth, adoption, or placement for adoption.
- **HIPAA Special Enrollment - Loss of Other Coverage:** The first of the month following the date the special enrollment request is received, provided the request for special enrollment is received within 31 days of the loss of coverage.
- **Section 125 Event:** The first of the month following the Section 125 Event request date unless the Section 125 Event is also a HIPAA Special Enrollment Event, in which case the applicable effective date for the HIPAA Special Enrollment event will apply.
- **Rehire:** The date specified below, for rehires.

Rehires and Reinstatement of Coverage

Compliance Requirements for Rehires

In general, when an Employee is rehired into a benefits-eligible position, the effective date of coverage will be determined by the Employer's rehire policy, if one is maintained. If no such policy exists, the employee will be subject to the standard eligibility and waiting periods for new hires as outlined in this Plan.

Notwithstanding any rehire policy maintained by the Employer, all eligibility and re-enrollment decisions, including the effective date of coverage and the status of any Cafeteria Plan elections, must comply with all applicable federal laws and regulations. These laws include, but are not limited to:

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- **Affordable Care Act (ACA) / Applicable Large Employers (ALE):** An Employee who resumes work after a break in service of at least thirteen (13) consecutive weeks (twenty-six (26) weeks for educational organizations) may be treated as a new Employee. If the break is shorter, the Employee is generally considered a "continuing Employee" and retains their prior status for measurement and stability periods. These rules apply unless the break qualifies under the ACA's "rule of parity," which allows a rehired Employee to be treated as a new hire when the break is at least four (4) weeks and longer than the Employee's immediately preceding period of employment.
- **Consolidated Omnibus Budget Reconciliation Act (COBRA):** For employers subject to COBRA, if a terminated Employee elected COBRA continuation coverage during a break in employment and is subsequently rehired into a benefits-eligible position, COBRA coverage will end and eligibility for coverage as an active Employee under the Plan will then be determined based on the general rehire rules outlined above.
- **Section 125 Cafeteria Plan Rules:** If an Employee previously made elections in a Section 125 Cafeteria Plan and is rehired within thirty (30) days of their termination, Section 125 rules require that the Employee's previous elections for the Plan Year be reinstated. This means Employees generally do not have the option to change existing Section 125 elections upon being rehired within this 30-day window.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Under USERRA, an individual entitled to have coverage reinstated upon returning to work following a military leave of absence shall be treated as if no break in coverage occurred during the leave. For more information, please refer to **The Uniformed Services Employment and Reemployment Rights Act** section below.

Coverage During a Family and Medical Leave Act (FMLA) Leave

Coverage during an FMLA leave of absence will be administered in accordance with the policies established by the Employer and applicable law including the following: (a) during an FMLA leave of absence, coverage under this Plan shall be maintained on the same terms and conditions as the coverage that would have been provided had the Covered Employee not taken the FMLA leave (including any Employee contribution requirement); and (b) if Plan coverage lapses during the FMLA leave, coverage will be reinstated upon the employee's return to work at the conclusion of the FMLA leave, but only for the person(s) who had coverage under the Plan when the FMLA leave began. It is the intention of the Employer to provide FMLA benefits only to the extent required by applicable law and not to confer greater rights than those required by law on any Member.

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Interaction with Other Leave Policies

In addition to the Benefits provided under this Plan, the Employer may maintain separate paid or unpaid leave policies to comply with applicable state and local laws. All Benefits under this Plan will be coordinated with those policies and any applicable state-mandated benefits in accordance with the Employer's general personnel policies and the requirements of law. Please contact the Employer for details on state-specific leave rights.

For More Information

The specific application of these rules can vary based on individual circumstances. Please contact the Plan Administrator for detailed information about how these policies apply to your unique situation.

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When Coverage Ends

For Employees

Employee coverage ends on the earliest of the following:

- **Termination of Plan.** The date the Plan terminates;
- **Loss of Eligibility.** The end of the month in which the Employee ceases to be an Eligible Employee, including due to:
    - Termination of employment;
    - Reduction in hours below the required eligibility threshold; or
    - Change in employment classification to a category not eligible for coverage.
- **Voluntary Termination due to Other Coverage:** The end of the month in which an Employee's written request is received to terminate their coverage due to enrollment in Medicare or another group health plan.
- **Failure to Pay Contributions:** When the Employee does not make a required contribution for coverage under the Plan. Termination will be retroactive to the last day for which the required contribution has been timely received, not to exceed sixty (60) days.
- **Fraud or Misrepresentation:** The effective date of a rescission of coverage due to Fraud or Material Misrepresentation, as described below in this section.
- **Active Military Duty:** The end of the month following the date the Employee enters active military duty for more than thirty-one (31) days. (See the **USERRA Section** below for information on how to continue coverage beyond this date.)
- **Death of the Covered Employee:** The date of the Employee's death.

NOTE: Employees whose coverage ends for reasons other than failure to pay premiums or due to Fraud or Material Misrepresentation may be eligible for continuation coverage under COBRA or similar state continuation laws. See the **COBRA** section of this document for more information.

For Dependents

Dependent coverage ends on the earliest of the following:

- The date the Employee's coverage under the Plan ends for any reason;
- For children covered until age 26, the last day of the month in which the child reaches age 26;

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- The end of the month in which the Dependent no longer qualifies as an eligible Dependent under the Plan, including:
    - In the case of a Spouse, due to divorce or legal separation.
    - For a child covered under a QMCSO, due to coverage no longer being required.
    - For a Disabled Child whose coverage continues beyond age 26, the child no longer meets the Plan's eligibility requirements, including no longer meeting the definition of Disabled Child or failing to provide required proof of disability.

NOTE: Dependents whose coverage ends may be eligible for continuation coverage under COBRA or similar state continuation laws. See the **COBRA** section of this document for more information.

Rescission of Coverage for Fraud or Material Misrepresentation

Members are responsible for providing accurate and truthful information, including information regarding family status, age, relationships, and eligibility, and promptly updating the Plan with any changes to previously provided information. Coverage under the Plan may be retroactively canceled or terminated (rescinded) if a Member commits Fraud or makes a Material Misrepresentation.

For this purpose, Fraud means any intentional act or omission made with the knowledge that it could result in unauthorized or inappropriate benefits being paid under the Plan. Fraud includes, but is not limited to:

- Knowingly providing false or misleading information related to eligibility, enrollment, or Claims;
- Failing to notify the Plan of a change in status that affects eligibility or coverage;
- Submitting Claims for services or supplies not received or not provided as claimed;
- Altering or forging prescriptions, Claim forms, or medical records;
- Allowing another person to use a Member's ID card issued by the Plan, or using another person's plan ID card;
- Participating in schemes with Providers to inflate, misrepresent, or fabricate charges.

The Plan reserves the right to take appropriate action in cases of Fraud, including denial of benefits, recovery of paid Claims, termination of coverage, and referral to law enforcement or regulatory authorities.

Material Misrepresentation means providing false, incomplete, or misleading information, or failing to provide information, whether intentionally or negligently, that the Plan or insurer relies on to determine eligibility for coverage, enrollment, or benefits, and where the correct

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information would have resulted in a denial of coverage, termination of coverage, or a change to the terms of coverage. Material Misrepresentation may include, but is not limited to:

- Failing to disclose that a Dependent no longer meets the eligibility requirements;
- Providing false information about marital status or Dependent status;
- Providing false health information on an enrollment form if used to determine eligibility.

A Rescission of Coverage based on Material Misrepresentation will only occur as permitted by law, including any required advance notice.

In the event the Plan Administrator implements a Rescission of Coverage, the following apply:

- A determination by the Plan Administrator that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal.
- A Member whose coverage is being rescinded will be provided with at least thirty (30) days' advance written notice of the intended rescission action, in accordance with applicable regulations under the Affordable Care Act.
- Claims incurred after the retroactive termination date will not be processed or paid under the Plan.
- Claims that were paid for services incurred after the retroactive termination date will be treated as erroneously paid Claims, subject to recovery by the Plan.

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COBRA Continuation Coverage

In General

Employees and Dependents who lose coverage under the Plan due to a Qualifying Event, as defined below in this section, may have the right to continue coverage for a limited period at their own expense under requirements under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA Obligations Depend on Employer Size

Federal COBRA continuation coverage requirements generally apply to group health plans sponsored by employers with 20 or more employees in the prior calendar year. Whether the Plan is subject to COBRA is determined annually based on the size of the Employer in the preceding year. As a result, COBRA obligations may change from year to year if the Employer's size changes. State continuation of coverage requirements vary from state to state but may apply to employers with less than 20 employees. Members should contact the Plan Administrator with questions about the applicability of state continuation of coverage requirements to the Plan.

Qualifying Events

Qualifying events for Employees include:

- Termination of employment (for reasons other than gross misconduct)
- Reduction in hours of employment

Qualifying events for Dependents include:

- Employee’s termination of employment (other than for gross misconduct) or reduction in hours
- Employee’s death
- Divorce or legal separation from the Employee
- Employee becoming entitled to Medicare
- A Dependent child ceasing to be eligible for coverage under the Plan

Maximum Periods of Continuation Coverage

The maximum period of continuation coverage is generally:

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- 18 months for loss of coverage due to termination or reduction in hours.
- Up to 29 months if an Employee or any Qualified Beneficiary is determined by the Social Security Administration (SSA) to be disabled.
- Up to 36 months if a Qualified Beneficiary experiences a second qualifying event during the initial 18-month period, such as the death of the former Employee, divorce, or a child losing Dependent status. (The Plan Administrator must be notified of this second qualifying event within **60 days** of the event.)

Early Termination of COBRA Continuation Coverage

A Qualified Beneficiary's COBRA continuation coverage may be terminated before the maximum period for any of the following reasons:

- The Plan Sponsor ceases to provide any group health plan to its employees.
- Failure to make premium payments in full on a timely basis (subject to a required grace period).
- The Qualified Beneficiary becomes covered under any other group health plan (unless the new plan contains a pre-existing condition exclusion or limitation, which is rarely permitted under current law).
- The Qualified Beneficiary becomes entitled to Medicare benefits after the date of election of COBRA coverage.

Cost of COBRA Coverage

Individuals who elect COBRA continuation coverage for medical and prescription drug benefits are responsible for paying the entire cost of that coverage. The cost is equal to the total monthly premium for the coverage in effect for similarly situated active employees and their dependents, including both the employee and employer portions, plus an additional administrative fee (for a maximum total of 102% of the applicable premium).

If continuation coverage is extended due to a Social Security–determined disability, the premium for the additional 11 months of coverage may be up to 150% of the applicable premium.

The Plan Administrator (or COBRA Administrator) determines the applicable premium rates each year based on the cost of coverage under the Plan. The applicable premium amounts and payment instructions are provided at the time COBRA continuation coverage is offered and whenever the premium rates change.

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Notice and Election Process

The Plan has contracted with a COBRA Administrator to handle COBRA continuation coverage. Members will receive a separate notice from the COBRA Administrator with detailed information regarding your COBRA rights, how to elect continuation coverage, and the cost of such coverage.

It is your responsibility to notify the COBRA Administrator of certain qualifying events, such as divorce, legal separation, or a Dependent child ceasing to be eligible, within sixty (60) days of the event.

COBRA Administrator Contact Information

The Plan Sponsor uses the following vendor for administration of COBRA:

Name: Wex
Phone: (701) 446-7802
Mailing Address: 700 26th Ave. E., West Fargo, ND 58078
Website: samuel.westrick@wexinc.com

It is your responsibility to notify the COBRA Administrator of certain qualifying events, such as divorce, legal separation, or a Dependent child ceasing to be eligible, within sixty (60) days of the event.

For all inquiries regarding your COBRA rights, eligibility, election, or payments, please contact the COBRA Administrator directly.

Additional Information

This summary is intended to provide a general description of your COBRA continuation coverage rights. Complete details will be provided by the COBRA Administrator when you become eligible for COBRA coverage.

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HIPAA Privacy Obligations of Plan Sponsor

Introduction

Certain designated members of the Company's workforce (“Workforce Members”) have access to the individually identifiable health information of Plan Members for administration functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is ePHI (ePHI).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI and ePHI. The following HIPAA definitions of PHI and ePHI apply to this section:

The Plan Sponsor shall have access to PHI and ePHI from the Plan only as permitted under this section or as otherwise required or permitted by HIPAA.

Provision of PHI to Plan Sponsor

Enrollment/Disenrollment Information

Enrollment and disenrollment information created by the Plan Sponsor is not considered PHI because, when the Plan Sponsor performs enrollment functions, it does so on behalf of enrollees rather than on behalf of the Plan. In addition, in accordance with 45 CFR §164.504(f)(1)(iii), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan without satisfying the conditions for disclosure of PHI to the Plan Sponsor set forth below.

Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

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Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described below, the Plan may disclose PHI and ePHI to the Plan Sponsor, provided that the Plan Sponsor is permitted to use or disclose PHI and ePHI only for Plan Administration Purposes. "Plan Administrative Purposes" means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, Claims processing, auditing, monitoring, and Plan management (including financial and administrative oversight and HIPAA compliance). Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor (for example, long-term disability or life insurance) or any employment-related actions or decisions. Notwithstanding any provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI or ePHI in a manner that is inconsistent with 45 CFR §164.504(f).

Conditions of Disclosure for Plan Administration Purposes

The Plan Sponsor agrees that with respect to any PHI (other than PHI disclosed pursuant to a signed authorization that complies with the requirements of the Privacy Rule), disclosed to it by the Plan (or a Business Associate on behalf of the Plan), Plan Sponsor shall:

- Not use or further disclose the PHI other than as permitted or required by the Plan (including this section) or as required by law;
- Ensure that any agent to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;
- Make available all PHI necessary for the Plan to comply with an individual's right to access PHI in accordance with 45 CFR §164.524, including the right to access electronic copies of PHI, if applicable;
- Make available PHI required for the Plan to comply with an individual's right to amend PHI, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;
- Make available PHI required for the Plan to comply with an individual's right to request an accounting of disclosures in accordance with 45 CFR §164.528;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the

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purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the firewall) described below is established.

Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any ePHI (other than ePHI disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) on behalf of the Plan, it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and Plan Sponsor (i.e., the firewall) described below is supported by reasonable and appropriate security measures;
- Ensure that any agent to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the ePHI; and
- Report to the Plan any security incident of which it becomes aware, as follows: Plan Sponsor will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy ePHI or to interfere with systems operations in an information system containing ePHI; in addition, Plan Sponsor will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of ePHI or interference with systems operations in an information system containing ePHI.

Adequate Separation Between Plan and Plan Sponsor ("Firewall")

The Plan Sponsor shall allow the individuals/roles/departments identified in its Plan Sponsor Certification Form (described below) access to the PHI. No other persons shall have access to PHI. These specified employees (or classes of employees) shall have access to and use of PHI only to the extent necessary to perform Plan Administration Functions. In the event that a specified employee does not comply with the provisions of this section, the employee shall be subject to disciplinary action by the Plan Sponsor for noncompliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

The Plan Sponsor shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit ePHI on behalf of the Plan.

Certification of Plan Sponsor

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The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan incorporates the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in this section.

Role of Claims Administrator

To the extent Gravie as Claims Administrator for the Plan discloses PHI or ePHI to the Plan Sponsor on behalf of the Plan, such disclosures must comply with the conditions for disclosure to the Plan Sponsor described above and the Minimum Necessary standard, where applicable. Furthermore, any disclosures will be conditioned upon receipt of the Plan Sponsor Certification described above. Gravie shall not disclose PHI to the Plan Sponsor for employment-related actions, decisions, or for any other employee benefit plan of the Plan Sponsor.

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Coordination of Benefits (COB)

In General

When a Member is covered by this Plan and one or more other plans, the plans will coordinate benefits when a Claim is received. This is called “Coordination of Benefits.” Coordination of Benefits rules help determine the order of payment of Covered Charges when two or more plans are paying.

Primary and Secondary Plans

Primary Plan means the Plan that pays for Health Care Expenses first. When the Plan is the Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

Secondary Plan means the Plan that pays for Health Care Expenses after the Primary Plan pays. When the Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

Important Note: The Plan will not pay more than it would have paid had it been the Primary plan.

Order of Benefit Determination

The order of benefit determination follows these rules, in order:

Rule 1: No COB Provision

If a plan does not contain a Coordination of Benefits provision consistent with this section, that plan is the Primary Plan and pays first.

Rule 2: Non-Dependent Before Dependent

The benefits of the Plan that covers the person as an employee, subscriber, or retiree (that is, other than a Dependent) are determined before those of the Plan that covers the person as Dependent. However, if the person is also a Medicare beneficiary, then Medicare is secondary to the plan covering the person as a Dependent and primary to the plan covering the person as other than a Dependent (for example a retired employee).

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Rule 3: Child Covered Under Multiple Plans - Parents Married

The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan. If both parents share the same birthday, the plan that has covered either parent for the longer period is the Primary Plan. For this purpose, "Birthday" means the month and day (e.g., January 19) the parent was born. The year of birth is not considered when determining which parent's birthday comes first.

Determining the order of plans by looking to whose birthday falls earlier in the year is referred to as the "Birthday Rule."

Rule 4: Child Covered Under Multiple Plans - Parents Not Married or Separated/Divorced

Custodial Parent not Remarried: If the custodial parent has not remarried, the custodial parent's plan is the Primary Plan and the non-custodial parent's plan is the Secondary Plan.

Custodial Parent Remarried: If the custodial parent has remarried:

- The custodial parent's plan is the Primary Plan.
- The step-parent's plan (if the child is covered) is the Secondary Plan.
- The non-custodial parent's plan is third in order.

Court Order: However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and that parent's plan has actual knowledge of those terms, then that plan is the Primary Plan.

Rule 5: Child Covered Under Multiple Plans - Parents Share Joint Custody

If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the Birthday Rule described in Rule 3 to determine which is the Primary Plan and which is the Secondary Plan.

Rule 6: Young Adult Dependent Under Parent(s) and Spouse's Plan(s)

For an adult Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a Dependent under a Spouse's plan, the Longer/Shorter rule described in #8 applies. 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 parents'

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plans, the order of benefits will be determined by applying the Birthday Rule described in Rule 3 to the Dependent child's parent or parents and the Dependent's Spouse.

Rule 7: Active versus Inactive Employee

The plan that covers a person as an active employee (or as a Dependent of an active employee) is the primary plan over a plan that covers the person as a laid-off or retired employee (or as a Dependent of a laid-off or retired employee). If the other plan does not include this rule and, as a result, the plans do not agree on the order of benefits, this rule is disregarded.

Rule 8: Continuation/COBRA Coverage Secondary

If a person has continuation coverage under Federal or State law and is also covered under another plan, the plan covering the person as an employee, member or subscriber or as a Dependent of an employee, member or subscriber is the Primary Plan and the continuation coverage is the Secondary Plan.

Rule 9: Longer/Shorter Rule

The benefits of a plan that has covered a person for the longer length of time are determined before the benefits of a plan that has covered the person for the shorter length of time.

This rule is referred to as the "Longer/Shorter Rule."

COB with Medicare

When you or a covered Dependent are entitled to Medicare and **this Plan pays second**, this Plan's benefits will be determined as follows:

1. **If you are enrolled in Medicare (Part A and/or B):** This Plan will coordinate benefits with Medicare as a secondary payer. We will first apply your Medicare benefits and then pay the remaining eligible expenses in accordance with the terms of this Plan.

2. **If you are eligible for Medicare but do not enroll:** This Plan may pay benefits as if you had enrolled in Medicare Part A and/or B, in which case you will be responsible for the difference between the Plan's calculated payment and the total cost of the service.

Important Note for ESRD Beneficiaries: If you are a Medicare beneficiary solely due to End-Stage Renal Disease (ESRD), the Medicare Secondary Payer rules apply. For the first 30 months of your Medicare eligibility or entitlement, this Plan will be the primary payer. After the 30-month coordination period has expired, this Plan will become a secondary payer to

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Medicare, and if you do not enroll, the Plan may cover your eligible Claims in accordance with provision number 2 above.

The Plan may coordinate benefits with respect to Medicare Part D, based on information available through the Centers for Medicare & Medicaid Services (CMS).

Provider Accepted Medicare Assignment: If a Provider has accepted assignment of Medicare, the Plan determines "allowable expenses" based upon the amount allowed by Medicare.

- The Plan's allowable expenses for a Participating Provider is the lesser of (1) the amount that the Participating Provider has contractually agreed to accept as reimbursement in full for Covered Services or (2) the Medicare allowable amount.
- The Plan's allowable expenses for a Non-Participating Provider is the lesser of (1) the usual and customary amount or (2) the Medicare allowable amount.
- The Plan pays the difference between what Medicare pays and the Plan's allowable expenses.

COB with Disability

If you are under a disability extension from a previous benefit plan, that plan will pay first, and the Plan will pay second.

COB with TRICARE/Medicaid/CHIP

The Plan will pay primary to TRICARE and State child health plans, to the extent required by state and federal law.

Your Responsibilities

Certain facts about healthcare coverage and services are needed to apply Coordination of Benefit rules and to determine benefits payable under the Plan and other plans. The Claims Administrator may get the facts it needs from or give them to any other organization or person for the purpose of applying these rules and determining benefits payable under the Plan. Each person claiming benefits under the Plan must give the Plan any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

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A payment made under another plan may have included an amount that should have been paid under the Plan. If it does, the Plan may pay that amount to the organization that made the payment. That payment will count as a valid payment under the plan.

Right of Recovery

If the Plan paid more than it should have paid, it may recover the excess from one or more of the following:

- The persons the Plan has paid or for whom it has paid; or
- Any other person or organization that may be responsible for the benefits or services provided under the Plan to the Covered Person.

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Qualified Medical Child Support Orders (QMCSOs)/National Medical Support Notice (NMSN)

The Plan extends medical benefits to an Employee's non-custodial child, as required by any Qualified Medical Child Support Order (QMCSO) or any National Medical Support Notice (NMSN) issued pursuant to state law.

A medical child support order is a judgment, decree, or order (including an approval of a property settlement) that:

- Is made pursuant to state domestic relations law (including a community property law) or certain other state laws relating to medical child support; and
- Provides for child support or health benefit coverage for a child of a participant under a group health plan and relates to benefits under the plan.

The Plan will comply with valid medical child support orders in accordance with applicable federal and state laws. If the Plan receives such an order, the Plan Administrator will review it in light of its procedures to determine whether it meets the applicable legal standards.

If coverage is required under a medical child support order, the child will be enrolled in accordance with the order’s terms, and the non-custodial parent may be required to contribute to the cost of coverage. Coverage will be provided on the same basis as for other eligible Dependents under the Plan.

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The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Continuation of Benefits

Covered Employees who are absent due to service in the uniformed services and/or their Covered Dependents may continue coverage pursuant to USERRA for up to 24 months after the date the Covered Employee is first absent due to uniformed service duty.

Eligibility

A Covered Employee is eligible for continuation under USERRA if the Covered Employee is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or the commissioned corps of the Public Health Service. “Duty” includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

Covered Dependents who have coverage under the Plan immediately prior to the date of the Covered Employee’s covered absence are eligible to elect continuation under USERRA.

Upon the Covered Employee’s return to work immediately following the Covered Employee’s leave under USERRA, no new waiting periods will apply.

Premium Payment

If continuation of Plan coverage is elected under USERRA, the Covered Employee or Covered Dependent is responsible for payment of the applicable cost of coverage (i.e., the premium or contribution required to maintain coverage under the Plan). If the Covered Employee is absent for not longer than 31 calendar days, the cost will be the amount the Covered Employee would otherwise pay for coverage. For absences exceeding 31 calendar days, the cost may be up to 102% of the cost of coverage under the Plan and will include the Covered Employee’s share as well as any portion previously paid by the Employer.

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Duration of Coverage

Elected continuation coverage under USERRA will continue until the earlier of:

1. Twenty-four months, beginning the first day of absence from employment due to service in the uniformed services;
2. The day after the Covered Employee fails to apply for or return to employment as required by USERRA, after completion of a period of service;
3. The early termination of USERRA continuation coverage due to the Covered Employee's court-martial or dishonorable discharge from the uniformed services; or
4. The date on which this Plan is terminated.

The continuation available under USERRA does not affect continuation available under "COBRA Continuation Coverage." Covered Employees should contact the Employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the Employer of any changes in marital status or a change of address.

Return to Work Requirements.

Under USERRA a covered employee is entitled to return to work following an honorable discharge as follows:

1. Less than 31 days service: By the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight-hour rest period.
2. Thirty-one to 180 days: The covered employee must apply for reemployment no later than 14 days after completion of military service.
3. One hundred and eighty-one days or more: The covered employee must apply for reemployment no later than 90 days after completion of military service.
4. Service-connected injury or illness: Reporting or application deadlines are extended for up to two years for persons who are hospitalized or convalescing.

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Assignment, Subrogation and Right of Recovery

In General

The Plan has an absolute right of subrogation and reimbursement. This means that if the Plan provides (or will provide in the future) benefits for a sickness or injury, and a Member recovers money from another person, entity, or insurance policy for that same sickness or injury, the Plan has a right to be repaid for those benefits.

For purposes of this section, "benefits" refers to the right to payment, reimbursement, or coverage for Healthcare Services, including the right to assert a Claim or Appeal relating to such payment, reimbursement, or coverage.

Non-Assignment

The Plan does not recognize assignments of rights or benefits to any third parties, including Providers. Although the Plan may make payments directly to Providers in the interests of convenience for Members, such payments do not make a Provider an assignee or otherwise confer on the Provider any rights under the Plan, including any right to claim any breach of fiduciary duty. This provision does not prohibit a Member from designating any individual to act on their behalf, but will not confer or transfer to that person any rights or benefits.

Specific Subrogation Provisions

Scope of Right: The Plan has a full and unrestricted right to recover benefits paid or payable due to a sickness or injury for which you are compensated by a third party. This right extends to any other insurance coverage you may have, including but not limited to, uninsured or underinsured motorist coverage.

No Reduction: The Plan's subrogation rights will not be reduced under any circumstances, even if:

1. You are not fully compensated for all your damages or losses (e.g., pain and suffering, lost wages, etc.).
2. You incur expenses in making a recovery, including attorneys' fees.

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Priority of Payment: Any and all amounts you recover through settlement, judgment, arbitration, or by any other means for the sickness or injury (regardless of how those amounts are characterized or allocated) must first be paid to the Plan to fully satisfy its subrogation rights, before any amount is retained by you. Such amounts are considered to be held in a constructive trust for the Plan.
Delegation of Authority: The Plan Administrator has delegated to Gravie the authority to pursue and manage these subrogation rights, and Gravie may further delegate this activity to other individuals or entities.

Your Obligation to Cooperate and Protect the Plan's Rights

As a condition of receiving Benefits under the Plan, you agree to fully cooperate with the Plan, the Plan Administrator, Gravie, and their designees in enforcing the Plan's subrogation rights. This includes:

1. Paying to the Plan all amounts due.
2. Signing any agreements, assignments, or other documents requested.

Consequence of Non-Cooperation: If you do not provide requested information or assistance, no Benefits will be payable under the Plan for costs related to that sickness or injury.

No Adverse Action: You shall take no action that directly or indirectly harms the Plan's subrogation rights.

Settlements: Any settlement you enter into for sickness or injury must fully recognize the Plan's priority right to be repaid in full from any recovered amounts, before you retain any portion of the settlement.

Minors/Deceased Members: If the sickness or injury involves a minor child or the wrongful death of a Member, these provisions apply to the parents/guardians (for minors) or the personal representative (for deceased Members).

Reimbursement Rights: You agree to hold any amounts recovered — whether through settlement, judgment, or otherwise — in a constructive trust for the Plan's benefit, up to the amount of benefits paid.

Liability for Failure to Reimburse: If you fail to reimburse the Plan for all Benefits paid (or to be paid) from any recovery you receive for your sickness or injury, you will be liable for *all expenses* (including fees and costs) incurred by the Plan, the Plan Administrator, Gravie, and their designees in their attempts to recover that money from you.

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Plan Administrator's Final Authority: The Plan Administrator retains all fiduciary responsibilities for the Plan. The Plan Administrator has the exclusive, final, and binding discretionary authority to interpret and administer the Plan, resolve any ambiguities, and make all factual determinations, except where specific fiduciary responsibilities have been expressly delegated to others. The rights of subrogation and reimbursement shall legally bind the Member’s guardian(s), estate, executor, personal representative, and heir(s).

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Your Rights Under ERISA

As a Member of the Plan, you are entitled to the following rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information About Your Plan and Benefits

You have the right to:

- Receive information about the Plan and your Benefits.
- Examine, without charge, at the Plan Administrator's office (and other specified locations, such as work sites), all documents that govern the Plan. This includes the Plan Document, any insurance contracts, collective bargaining agreements (if applicable), and a copy of the latest annual report (Form 5500 Series), if required to be filed. This report is also available at the U.S. Department of Labor's Public Disclosure Room.
- Obtain copies of documents that govern the Plan upon written request to the Plan Administrator. This includes the Plan Document, insurance contracts, collective bargaining agreements (if applicable), the latest annual report (Form 5500 Series), and the updated Summary Plan Description (SPD). The Plan Administrator may charge a reasonable fee for these copies.
- If an annual financial report is required, receive a Summary Annual Report (SAR) which summarizes the Plan's annual financial report. The Plan Administrator is legally required to provide you with this SAR.

Prudent Actions by Plan Fiduciaries

ERISA imposes duties on the individuals responsible for operating the Plan:

- **Fiduciary Duties:** The individuals who operate the Plan are called "fiduciaries." They have a duty to act prudently and solely in the interest of the Plan's Members.
- **No Discrimination:** No one, including the Employer, a union, or any other person, may fire an Employee or discriminate against an Employee in any way to prevent them from obtaining a Benefit or exercising their rights under ERISA.

Enforce Your Rights

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If your Claim for a Benefit is denied or ignored, in whole or in part, you have specific rights and steps you can take to enforce them:

- **Denied Claims:** You have the right to know why your Claim was denied, to obtain copies of documents relevant to that decision without charge, and to appeal any denial, all within specific timeframes. Please refer to the Claims & Appeals section below for details.
- **Steps to Enforce Rights:**
    - **Failure to Provide Documents:** If you request a copy of Plan documents or the latest annual report and do not receive them within thirty (30) days, you may file a lawsuit in a Federal court. The court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless the delay was due to reasons beyond the Plan Administrator's control.
    - **Denied or Ignored Claims:** If your Claim for Benefits is denied or ignored, in whole or in part, you may file a lawsuit in a state or Federal court after you have completed the Appeals Program procedures outlined in the Plan (Addendum 1: Claim and Appeal Procedures).
    - **Qualified Medical Child Support Orders:** If you disagree with the Plan's decision (or lack thereof) concerning the qualified status of a Qualified Medical Child Support Order, you may file a lawsuit in Federal court.
    - **Misuse of Funds/Discrimination:** If Plan fiduciaries misuse Plan money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file a lawsuit in a Federal court.
- **Court Costs and Legal Fees:** The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your Claim is frivolous).

Exhaustion of Administrative Procedures Required

To the fullest extent permitted by applicable law, your right to maintain a court action is subject to the Plan's requirement that Administrative Procedures (such as the Appeals Program) be completed first. This is called Exhaustion of Administrative Remedies. Failure to exhaust Administrative Procedures may prevent you from bringing an action in court.

COBRA Rights

If you lose coverage under the Plan due to a Qualifying Event, you (and your Spouse or Dependents) may have the right to continue your Healthcare Coverage under COBRA. You

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may have to pay for this coverage. Please review the COBRA Notice of Rights in this document and the Plan rules governing COBRA Continuation Coverage.

Assistance with Your Questions

For questions about the Plan, contact the Plan Administrator.

For questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you may contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor (DOL). You can find their contact information in your telephone directory or by contacting the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also **obtain certain publications about rights and responsibilities under ERISA** by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

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Additional Member Responsibilities

As a Member of the Plan, you have certain responsibilities to help ensure the smooth operation of your Plan.

Your Responsibilities

Provide Information: You are responsible for supplying information (to the extent possible) that Gravie (as Claims Administrator) requires for Plan processes such as enrollment, Claims payment, and Benefit management.

Financial & Discount Disclosure: You are responsible for advising Gravie (as Claims Administrator) of any discounts or financial arrangements between you and a Provider or manufacturer for Healthcare Services that alter the charges you pay.

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Additional Information

Michelle's Law

Under Michelle's Law, group health plans and health insurers are prohibited from terminating the coverage of a student Dependent whose enrollment in a plan requires student status at a postsecondary educational institution, if the student status is lost because of a qualifying Medically Necessary Leave of Absence.

Michelle's Law applies to a group health plan or related insurance coverage only if the plan or insurer receives written certification by the student Dependent's treating physician stating that (1) the child is suffering from a serious illness or injury and (2) the Leave of Absence (or other change in enrollment) is Medically Necessary.

A student Dependent is one who, regarding group health plan or health insurance coverage is both:

- A Dependent child, under the Plan's or coverage's terms, of a participant or beneficiary in the plan or coverage; and
- Was enrolled in the plan or coverage, on the basis of being a student at a post-secondary educational institution, immediately before the first day of the Medically Necessary Leave of Absence involved.

Special Enrollment Rights

If you acquire a new Dependent, or if you decline coverage under the Plan for yourself or an eligible Dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. You have the right to request special enrollment (outside of the Plan's annual enrollment period) for yourself and your eligible Dependents under the following circumstances.

Loss of Other Coverage (Except Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an Eligible Dependent (including your Spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your Dependents in the Plan if you or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 30 days after your

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or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Eligibility Under Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible Dependent (including your Spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your Dependents in the Plan if you or your Dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your Dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your Dependents (including your Spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under the Plan, you may be able to enroll yourself and your Dependents in the Plan. However, you must request enrollment within 60 days after your or your Dependents' determination of eligibility for such assistance.

Women's Health and Cancer Rights Act

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

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

These Benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical Benefits provided under the Plan.

If you would like more information on WHCRA benefits, please call your Plan Administrator.

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Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost-sharing restrictions and treatment duration limitations and other areas covered by MHPAEA. For further details, please contact the Plan Administrator.

Genetic Information Nondiscrimination Act (GINA)

Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with GINA. GINA prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

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ATTACHMENT A:
Schedule of Benefits

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Before You Begin

How To Use this Schedule of Benefits

This Schedule of Benefits ("Schedule") provides the primary, detailed description of the Plan's Covered Services, Cost-Sharing requirements (including Copayments, Deductibles, and Coinsurance), and any Prior Authorization requirements. It is intended to serve as the definitive guide to the Benefits available under the Plan. Capitalized terms used in this Schedule are defined in the **Definitions** section. For additional information about eligibility and Plan administration, refer to the main body of the Summary Plan Description (SPD).

If You Have Questions About Your Plan or Benefits

Gravie is the Claims Administrator for the Plan. If you have any questions or concerns about your coverage, our Gravie Care® Customer Service Center is here to help. Contact Gravie Care® using the number on your Member ID Card or by visiting member.gravie.com.

When contacting Gravie Care®, please have your Member ID card available. If your question is about a bill, please be ready with details such as the date of service, the type of service, the Provider's name, and the charges involved. Keep in mind that our phone representatives cannot change the terms of the Plan.

Member ID Cards

Gravie will issue you a Member ID card with important coverage details. Please review the information on your card carefully. If you find any errors, please notify Gravie Care® immediately. Incorrect ID card information can delay or temporarily deny Claims for Benefits or bills. Remember to present your Member ID card every time you receive services. Each family member covered under the Plan will need to present an ID card at the time of service. Please remember, your Member ID card is personal to you as a Member. Allowing another individual to use it could result in the card being deactivated and impact your ability to receive Benefits under the Plan.

Prior Authorization

Some services must be approved in advance through a process called Prior Authorization (or Precertification) to confirm that they are Medically Necessary and covered under the Plan. If

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Prior Authorization is required and not obtained, benefits may be reduced or denied. Additional information on Prior Authorizations may be found in the **Clinical Programs** section of this Schedule.

Claims

To receive Benefits under the Plan, a Claim must be submitted to the Claims Administrator, either by you or your Provider. A Claim is a request for the Plan to pay for Covered Services that you have received. Information on how to submit a Claim may be found in the **Claims & Appeals Procedures** section of this Schedule.

Appeals

If a Claim is denied in whole or in part, or you receive any type of Adverse Benefit Determination you have the right to file an Appeal. The Appeal process allows you to request a review of the decision and provide additional information. More information on the Appeals process may be found in the **Claims & Appeals Procedures** section of this Schedule.

How Exclusions are Organized

For ease of understanding, certain exclusions and limitations are described within the Benefit section to which they most commonly apply. This organizational approach is intended to help participants more easily locate information relevant to specific types of services.

The General Exclusions section summarizes exclusions that commonly apply across the Plan. Additional exclusions described in specific Benefit sections also apply, even if they are not repeated in the General Exclusions section, unless the Plan expressly states otherwise. In other words, the placement of an exclusion or limitation within a particular Benefit section does not limit its applicability. Unless otherwise stated, exclusions and limitations apply based on the nature of the service, not the Benefit category, Provider type, or place of service under which the service is billed.

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Understanding Costs and Coverage

In General

This section provides a summary of your financial responsibilities under the Plan, including your Cost-Sharing Amounts and any limits on your Benefits. All capitalized terms are defined in the **Health Plan Definitions** section below. Please review this entire Schedule to ensure a complete understanding of your Benefits.

How the Plan Pays for Services

The Plan helps with medical expenses, but it doesn't cover everything. For an expense to be a Covered Service under the Plan, it must be Medically Necessary, provided by a Healthcare Professional, and meet all other terms and conditions of the Plan. The Plan will generally cover a portion of the cost for most Covered Services. You, as the Member, are responsible for any applicable Cost-Sharing.

Your Cost-Sharing Terms

Cost-Sharing is the portion of healthcare expenses you are responsible for paying when you receive Covered Services under the Plan. Cost-Sharing includes:

- **Copayment (Copay):** A fixed dollar amount you pay for a Covered Service.
- **Coinsurance:** A percentage of the Covered Charge for a Covered Service that you pay after meeting your Deductible.
- **Deductible:** The amount you must pay for Covered Services each Plan Year before the Plan starts paying its share of the costs. Only Covered Charges accrue toward the Deductible.
- **Out-of-Pocket Maximum (OOPM):** The annual total amount you will be responsible for paying in Cost-Sharing (Deductibles, Copayments, and Coinsurance) for In-Network Covered Services. Once this limit is reached, the Plan pays 100% of In-Network Covered Charges for the remainder of that year.

Table 1: Plan Deductible Amounts

Coverage Tier	In-Network	Out-of-Network
Individual	$6,500	$10,000

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Family Deductible	$13,000 **Embedded Deductible:** For family coverage, the Plan includes an Embedded Deductible. This means no individual Member has to pay more than the Individual Deductible before the Plan begins paying for that Member's Covered Services.	$20,000

Table 2: Plan Out-of-Pocket Amounts

Coverage Tier	In-Network	Out-of-Network
Individual	$8,500 **Special Note:** Specialty Medications covered under the SaveOnSP Specialty Copay Program are *not* considered Essential Health Benefits (EHBs) as defined under the Affordable Care Act. As a result, any Cost-Sharing Amounts (such as Copayments or Coinsurance) associated with these drugs do not apply toward your Out-of-Pocket Maximum (OOPM).	N/A - The Out-of-Pocket Maximum does not apply to Out-of-Network services.
Family	$17,000 **Embedded OOPM:** For family coverage, the Plan includes an In-Network Embedded Out-of-Pocket Maximum. This means no individual Member will pay	N/A - The Out-of-Pocket Maximum does not apply to Out-of-Network services.

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	more than the Individual In-Network Out-of-Pocket Maximum before the Plan covers 100% of that Member's In-Network Covered Services for the rest of the Plan Year. **Special Note:** Specialty Medications covered under the SaveOnSP Specialty Copay Program are *not* considered Essential Health Benefits (EHBs) as defined under the Affordable Care Act. As a result, any Cost-Sharing Amounts (such as Copayments or Coinsurance) associated with these drugs do not apply toward your Out-of-Pocket Maximum (OOPM).	

Plan Year vs. Accumulator Period

This Plan has two important time periods you should be aware of:

- **Plan Year**: The Plan Year is the period beginning on the first day of June and ending on the last day of May. The Plan Year is used for administrative and reporting purposes, such as eligibility tracking, premium payments, and other general plan operations.
- **Accumulator Period**: The Accumulator Period is the timeframe used to calculate Cost-Sharing limits such as your **Deductible** or **Out-of-Pocket Maximum**. This period may differ from the Plan Year. For this Plan, the Accumulator Period runs on a Calendar Year (January 1 - December 31).

Why This Matters

Your Deductible and Out-of-Pocket Maximums reset based on the Accumulator Period, not the Plan Year. This means:

- Any amounts you pay toward your Deductible or Out-of-Pocket Maximum between January 1 and December 31 will count toward your limit for that Accumulator Period.

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- On January 1, your deductible and out-of-pocket maximums reset to $0, regardless of the Plan Year.

Be sure to review your Explanations of Benefits (EOBs) or contact Gravie Care® if you have questions about where you stand within the current Accumulator Period.

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In-Network vs. Out-of-Network Services

In General

The amount you pay for Healthcare Services will vary based on whether you use Participating (In-Network) or Non-Participating (Out-of-Network) Providers. In general, the cost is lower when you use Participating (In-Network) Providers.

In-Network Services

When you receive Healthcare Services from a Participating (In-Network) Provider, your Cost-Sharing is based on the Negotiated Rate with the Provider. Participating Providers have agreed to accept the Plan's Negotiated Rate as full payment for Covered Services, subject to any applicable Cost-Sharing, and cannot Balance Bill you for the difference between their normal fee and the Negotiated Rate.

For In-Network Services, you generally pay less out-of-pocket, and these amounts generally count toward your In-Network Out-of-Pocket Maximum. Once your Out-of-Pocket Maximum is met, the Plan covers most In-Network Services at 100% of the Negotiated Rate for the rest of the year.

Out-of-Network Services

When you receive Healthcare Services from a Non-Participating (Out-of-Network) Provider, their charges are often higher because there is not a standard In-Network contract in place and actual costs can vary by provider. The Plan covers these costs based on the Allowed Amount.

For Out-of-Network Services that are not subject to the No Surprises Act, you are responsible for any applicable Deductible and Coinsurance, calculated based on the Allowed Amount. Additionally, you may be responsible for the portion of the Billed Amount that exceeds the Plan's Allowed Amount (often referred to as Balance Billing).

Important: Your Out-of-Network expenses (including any applicable Deductibles or Coinsurance, and any Balance-Billing, if applicable) generally **do not** count toward your Out-of-Pocket Maximum unless required by law, such as the No Surprises Act (NSA) described

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below. This means that for services not subject to NSA protections, or unless another exception applies, the costs you incur for Out-of-Network services will not count toward your Out-of-Pocket Maximum, and you will remain responsible for such costs.

Continuity of Care

You may be eligible to continue care at the In-Network level with a Provider or Facility at the time the Provider's or Facility's Network contract terminates or there is otherwise a change in the contract with that Facility or Provider that would terminate or result in a loss of your Benefits with respect to the Facility or Provider, in accordance with applicable law.

Reliance on Incorrect Provider Directory Information

If you or a Dependent receives Healthcare Services from an Out-of-Network Provider based on incorrect information provided by the Plan indicating that the Provider was In-Network, the Plan will treat the services as if they were provided In-Network for purposes of your Cost-Sharing obligations.

This means your Copayments, Coinsurance, and other Cost-Sharing Amounts will be no greater than if you had received care from a Participating (In-Network) Provider, and will be counted toward your In-Network Deductible and Out-of-Pocket Maximum.

This protection applies if either:

- The Plan's website, Provider directory, or lookup tools incorrectly showed the Provider as In-Network; or
- You contacted the Plan and were told the Provider was In-Network, even though no online information was available.

If you believe you were charged Out-of-Network rates due to incorrect provider information, please contact Gravie Care® for assistance and review.

The No Surprises Act

The No Surprises Act (NSA) protects you from unexpected medical bills ("surprise bills") in specific situations. These special rules apply to your Cost-Sharing when you receive the following services:

- Emergency Services;
- Certain Non-Emergency Services provided by an Out-of-Network Provider at an In-Network Facility; and

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- Air Ambulance Services from an Out-of-Network Provider.

How Your Costs Are Determined for Emergency Services and Non-Emergency Services Provided by an Out-of-Network Provider at an In-Network Facility

For these services, your Cost-Sharing amounts will be the same as if the services were provided by an In-Network Provider or Facility, and any Cost-Sharing you owe will apply toward your In-Network Deductible and/or Out-of-Pocket Maximum.

Your Cost-Sharing will be based on a Recognized Amount, determined as follows:

- The amount set under an applicable All-Payer Model Agreement, or
- If none applies, the amount determined by state law, or
- If neither applies, the lesser of the Provider's Billed Charge or the Qualifying Payment Amount (QPA).

The QPA is generally the median contracted rate the Plan would have paid for the same service provided by an In-Network Provider in the same geographic area, adjusted for inflation, as determined under federal rules.

You are protected from being Balance Billed for these services. You are only responsible for applicable In-Network Cost-Sharing amounts.

Notice and Consent Exception for Certain Non-Emergency Services

In limited cases, Non-Participating Providers at certain In-Network Facilities may ask you to sign a "Notice and Consent" form to waive your balance billing protections for specific Non-Emergency or Post-Stabilization services received at an In-Network Facility or Emergency Department. You are never required to sign this form. If you choose not to sign, you cannot be billed more than the In-Network Cost-Sharing amount for those Covered Services.

How Your Costs Are Determined for Air Ambulance Services

For Air Ambulance Services provided by an Out-of-Network Provider, your Cost-Sharing will be the same as if the services were provided by an In-Network air ambulance Provider. Your Cost-Sharing for these services will be calculated based on the lesser of the Provider's Billed Charge or the Qualifying Payment Amount (QPA), as determined under federal rules. Any Cost-Sharing you owe for Air Ambulance Services provided by an Out-of-Network Provider will apply toward

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your In-Network Deductible and/or Out-of-Pocket Maximum. You are also protected from being Balance Billed for Air Ambulance Services provided by an Out-of-Network Provider.

Important Information About the Pharmacy Network

Member Choice Network (Effective through March 31, 2026)

The Plan utilizes the **Member Choice Network** model to administer retail pharmacy benefits. Under this model, each Member is assigned to one of two specific retail pharmacy networks: one anchored by Walgreens and one anchored by CVS.

- **Network Assignment:** Network assignment is determined by a Member's prescription fill history over the prior six (6) months. New Members, or Members without recent prescription history, are automatically assigned to the Walgreens-anchored network by default.
- **Pharmacy Access:** While the networks are centered around an anchor pharmacy, **Members are not required to use CVS or Walgreens.** You may utilize any participating pharmacy that is within your specific assigned network. Prescriptions filled at a pharmacy outside of your assigned network may result in a denial of benefits or full financial responsibility for the member.
- **Changing Your Network:** You may change your assigned retail network once per calendar year or following certain life events (such as a change in residence). To request a change, contact Express Scripts. Please note that network changes typically require one (1) business day to take effect.

National Plus Network (Effective April 1, 2026)

Effective April 1, 2026, the Plan will transition from the "Member Choice" anchored network model to the National Plus network, an open in-network retail model. With this change, Members may utilize any participating retail pharmacy within the Plan's total network without the need for a designated network ("anchor") assignment. All other Plan provisions regarding In-Network versus Out-of-Network Benefits, including the need to use Participating Providers to avoid a denial of benefits or increased financial responsibility, remain in effect.

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ACA Preventive Services

In General - The ACA Preventive Services Mandate

The Affordable Care Act (ACA) requires coverage of certain Preventive Services with no Cost-Sharing when provided by In-Network Providers. These services are based on recommendations from the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA).

Cost-Sharing Overview for ACA Preventive Services

- **In-Network:** No Member Cost-Sharing. Plan pays 100% of Covered Charges.
- **Out-of-Network Member Cost-Sharing:** 50% coinsurance after the OON deductible is met.

The above Cost-Sharing applies to all ACA Preventive Services listed below, unless otherwise specified.

Covered ACA Preventive Services

The Plan covers ACA Preventive Services that fall within the following categories, as required by the ACA:

- **Evidence-based screenings** rated “A” or “B” by the United States Preventive Services Task Force (USPSTF).
- **Immunizations** recommended by the Advisory Committee on Immunization Practices (ACIP).
- **Preventive care and screenings** for infants, children, and adolescents per guidelines from the Health Resources and Services Administration (HRSA).
- **Additional preventive care and screenings** for women per HRSA guidelines.

Below are examples of ACA Preventive Services covered by the Plan.

Adult ACA Preventive Services

Annual physicals, tobacco cessation counseling, blood pressure testing, heart rate testing/exam, lung exams, mental health/substance use disorder screenings, health screenings

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(cholesterol, diabetes, HIV, STD/STI, tuberculosis) and other evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force (USPSTF).

Children's ACA Preventive Services

Well-baby and well-child visits, fluoride varnish application, various screenings, counseling, and other evidence-informed preventive care and screenings provided in the comprehensive guidelines supported by HRSA (i.e., the Bright Futures/AAP Periodicity Schedule) for infants, children, and adolescents.

Immunizations

Immunizations recommended for routine use by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) for children, adolescents, and adults.

Women's ACA Preventive Services

- **Visits & Screenings:** Well-woman visit, cervical cancer screening, breast cancer screening (mammograms), osteoporosis screening, and other supported visits and screenings. Patient navigation services for breast and cervical cancer screenings are also covered.
- **Reproductive Health:** At least one form of contraception in each category identified for women in the current FDA Birth Control Guide, along with items and services integral to the provision of a recommended contraceptive method.

  NOTE: Contraceptives considered ACA Preventive Services are generally covered under the **Prescription Drug and Pharmacy Benefit,** except for certain methods that require Provider administration—such as Intrauterine Devices (IUDs) and subdermal implants—which are covered under the **Medical Benefit**.

- **Prenatal, Postpartum & Breastfeeding Support:** Routine prenatal care, gestational diabetes screening, screening for hepatitis B virus (HBV) infection at initial prenatal visit, breastfeeding/lactation support, counseling, and supplies (including one double-electric breast pump per year). This coverage applies even if a pregnancy is considered high-risk due to maternal age, pre-existing conditions, or other factors. Additional services or procedures that are not part of routine prenatal care, including those needed because

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of high-risk factors, will not be considered preventive and may be subject to standard cost-sharing.
- **Other Recommended Services:** Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

Telemedicine Services

ACA Preventive Services (e.g., counseling, check-ups) provided through real-time audio and video technology, as a virtual alternative to an in-person office visit by a treating Provider who is associated with a physical office. Telemedicine visits are subject to the same coverage, limitations, and exclusions that apply to in-person ACA Preventive Services.

Important Note Regarding ACA Covered Preventive Services

The above list of services is not a complete list. Covered ACA Preventive Services, eligible populations, and frequency limits may change as clinical guidelines are updated. Some services may be covered only if specific criteria are met.

For questions about specific services and whether they qualify as ACA Preventive Services, please contact Gravie Care® at the number listed on the back of your Member ID card or send a secure message via member.gravie.com/contact.

You may also find a list of ACA Prevent Services here: https://www.healthcare.gov/coverage/preventive-care-benefits/.

Limitations and/or Exclusions for Preventive Services

In addition to the Plan's general exclusions, the following specific limitations and exclusions apply to ACA Preventive Services:

- When prevention is not the primary purpose of a visit, the ACA Preventive Service portion remains covered at 100%, but any non-ACA Preventive Services may require Cost-Sharing.
- Age recommendations, frequency limitations, and Medical Necessity requirements may apply based on current federal guidelines and Plan utilization management requirements.
- Some ACA Preventive Services may only be covered annually or at defined intervals.
- Prior Authorization may be required for certain ACA Preventive Services (such as lung cancer screening).

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- To be covered at 100%, ACA Preventive Services must be billed with diagnosis and procedure codes that align with applicable federal preventive care guidelines. If a Preventive Service is not billed appropriately, Cost-Sharing may apply.
- If an ACA Preventive Service transitions to a non-ACA Preventive Service (e.g., follow-up colonoscopy after polyp removal or other diagnostic services), applicable Cost-Sharing for the diagnostic service will apply.
- Coverage details for ACA Preventive Services may change as federal guidelines are updated.

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Expanded Preventive Services

In General

Certain services that are not ACA Preventive Services are still covered under the Plan at 100% when received In-Network. These services are referred to throughout this document as "Expanded Preventive Services" and include the following:

1. Prostate-Specific Antigen (PSA) blood tests and digital rectal examinations to screen for prostate cancer for men forty (40) years of age or over who are symptomatic or in a high-risk category and for all men fifty (50) years of age or older.
2. Retinopathy screening for Members with diabetes.
3. Hemoglobin A1c testing for Members diagnosed with diabetes.
4. International Normalized Ratio (INR) testing for Members diagnosed with liver disease or bleeding disorders.
5. Low-density Lipoprotein (LDL) testing for Members diagnosed with heart disease.
6. Surveillance tests for ovarian cancer for women, including CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examination, or other proven ovarian cancer screening tests for women who are at risk for ovarian cancer due to family history or testing positive for BRCA1 or BRCA2 mutations.
7. One (1) routine eye examination per Member per Plan Year (in addition to any vision exams/screenings already required by the ACA).
8. One (1) routine hearing exam per Member per Plan Year (in addition to any hearing exams/screenings already required by the ACA).
9. One (1) routine postnatal care exam that includes a health exam, assessment, education, and counseling provided during the period immediately after childbirth (in addition to any well-woman exams required by the ACA).
10. Routine prenatal care beyond what is required by the ACA.
11. Certain vaccines/immunizations beyond what is required by the ACA.

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Office Visit Services

In General

The Plan covers Office Visit Services, which refer to Medically Necessary services provided by a Provider in a clinical office setting or Convenience Care Clinic that do not require the resources of a Hospital, Outpatient Facility, or Urgent Care Center. These services are intended for care that does not involve an urgent condition or Emergency Medical Condition; that is typically scheduled in advance; and may include routine health evaluations, follow-up visits, and ongoing management of chronic conditions.

Choosing a Primary Care Provider (PCP)

As a participant in this Plan, you have the option to select a **Primary Care Provider (PCP)** to help manage your overall health care needs. A PCP can provide general medical care, coordinate specialty care, and serve as your main point of contact for preventive services and treatment.

Choosing a PCP is recommended but not required. You are free to see any Eligible Provider in the Plan's network and you do not need a referral to see a Specialist.

You have the right to select any Participating PCP who is available to accept you or your Dependents, including a pediatrician for children. You do not need Prior Authorization to access obstetrical or gynecological (OB/GYN) care from an In-Network Healthcare Professional specializing in those areas.

Distinguishing Office Visits from Other Services

Relationship to Urgent Care Services: Office Visit Services are distinct from Urgent Care Services, which are intended for more immediate or specialized needs outside of a regular office setting. Please refer to the **Urgent Care Services** section for coverage details on these services.

Relationship to Outpatient Hospital/Facility Services: Office Visit Services refers to care you receive at a doctor's office or clinic, typically billed as *Place of Service 11*. **Outpatient Hospital/Facility Services** refer to care you receive at a Hospital or other Outpatient Facility,

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rather than a doctor's office, and are typically billed as *Place of Service 19 or 22*. These billing distinctions can affect how your services are covered and what Cost-Sharing applies.

Relationship to Preventive Services: While Office Visit Services may include certain ACA or Expanded Preventive Services, coverage for these services is described separately in the **ACA Preventive Services** and **Expanded Preventive Services** sections.

Remote Office Visit Services (Telemedicine and Designated Virtual Care)

Some Office Visit Services may be provided remotely via Telemedicine or through specific virtual care platforms. These Services are covered when they are Medically Necessary and delivered by an Eligible Provider in accordance with applicable state and federal laws.

General Telemedicine Services: These are Telemedicine Services provided by Providers who are part of your Plan's Participating Provider network and generally associated with a physical office or who are part of a virtual care program other than the designated virtual care services program via Teladoc Health® described below. Telemedicine Services are subject to the same Cost-Sharing, limitations, and exclusions as equivalent in-person Office Visit Services.

Designated Virtual Care Services: Your Plan also includes access to designated virtual care programs. These Services are provided by a dedicated network of Providers via phone or video. For more information on how to access these services you can contact Gravie Care® at the number on your Member ID Card, or you may contact the program(s) directly using the contact information outlined above in the **Plan Information** section of this SPD.

Cost-Sharing for Office Visit Services

Office Visit Cost-Sharing amounts typically include only the consultation or exam (known as Evaluation and Management). If additional services are provided during the visit—such as lab tests, imaging, injections, or minor procedures—those services may be billed separately and may be subject to additional Cost-Sharing (such as the Deductible and Coinsurance) as described in the table below.

Benefits Table: Office Visit Services

This table outlines Member Cost-Sharing for Office Visit Services.

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Office Visit Services	In-Network	Out-of-Network
Primary Care Services Services provided by a Primary Care Provider such as diagnosis and treatment of new symptoms (e.g., cough, rash, pain); management of chronic conditions (e.g., diabetes, high blood pressure); or follow-up care after illness, injury, or hospitalization. (**Note:** While Preventive Services such as screenings and immunizations may be provided as part of Primary Care Services, these services are addressed separately in the **ACA and Expanded Preventive Services** sections of this Schedule.)	$30 copayment per visit. Deductible does not apply.	50% coinsurance after the OON deductible is met.
Office Surgical Procedures Non-routine medical procedures or surgeries performed in a Provider's office that are not considered routine or preventive, such as biopsies, mole removal, port wine stain elimination, stitches, oral surgery, or endoscopies.	No Charge.	50% coinsurance after the OON deductible is met.
Specialty Care Services Office-based visits with a Specialist for conditions requiring specialized care (e.g., a Dermatologist, Endocrinologist, Neurologist, etc.)	$50 copayment per visit. Deductible does not apply.	50% coinsurance after the OON deductible is met.

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Habilitative & Rehabilitative Therapy Services for Habilitative and Rehabilitative Therapy, including Physical, Speech, and Occupational Therapy. **NOTE:** Cardiac Rehabilitation Services will always be covered under the Outpatient Hospital and Facility benefit level. (For more detailed information, including specific conditions and limitations, please see the **Habilitative & Rehabilitative Therapy** section of this Schedule.)	$50 copayment per visit. Deductible does not apply.	50% coinsurance after the OON deductible is met.
Chiropractic Services Services to treat acute musculoskeletal conditions, by manual manipulation therapy.	$50 copayment per visit. Deductible does not apply.	50% coinsurance after the OON deductible is met.
Mental Health (MH) or Substance Use Disorder (SUD) Services Visits with a MH/SUD Provider for individual or group therapy sessions, psychiatric evaluations and medication management, substance use counseling, etc. For more detailed information, including specific conditions and limitations, please see the **Mental Health & Substance Use Disorder Treatment** section of this Schedule.	$30 copayment per visit. Deductible does not apply.	50% coinsurance after the OON deductible is met.
Labs & Pathology Services	20% coinsurance after	50% coinsurance after the

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Laboratory tests performed to diagnose or monitor health conditions - e.g., blood tests, urinalysis, STD screenings, flu or strep tests.	the INN deductible is met.	OON deductible is met.
Routine Imaging (Basic Imaging) Standard imaging tests such as x-rays, ultrasounds, or mammograms, used to diagnose various conditions.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Advanced Imaging High-tech imaging procedures that provide detailed internal views such as Magnetic Resonance Imaging (MRI), Computed Tomography (CT) scans, Nuclear Medicine, Interventional Radiology, or Positron Emission Tomography (PET) scans.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Diagnostic Testing - Other Examples include: Vestibular testing/ EMG/VNG, Gastrointestinal Motility & Reflux Tests, Pulmonary Tests, etc.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Genetic Testing Testing for inherited cancer risks (e.g., BRCA, Lynch syndrome); carrier screening for conditions like cystic fibrosis before or during pregnancy; and prenatal screening (e.g., NIPT) for conditions like	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.

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Down syndrome.		
Infusion Therapy (Non-Chemotherapy) Administration of specialized medications such as monoclonal antibodies or immunoglobulin therapy (IVIG) via IV infusion.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Allergy Testing, Treatment and Injections Diagnostic testing and treatment for allergies such as skin prick tests, blood allergy tests, and allergy injections.	No Charge.	50% coinsurance after the OON deductible is met.
Injections (Non-Allergy) Administration of injections to treat medical conditions such as autoimmune disease, chronic pain, and hormonal imbalances.	No Charge.	50% coinsurance after the OON deductible is met.
Retail/Convenience Care Clinics Walk-in clinics in retail settings such as pharmacies or grocery stores for minor illnesses.	$30 copayment per visit. Deductible does not apply.	50% coinsurance after the OON deductible is met.
Telemedicine Services Office Visit Services provided through real-time audio and video technology, as a virtual alternative to an in-person office visit by a treating Provider who is associated with a physical office.	Telemedicine visits are subject to the same coverage, limitations, and exclusions that apply to in-person Office Visit Services.	

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On-Demand Virtual Care from Teladoc® Health On-demand virtual care available 24/7 from a network of Teladoc® Health contracted doctors for general illness, dermatology, and mental health services.	No Member cost.
Virtual Physical Therapy (Sword Thrive) from Sword Health	No Member cost.
Zerigo Digital Health Solution	No Member cost.

Limitations and Exclusions for Office Visit Services

In addition to the Plan's general exclusions, the following specific limitations and exclusions apply to Office Visit Services:

Limitations

- Some Office Visit Services may require Prior Authorization.
- Certain services **are not covered under the Office Visit Services Benefit**. If provided in an office setting, they will be subject to the applicable Outpatient Hospital and Facility Cost-Sharing Amount. Such services include:
    - Chemotherapy;
    - Radiation Therapy;
    - Dialysis; and
    - Cardiac Rehabilitation Services (e.g., structured and supervised exercise, education, and counseling programs designed to improve cardiovascular health).
- Certain injections may be billed as surgical procedures and subject to the applicable Cost-Sharing for Office Surgical Procedures.
- Chiropractic Services are generally limited to conditions related to the spine or joints and subject to the specific exclusions below.

Exclusions

The Plan does not cover the following:

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- Charges for completing forms, including for employment or school physicals (unless mandated by law), or other administrative or non-medical services are not covered. However, Medically Necessary exams provided as part of such visit may be covered under the applicable Office Visit (or ACA Preventive Services) benefit.
- Fees charged by Providers for missed or late-canceled appointments.
- The following Chiropractic Services:
    - Routine maintenance Chiropractic Services.
    - Laboratory services (including blood, hair, and urine analysis) related to Chiropractic Services.
    - Manipulation under anesthesia related to Chiropractic Services.
    - Chiropractic Advanced Imaging (e.g., MRIs).

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Outpatient Services

In General

The Plan covers Medically Necessary Outpatient Services provided at an Outpatient Hospital, Ambulatory Surgical Center, or other Facility, including Partial Hospitalization Programs (PHPs) and Intensive Outpatient Programs (IOPs).

Understanding Separate Cost-Sharing Components for Outpatient Services

When you receive Outpatient Services, your Cost-Sharing may include multiple components. This is because different Providers and services involved in a single procedure may be billed separately and subject to different Cost-Sharing requirements under the plan. For example, charges for the Facility itself, the Professional Fees of Providers, and other related services may each be subject to distinct Cost-Sharing amounts.

Facility Fees: Facility Fees are charges that are billed by the Hospital, Ambulatory Surgical Center, or other Facility for the use of their premises, equipment, and supporting personnel that enable the delivery of Healthcare Services. Facility Fees are separate from Professional Fees (e.g., from a surgeon or Physician) and may include, but are not limited to, use of operating rooms, outpatient departments, or treatment rooms; general nursing care; administration of anesthesia or other medications during treatment; blood and blood plasma; and other diagnostic or treatment-related services and supplies.

Professional Fees: Professional Fees are charges billed by Physicians, surgeons, anesthesiologists, radiologists, pathologists, or other Providers for the services they personally render during your Outpatient Hospital or Facility visit. This includes, but is not limited to, the surgeon's fee, the anesthesiologist's fee, and fees for other Physicians or Providers who provide services related to your Outpatient care.

Ancillary Services for Outpatient Hospital or Facility Visits: When you receive care at an Outpatient Hospital or Facility, related services—such as labs, imaging, anesthesia, and medical supplies—are typically reviewed as part of the primary diagnosis or procedure. If the primary service is covered, these Ancillary Services are generally covered as well and may be applied to the same Cost-Sharing structure (such as Coinsurance under the applicable

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Outpatient Hospital and Facility Services Benefit). If the primary service is not covered, related services may also be denied.

Benefits Table: Outpatient Services

This table outlines Member Cost-Sharing for Outpatient Services.

Outpatient Service Type	In-Network Member Cost-Sharing	Out-of-Network Member Cost-Sharing
Second Surgical Opinion Consultation with an independent, qualified physician on an outpatient basis to help determine whether a recommended surgery is medically necessary or if alternative treatment options may be appropriate.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Facility Fees The costs billed by a Hospital, Ambulatory Surgical Center, or other licensed Outpatient Facility for the use of their physical premises, equipment, and supporting staff that enable the delivery of Healthcare Services.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.

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Professional Fees Charges for services provided by Physicians or other licensed Healthcare Professionals for diagnosing, treating, or managing a medical condition. Administration of anesthesia may also be included on a bill as a Professional Fee.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Surgical Procedures Includes services such as endoscopy, laparoscopic surgery, tonsillectomy, breast lumpectomy, implantation of Cochlear Implants, Reconstructive Surgery.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Habilitative & Rehabilitative Therapy Services for Habilitative and Rehabilitative Therapy, including Physical, Speech, and Occupational Therapy. (For more detailed information, including specific conditions and limitations, please see the **Habilitative & Rehabilitative Therapy** section of this Schedule.)	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Outpatient Mental Health (MH) or Substance Use Disorder (SUD) Treatment	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.

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Intensive outpatient or partial hospitalization programs. (For more detailed information, including specific conditions and limitations, please see the **Mental Health & Substance Use Disorder Treatment** section of this Schedule)		
Labs & Pathology Includes services such as blood tests, urinalysis, and tissue analysis.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Routine Imaging (Basic Imaging) Standard imaging tests such as x-rays, ultrasounds, or mammograms, used to diagnose various conditions.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Advanced Imaging High-tech imaging procedures that provide detailed internal views such as Magnetic Resonance Imaging (MRI), Computed Tomography (CT) scans, or Positron Emission Tomography (PET) scans.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Other Diagnostic Testing Diagnostic tests not specifically categorized as Labs, Basic Imaging, or Advanced Imaging (e.g., pulmonary function tests, sleep studies, nerve conduction studies).	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.

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Genetic Testing and Molecular Diagnostics Testing for inherited cancer risks (e.g., BRCA, Lynch syndrome); carrier screening for conditions like cystic fibrosis before or during pregnancy; and prenatal screening (e.g., NIPT) for conditions like Down syndrome. (For more detailed information, including specific conditions and limitations, please see the **Genetic Testing and Molecular Diagnostics** section of this Schedule.)	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Chemotherapy & Radiation Treatment Cancer treatments delivered through intravenous medications or targeted radiation such as IV chemotherapy, radiation therapy, and immunotherapy.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Dialysis (Renal Disease Treatment) Treatment for kidney failure that removes waste and excess fluids from the blood.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Outpatient IV Infusion Therapy Intravenous administration of medications or fluids for conditions other than chemotherapy (e.g., for	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.

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autoimmune disorders, infections, dehydration).		
Outpatient Allergy Testing/ Treatment Allergy tests (e.g., skin prick tests, blood tests) and allergy injections or immunotherapy administered in an outpatient setting.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Outpatient Injections (Non-Allergy) Administration of injectable medications (e.g., for pain management, chronic conditions, or vaccines not covered as preventive) in an outpatient setting, when not part of a separate office visit or surgical procedure.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Telemedicine Services Outpatient services provided through real-time audio and video technology, as a virtual alternative to an in-person Outpatient visit by a treating Provider who is associated with the Outpatient Hospital or Facility.	Telemedicine visits are subject to the same coverage, limitations, and exclusions that apply to in-person Outpatient Hospital or Facility Services.	

Limitations and Exclusions for Outpatient Hospital and Facility Services

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In addition to the Plan's general exclusions, the following specific limitations and exclusions apply to Outpatient Hospital and Facility Services:

- Coverage for surgical implantation of Cochlear Implants is subject to Prior Authorization and is limited to individuals with the following conditions:
    - **Adults (18+):** Moderate-to-profound hearing loss unmanageable with hearing aids, with stimulable nerves, commitment to rehab, and no contraindications.
    - **Children (1+):** Severe-to-profound bilateral hearing loss with minimal hearing aid benefit, stimulable nerves, ability to rehab, and no contraindications per FDA.

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Inpatient Hospital & Facility-Based Services

In General

The Plan covers Medically Necessary Healthcare Services for the treatment of a sudden or serious illness or injury that requires the level of care only available in an Acute Care Facility, Hospital, or Residential Treatment Facility. Prior Authorization is generally required for Inpatient Hospitalization.

Cost-Sharing Overview for Inpatient Hospital/Facility Services

- In-Network Member Cost-Sharing: 20% coinsurance after the INN deductible is met.
- Out-of-Network Member Cost-Sharing: 50% coinsurance after the OON deductible is met.

Covered Inpatient Hospital/Facility Services

Below are examples of services that will be covered by the Plan when provided in an Inpatient Hospital or Facility:

- **Laboratory & Pathology Services:** Includes services such as blood tests, urinalysis, and tissue analysis.
- **Routing Imaging (Basic Imaging):** Standard imaging tests such as x-rays, ultrasounds, or mammograms, used to diagnose various conditions.
- **Advanced Imaging:** High-tech imaging procedures that provide detailed internal views such as Magnetic Resonance Imaging (MRI), Computed Tomography (CT) scans, or Positron Emission Tomography (PET) scans.
- **Habilitative & Rehabilitative Therapy:** Services for Habilitative and Rehabilitative Therapy, including Physical, Speech, and Occupational Therapy. (For more detailed information, including specific conditions and limitations, please see the **Habilitative & Rehabilitative Therapy** section of this Schedule.)
- **Inpatient Mental Health and Substance Use Disorder Treatment:** Room and Board, Physician services, therapy, and related services in a Hospital, Residential Treatment Center, or other licensed Facility. (For more detailed information, including specific conditions and limitations, please see the **Mental Health & Substance Use Disorder Treatment** section of this Schedule.)
- **Labor/Delivery and Maternity/Newborn Care:** Labor, delivery, postpartum, and neonatal care. (For more detailed information, including specific conditions and

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limitations, please see the **Pregnancy, Childbirth, and Postpartum Care** section of this Schedule.)

- **Inpatient-Administered Drugs and Biologics:** Includes IV medications, chemotherapy, or pain management.
- **Blood Transfusions:** Includes administration and processing of blood products.
- **Surgery for implantation of Cochlear Implants.** Subject to Prior Authorization, the Plan provides coverage for the surgical implantation of Cochlear Implants for individuals with the following conditions:
    - **Adults (18+):** Moderate-to-profound hearing loss unmanageable with hearing aids, with stimulable nerves, commitment to rehab, and no contraindications.
    - **Children (1+):** Severe-to-profound bilateral hearing loss with minimal hearing aid benefit, stimulable nerves, ability to rehab, and no contraindications per FDA.
- **Reconstructive Surgery.** Medically Necessary surgery needed due to an illness, injury, or congenital (birth) condition.

Note: Skilled Nursing Facility Services are treated as a separate Benefit and described separately under the **Skilled Nursing Facility Services** section of this Schedule.

Understanding Inpatient Hospital Billing

When you are admitted to a Hospital or Facility, the services you receive are typically billed in **two separate categories**:

1. **Facility Charges** – Billed by the Hospital or Facility for the use of the facility, staff, and equipment.
2. **Professional Charges** – Billed separately by Physicians or other licensed Healthcare professionals for the care they provide.

Facility Charges generally include:

- Room and board (including intensive care)
- Nursing services
- Use of the operating and recovery rooms
- Surgical supplies and equipment provided by the Facility
- Medications administered during your stay
- Laboratory tests and imaging services performed by the Facility
- Ancillary services (e.g., physical, occupational, or respiratory therapy) provided by the Facility

Professional Charges may include:

- Surgeon's services for performing surgery

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- Anesthesiologist's services for administering anesthesia
- Radiologist's services for interpreting imaging studies
- Pathologist's services for interpreting lab specimens
- Specialist consultation services during your stay
- Therapy services billed by an independent provider rather than the hospital

It is common to receive **multiple bills** for the same Inpatient Hospital or Facility stay — one from the Hospital or Facility for Facility Charges, and separate bills from the Providers for professional charges.

Your Cost-Sharing applies **separately** to each bill, even when they relate to the same stay. This means you may have Cost-Sharing for the Facility Charges and additional Cost-Sharing for one or more Professional Charges.

Limitations and Exclusions for Inpatient Hospital Services

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific limitations and exclusions apply to Inpatient Hospital & Facility-Based Services:

- Services provided by a Private Duty Nurse are not covered.
- The Plan does not cover Custodial Care (i.e., services that are primarily for assistance with Activities of Daily Living (e.g., bathing, dressing, eating).
- The Plan does not cover items provided solely for personal comfort or convenience (e.g., guest meals, telephone, television, internet access charges).
- Inpatient Admissions or Hospitalizations are not covered when the primary reason for admission is not a Covered Benefit under the Plan (e.g., Infertility Treatment).
- Inpatient Hospitalization is generally subject to Prior Authorization. Inpatient Admissions or Hospitalizations for which Prior Authorization is required but was not obtained are not covered.

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Urgent Care Services

In General

The Plan covers Medically Necessary Urgent Care Services provided by a Provider in an Urgent Care Center or other approved Facility.

Covered Urgent Care Services

Urgent Care Services are for unexpected illnesses or injuries that require prompt medical attention but are not what a prudent layperson would consider to be an Emergency Medical Condition. Examples of Covered Urgent Care Services include minor sprains, cuts, fevers, ear infections, and other conditions.

Benefits Table: Urgent Care Services

This table outlines Member Cost-Sharing for Urgent Care Services:

Urgent Care Services	In-Network	Out-of-Network
Services coded and billed as Urgent Care Services, regardless of the physical location or whether the clinic or Facility bills under a Hospital's Tax ID (TIN).	$75 copayment per visit. Deductible does not apply.	50% coinsurance after the OON deductible is met.

Limitations and Exclusions for Urgent Care Services

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific limitations and exclusions apply to Urgent Care Services:

- The Plan does not cover treatment or follow-up care for chronic conditions under the Urgent Care Services benefit. These services are covered under other Benefits, such as Primary Care Services or Specialty Care Services, as part of your Office Visit Services or Outpatient Hospital and Facility Benefits.
- Services that are not billed with urgent care codes are processed under the applicable Benefit category for the type of service or place of service.

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Emergency Services

In General

The Plan covers all Emergency Services, including the initial evaluation, treatment, stabilization (Initial Emergency Services), and Post-Stabilization Services necessary to treat an Emergency Medical Condition. These services are covered regardless of whether they are received at an In-Network or Out-of-Network facility or provided by a Participating or Non-Participating Provider.

Prudent Layperson Standard

Coverage for Emergency Services is based on the Prudent Layperson Standard. This means services will be covered if a reasonable person with average knowledge of health and medicine could expect the condition to be serious enough to require immediate medical attention—even if the final diagnosis does not confirm an emergency.

Initial Emergency Services

Initial Emergency Services are provided to evaluate and stabilize an Emergency Medical Condition. These services are covered without Prior Authorization and include:

- An appropriate medical screening examination, within the capabilities of the emergency department or facility, to determine whether an Emergency Medical Condition exists;
- Any further examination or treatment required to stabilize the individual;
- Facility services, such as emergency room usage fees, room and board, nursing care, supplies, and equipment used during emergency treatment;
- Professional (Physician) services, including those provided by emergency room doctors, radiologists, anesthesiologists, and other specialists involved in the emergency evaluation and stabilization; and
- Diagnostic services, including laboratory tests, imaging, and other procedures needed as part of the emergency evaluation.

You can receive Initial Emergency Services at an Emergency Department, which includes both Emergency Departments of a Hospital (including Outpatient Hospital departments that offer Emergency Services) and independent freestanding Emergency Departments geographically distinct and licensed separately from a Hospital under state law. Coverage extends to

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necessary medical examination and treatment to stabilize your condition anywhere within the Emergency Department.

Post-Stabilization Services

Post-Stabilization services are generally covered like other Emergency Services, which means you are protected from higher Out-of-Network costs and Balance Billing.

However, these services will NOT be treated as Emergency Services (and your usual Out-of-Network Cost-Sharing will apply) if all of the following are met:

- **You're Medically Stable for Transfer:** The emergency Physician or treating Provider confirms you are medically stable and can safely travel to an In-Network Provider or Facility using non-medical or Non-Emergency Transportation, considering your condition and the travel distance.
- **You Receive a Clear Notice & Consent:** The Out-of-Network Provider or Facility gives you a clear notice explaining their Out-of-Network status, your estimated costs, and your rights, and gets your written consent to receive Out-of-Network care. This notice must follow federal rules (45 CFR 149.420(c) through (g)).
- **You Can Understand & Consent:** You (or your authorized representative) are in a condition to understand this information and provide informed consent.
- **State Law Compliance:** The Provider or Facility also follows any other relevant state laws about Post-Stabilization services.

If **any** of the above conditions are **not** met, Post-Stabilization Services will be treated as Emergency Services. This means you will only pay your In-Network Cost-Sharing amounts, even if the Provider or Facility is Out-of-Network.

If **all** of the above conditions are met, Post-Stabilization Services will **not** be treated as Emergency Medical Services. In this case, they will be subject to the applicable Cost-Sharing amount for Out-of-Network Outpatient Hospital & Facility Services.

Important Notification Requirements for Inpatient Admissions

You should notify the Utilization Management (UM) Administrator of any Inpatient Admission within forty-eight (48) hours or as soon as reasonably possible. This notification requirement applies whether the services are provided by a Participating Provider or a Non-Participating Provider.

Delayed Notification Due to Incapacity

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If you are unable to provide notice because you are Incapacitated, or if you are a minor and your parent or guardian was not aware of your admission, then the deadline to provide notice begins when:

- Your Incapacity ends and you are able to give notice; or
- Your parent or guardian becomes aware of the admission.

For this purpose, you are considered Incapacitated only if you are physically or mentally unable to provide the notice yourself due to an Emergency Medical Condition, and you cannot provide the notice through another person on your behalf.

Cost-Sharing for Inpatient Admissions Within 24 Hours of Emergency Services

If you are admitted within twenty-four (24) hours of the Emergency Services visit, Benefits will be subject to the applicable Cost-Sharing for Inpatient Hospital Services.

Benefits Table: Emergency Services

This table outlines Member Cost-Sharing for Emergency Services:

Type of Service	In-Network Emergency Services	Out-of-Network Emergency Services
Initial Emergency Services and Post-Stabilization Services	$500 copayment per visit. No additional cost-sharing applies.	Covered at In-Network Cost-Sharing levels, based on the Recognized Amount.

Limitations and Exclusions for Emergency Services

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific limitations and exclusions apply to Emergency Services:

Limitations

- Post-Stabilization Services are not subject to Balance Billing protections and may be reimbursed under the Plan's standard Out-of-Network Cost-Sharing amounts if the applicable notice and consent requirements described above are met.
- Non-Emergency Services received in an Emergency Department are not covered or may be subject to higher Cost-Sharing, except when the visit reasonably appeared to a prudent layperson to require emergency medical attention.

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Exclusions

The Plan does not cover Observation Care exceeding forty-eight (48) hours per episode of care.

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Ambulance Services

In General

The Plan provides coverage for Medically Necessary Ambulance Services as described below.

Ground Ambulance Services

The Plan covers Medically Necessary ground Ambulance Services, including both transport and non-transport services, for Emergency Medical Conditions and other Covered Services.

Emergency Ground Ambulance Transport

Covered for transport to the nearest Hospital or medical center able to render initial care for an Emergency Medical Condition. This includes transport from the scene of an accident or sudden illness.

Important Note: While the Plan covers Ground Ambulance Services for emergencies at the In-Network level even when provided by an Out-of-Network Provider, coverage for Out-of-Network services is based on the Allowed Amount. Because these services are not protected by the No Surprises Act, an Out-of-Network ambulance provider may Balance Bill you for charges that exceed the Allowed Amount. This means the Provider may charge you for the amount that exceeds the Plan's Allowed Amount.

Non-Emergency Ground Ambulance Transport

Covered for:

- Medically Necessary transport when other means of transportation would endanger the Member's health or are not appropriate given the Member's medical condition.
- Transfers between Hospitals when the transferring Hospital is unable to provide Medically Necessary care and the Member requires transfer to the nearest Hospital that can provide such care. Such transfers are covered only when the medical condition is a Critical Medical Situation; the transfer is ordered by a Physician; and it is coordinated with a receiving Physician.

Non-Transport Ambulance Service

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Covered for Medically Necessary on-scene care provided by Ambulance Service personnel without subsequent transport of the Patient.

Air Ambulance Services

The Plan covers Air Ambulance Transport to the nearest Hospital or Facility able to render Medically Necessary care.

Covered Air Ambulance Services provided by an Out-of-Network Provider are subject to the same Cost-Sharing requirements that would apply if the services were provided by an In-Network Provider of Air Ambulance Services. Your Cost-Sharing will be calculated as the lesser of the QPA and the Billed Charges for the services. You are only responsible for paying your Cost-Sharing as described in the **In-Network vs. Out-of-Network** section of this Schedule ("Special Rules for Services Subject to the No Surprises Act"). This means you cannot be Balance Billed for Covered Air Ambulance Services.

Benefits Table: Ambulance Services

This table outlines Member Cost-Sharing for Ambulance Services:

Ambulance Service Type	In-Network	Out-of-Network
Ground Ambulance - Emergency Transport	20% coinsurance after the INN deductible is met.	20% coinsurance after the INN deductible is met.
Ground Ambulance - Non-Emergency Transport	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Ground Ambulance - No Transport	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Air Ambulance Services	20% coinsurance after the INN deductible is met.	20% coinsurance after the INN deductible is met.

Limitations and Exclusions for Ambulance Services

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific limitations and exclusions apply to Ambulance Services:

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- Air Ambulance Transportation is not covered unless Medically Necessary.
- Non-Emergency Ambulance Service from Hospital to Hospital for transfers or admission performed only for convenience are not covered.
- Non-Emergency Ground Ambulance Transport requires Prior Authorization.

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Home Health Services

This section describes coverage for Medically Necessary Home Health Services, including Palliative Care Services, and Home Infusion Therapy, when received in your home. All services must be ordered by a Provider and rendered by a Provider or Qualified Healthcare Professional acting within the scope of their license and in accordance with Plan requirements.

Skilled Home Health Care

The Plan covers Skilled Home Health Care that is received from a licensed home health agency. These services are provided in your home as an alternative to Hospital, Facility, or office-based care.

Skilled Home Health Care may include:

- Physical Therapy;
- Occupational Therapy;
- Speech Therapy;
- Respiratory Therapy; and
- Other Medically Necessary therapeutic services rendered in your home.

For Skilled Home Health Care to be received in your home, you must be Homebound, or the Plan must determine the services are Medically Necessary and the most cost-effective. While Skilled Home Health Care is covered under the Home Health Benefit, Custodial Care (i.e., assistance with personal care of Activities of Daily Living) is not.

Skilled Home Health Care and Palliative Care services (described below) have a combined limit of one hundred (100) visits (with 4 hours of service equaling 1 visit) per Member per Plan Year.

Palliative Care

The Plan covers Palliative Care if you are eligible to receive Palliative Care in the home but are not Homebound. Palliative Care includes symptom management, education, and establishing goals of care.

Palliative Care and Skilled Home Health Care services (described above) have a combined limit of one hundred (100) visits (with 4 hours of service equaling 1 visit) per Member per Plan Year.

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Home Infusion Therapy

The Plan also covers Home Infusion Therapy, subject to Prior Authorization, when:

- The therapy is prescribed by a Physician and deemed Medically Necessary.
- The Services are administered by a licensed Provider or through a licensed Home Health Agency.
- The therapy is one that can be safely delivered in a home setting and includes medications, equipment, and supplies needed for infusion.

Benefits Table: Home Health Services

This table outlines Member Cost-Sharing for Home Health Services:

Type of Service	In-Network Emergency Services	Out-of-Network Emergency Services
Skilled Home Health Care	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Palliative Care	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Home Infusion Therapy	No Charge.	50% coinsurance after the OON deductible is met.

Limitations and Exclusions for Home Health Services

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific limitations and exclusions apply to Home Health Services:

- Visits for administration of non-covered medication or related Non-Covered Services under the Plan.
- Services that are defined as Non-Skilled Care or Custodial Care are not covered. This includes, but is not limited to, personal care, companionship, assistance with Activities of Daily Living, and any such services provided by your family members or anyone residing in your home.
- Home Health Services provided at any site other than your place of residence.
- Healthcare Services, equipment, or supplies provided solely for convenience, or due to lack of transportation, or for other non-medical reasons.

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- A Healthcare Service is not considered Skilled Care solely because it is performed by, or under the supervision of, a Nurse or other Qualified Healthcare Professional. If a Healthcare Service can be safely and effectively performed by an individual without specialized medical training (such as a family member) or can be self-administered, the service will not be regarded as Skilled Care, even if provided by a Nurse. The unavailability of an individual without specialized medical training to perform such a service does not change its classification. For services that include both Skilled and non-skilled components (commonly referred to as “Blended Services”), only the Skilled Care portion of the Service is covered under the Plan. Non-Skilled Care provided by a Nurse will not be treated or covered by the Plan as Skilled Care. These exclusions apply even when services are recommended by a Provider.
- Respite Care Services in a Home Health Setting.
- Private Duty Nursing care, except for short-term Medically Necessary services (up to 120 hours) provided by a Nurse or Healthcare Professional, as recommended by the Member's treating Provider, solely for the initial home stabilization of a device-based respiratory support system, such as a newly placed ventilator or tracheostomy.

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Medical Equipment and Supplies

In General

The Plan covers Medically Necessary Equipment and Supplies, and certain nutritional products when ordered or prescribed by a Physician and provided by Durable Medical Equipment (DME)/Prosthetic Vendors or other Eligible Providers.

For purposes of the Plan, Equipment and Supplies means items that are:

- Medically Necessary;
- Prescribed by a Physician or other authorized Health Care Provider; and
- Primarily and customarily used for the diagnosis, treatment, or management of an Illness, injury, or medical condition.

Durable Medical Equipment (DME)

Medically Necessary DME, including wigs for hair loss resulting from a medical condition, wheelchairs, walkers/crutches, canes, hospital beds, oxygen equipment, and nebulizers.

Prosthetics and Orthotics

Medically Necessary Orthotics and Prosthetics, including custom molded foot orthotics, Cochlear Implants, therapeutic shoes for diabetes, prosthetic shoes, contact lenses necessary to treat specific eye diseases such as keratoconus, aphakia, or severe corneal disease, and rehabilitative foot orthotics following surgery or trauma.

Equipment and Supplies Nutrition Support

The Plan covers Equipment and Supplies for and administration of nutrition support when Medically Necessary and prescribed by a Provider to treat a diagnosed medical condition. Coverage includes Equipment and Supplies for:

- **Parenteral and Enteral Nutrition** when it is the sole or primary source of nutrition, is required to treat a specific diagnosed medical condition that prevents adequate oral intake of food, and is administered through a feeding tube or other Medically Necessary device.
- **Amino acid-based formulas** prescribed to manage severe food allergies, malabsorption disorders, or metabolic conditions;

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- **Special dietary treatment** for diagnosed metabolic disorders, such as, but not limited to, phenylketonuria (PKU), consistent with applicable state or federal mandates;
- **Other oral nutritional or electrolyte substances**, but only when prescribed to treat a diagnosed medical condition and when considered Medically Necessary.

Important Note: Equipment and Supplies used to administer nutritional products are covered under the **Medical Equipment and Supplies Benefit** when billed separately from the nutritional formulas (such as Total Parenteral Nutrition (TPN) or Total Enteral Nutrition (TEN) formulas). The nutritional formulas themselves are covered under the **Prescription Drug/Pharmacy Benefit**. If the Equipment and Supplies are billed together with the nutritional formulas, the total charge is processed under the **Prescription Drug/Pharmacy Benefit**.

Other Medically Necessary Equipment and Supplies

Other Equipment and Supplies deemed Medically Necessary for your care. For verification of eligible Equipment and Supplies, call Gravie Care®.

Note: Certain types of Equipment and Supplies are covered under separate benefits. For example:

- For coverage of continuous glucose monitors, glucose meters, and diabetic test strips, please refer to the **Prescription Drug/Pharmacy Benefit** section of this Schedule.
- Double-electric Breast pumps are covered under **Preventive Services.**
- Blood pressure monitors are covered under **Expanded Preventive Services.**
- Peak Flow Meters are covered under **Expanded Preventive Services**.
- Nutritional formulas such as Total Parenteral Nutrition (TPN) or Total Enteral Nutrition (TEN) are covered under the **Prescription Drug/Pharmacy Benefit**.
- While Cochlear Implants are covered as a prosthetic device, the surgical implantation of the device is covered under the applicable **Outpatient** or **Inpatient Hospital/Facility** surgical benefit.

Benefits Table: Medical Equipment & Supplies

This table outlines Member Cost-Sharing for Medical Equipment & Supplies:

Type of Equipment/Supply	In-Network Provider	Out-of-Network Provider

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Durable Medical Equipment (DME)	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Prosthetics & Orthotics	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Equipment and Supplies for Nutrition Support	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Other Medically Necessary Equipment and Supplies (unless covered under another benefit)	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.

Exclusions and Limitations for Medical Equipment and Supplies

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific limitations and exclusions apply to Medical Equipment and Supplies:

Coverage Limitations

- Benefits are limited to the most cost-effective and Medically Necessary alternative.
- Plan payment for rental shall not exceed the purchase price (unless the Plan determines the item is rental-only).
- Wigs for hair loss are limited to a maximum of one wig per member per Plan Year.
- Non-Participating DME Providers must have a valid Medicare provider number.
- Replacements are covered only when items are no longer functional and/or not repairable due to normal wear or use.

Administrative Costs Not Covered

- Sales tax, mailing, or delivery charges.
- Installation costs for wiring, plumbing, or equipment.

Damage & Misuse Not Covered

- Replacement or repair due to misuse, abuse, carelessness, loss, or theft.

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Equipment & Supplies Not Covered

- Disposable or non-durable supplies and appliances.
- Equipment solely for operating non-covered items.
- Duplicate or similar items when member already has functional equipment.

Specific Items Not Covered

- Nutritional and electrolyte supplements, vitamins, minerals, meal replacements taken for general health, weight management, or sports performance.
- Contact lenses (except when medically necessary for keratoconus or to restore functional vision).
- Hearing aids, devices to improve hearing (except Cochlear Implants as described in this Schedule), and related fittings or Healthcare Services.
- Communication aids (speech processors, communication boards, computer-assisted communication).
- Household items (e.g., air conditioners, exercise equipment, hypoallergenic bedding).
- Home modifications (e.g., ramps, elevators, swimming pools).
- Vehicle modifications (e.g., handbrakes, hydraulic lifts, and car carrier).
- Over-the-counter orthotics and appliances.
- Orthopedic shoes (except as otherwise covered under this Schedule).

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Hospice Care Services

In General

The Plan covers Hospice Care Services for terminally ill individuals who enroll in a Licensed Hospice Program. Hospice Services focus on comfort and support rather than curative or restorative treatment for the terminal illness. Generally, to be eligible for enrollment in a hospice program, an individual must be certified by a Physician as terminally ill with a life expectancy of six (6) months or less and choose a palliative treatment focus, meaning the individual prefers comfort and supportive services over treatments designed to cure or restore their health.

Covered Services

Covered Hospice Care Services are provided according to an approved treatment plan and may include:

- **Routine Home Care** provided in your home by a team of professionals (which may include a Physician, Nurse, social worker, and spiritual counselor).
- **Continuous Care** provided in your home when Medically Necessary.
- **Medically Necessary Inpatient Services**, available at a Hospice Center or other appropriate Facility.
- **Respite Care** authorized in advance to provide temporary relief for your primary caregivers (family members or friends) in your home or an appropriate setting, when needed to maintain you at home.
- **Medications** for pain and symptom management.
- **Medically Necessary DME**.

Benefits Table: Hospice Care Services

This table outlines Member Cost-Sharing for Hospice Care Services:

Type of Service	In-Network Provider	Out-of-Network Provider

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Covered Hospice Care Services • Routine Home Care • Continuous Care • Respite Care • Inpatient Care • Medication* *Certain medications may fall under the Plan's **Prescription Drug/Pharmacy** Benefit. Contact Gravie Care® with questions.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
DME	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.

Limitations and Exclusions for Hospice Care Services

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific conditions, limitations, and exclusions apply to Hospice Care Services:

Program Requirements

- Services must be provided under the direction of a Licensed Hospice Program.
- Care must be included in the Hospice Care plan approved by the attending Physician.
- The Member must be certified as terminally ill for the period services are provided.
- Hospice care services provided for more than twelve (12) months require Plan review to determine if continued care meets Medical Necessity criteria. Coverage beyond 12 months is not guaranteed and depends on review outcomes.

Services Not Covered

- Curative treatments intended to reverse the terminal illness.
- Services for illnesses or conditions unrelated to the terminal diagnosis (unless otherwise covered under the plan).
- Experimental and/or Investigational treatments.
- Room and board charges when receiving Outpatient services at a Hospice Center or other Facility
- Private Duty Nursing care.

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- Services provided by family members or unpaid caregivers (even if licensed).
- Bereavement counseling for non-Members.
- Curative treatments intended to reverse the terminal illness.
- Services for illnesses or conditions unrelated to the terminal diagnosis (unless otherwise covered under the Plan).

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Habilitative and Rehabilitative Services

In General

The Plan covers Medically Necessary Habilitative and Rehabilitative Services to help individuals develop, improve, or restore functional skills.

Habilitative Services

Habilitative Services help individuals develop or improve skills they may not have acquired due to a congenital condition, developmental delay, or disability.

- **Physical Therapy (PT):** Improves strength, mobility, and functional independence.
- **Occupational Therapy (OT):** Enhances skills for daily living, such as dressing, eating, and using adaptive equipment.
- **Speech Therapy (ST):** Supports speech, language, communication, and swallowing abilities.
- **Applied Behavior Analysis (ABA):** Focuses on communication, social skills, and behavioral development, commonly for individuals with autism spectrum disorder.
- **Post-Cochlear Implant Aural Therapy:** Assists with auditory processing and communication after cochlear implantation.

Rehabilitative Services

Rehabilitative Services help individuals recover or regain lost skills due to injury, illness, or disability.

- **Physical Therapy (PT):** Strength training, post-surgical rehabilitation, balance and coordination exercises, pain management.
- **Occupational Therapy (OT):** Activities of Daily Living (ADL) training, cognitive rehabilitation, work hardening, and home safety assessment.
- **Speech Therapy (ST):** Treatment for speech, language, voice, swallowing disorders, and cognitive-communication therapy.
- **Post-Cochlear Implant Aural Therapy:** Supports individuals adapting to hearing loss after an injury or illness.

Service Locations

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Services may be provided in:

- Offices/Clinics.
- Outpatient settings (Rehabilitation centers, Outpatient Hospitals/Facilities).
- Inpatient Rehabilitation units following Hospitalization.
- The home, for those unable to travel.

Cost-Sharing varies by service setting (e.g., Office, Outpatient, Inpatient, or home). For details on how your specific service will be billed, you may reach out to your treating Provider. Please also refer to the Benefits Table or contact Gravie Care®.

Benefits Table: Habilitative and Rehabilitative Therapy Services

This table outlines Member Cost-Sharing for Habilitative and Rehabilitative Services:

Type of Service	In-Network Provider	Out-of-Network Provider
Habilitative or Rehabilitative Services received as part of an Office Visit with a Specialist.	$50 copayment per visit. Deductible does not apply.	50% coinsurance after the OON deductible is met.
Habilitative or Rehabilitative Services received in an Outpatient Hospital or Facility setting.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Habilitative or Rehabilitative Services received in an Inpatient Hospital or Facility Setting.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Habilitative or Rehabilitative Services received in the home as part of Home Health Services.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Virtual Physical Therapy via Sword Health.	No Member Cost-Sharing.	

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Limitations and Exclusions for Habilitative & Rehabilitative Services

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific conditions, limitations, and exclusions apply to Rehabilitative Services and Habilitative Services:

General Conditions and Limitations on Coverage:

- Occupational Therapy (OT), Speech Therapy (ST), and Physical Therapy (PT) must be provided by a Licensed Healthcare Provider operating within their scope of practice, or ordered by a Physician, Physician Assistant, or Nurse Practitioner and provided under the supervision of a licensed therapist.
- Coverage for Habilitative Services or Rehabilitative Services may be limited to treatment that demonstrates measurable and sustainable functional improvement within a reasonable period of time (typically two weeks to three months, depending on the individual's physical and mental capacities). Services that do not demonstrate such improvement will not be covered, and maintenance therapies will not be covered.
- Post-Cochlear Implant Aural Therapy may require enrollment in an educational program or continued follow-up care.

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Skilled Nursing Facility Services

In General

The Plan covers Medically Necessary Skilled Nursing Services in a Skilled Nursing Facility (SNF) when Physician-ordered following a Hospital stay, limited to one hundred twenty (120) days per Member per Plan Year.

Covered Services

Covered services may include but are not limited to: Administration of intravenous medications, complex wound care, and skilled monitoring of an unstable condition.

Cost-Sharing for Skilled Nursing Facility Services

The following Cost-Sharing applies to Skilled Nursing Facility Services:

- In-Network: 20% coinsurance after the INN deductible is met.
- Out-of-Network: 50% coinsurance after the OON deductible is met.

Limitations and Exclusions for Skilled Nursing Facility Services

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific conditions, limitations, and exclusions apply to Skilled Nursing Facility Services:

- Coverage is limited to a maximum of 120 days per Member per Plan Year.
- Coverage is limited to services and care that would be considered eligible for reimbursement under Medicare guidelines.
- Custodial Care, Long-Term Care, and other services that do not meet Medicare's criteria for Skilled Care are not covered. The Plan reserves the right to determine eligibility for benefits based on Medicare coverage standards, including Medical Necessity and the need for Skilled Care.
- Services must be directed by a Physician.
- Services are subject to Prior Authorization.
- Services provided by a Private Duty Nurse are not covered.
- A Healthcare Service is not considered Skilled Care solely because it is performed by, or under the supervision of, a Nurse or other qualified Healthcare Professional. If a Healthcare Service can be safely and effectively performed by

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an individual without specialized medical training (such as a family member) or can be self-administered, the service will not be regarded as Skilled Care, even if provided by a Nurse. The unavailability of an individual without specialized medical training to perform such a service does not change its classification. For services that include both Skilled and non-skilled components (commonly referred to as “Blended Services”), only the Skilled Care portion of the Service is covered under the Plan. Non-Skilled Care provided by a Nurse will not be treated or covered by the Plan as Skilled Care. These exclusions apply even when services are recommended by a Provider.

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Transplant Services

In General

The Plan covers Medically Necessary transplant services when authorized by the Plan and received at a Designated Transplant Network provider (unless otherwise approved). All services are subject to ongoing evaluation for therapeutic treatment and safety, with guidelines updated annually or as new information becomes available.

Covered Transplant Services

The Plan provides coverage for the following when Medically Necessary and not and/or Investigational:

- Bone marrow and peripheral stem cell transplants (with or without high-dose chemotherapy)
- Heart, heart/lung, lung, kidney, kidney/pancreas, liver, pancreas, and small bowel transplants

Coverage includes private room, post-surgical treatment, and related drugs. Donor medical and hospital expenses are covered only when the recipient is a Member and the transplant is approved via Prior Authorization. Donor complications are not covered.

Coverage for transplant services is subject to the Plan's Cost-Sharing requirements based on the type of service and service location. Refer to the following sections for applicable Cost-Sharing information:

- Preventive Services
- Office Visit Services
- Outpatient Services
- Inpatient Hospital and Facility Services

Designated Network Providers

Members must get Transplant Services from a Designated Network Provider. If there are no Designated Network providers in the network, it is important to contact Gravie Care.

The Designated Network Provider for the Plan is:

Aetna Institutes of Excellence® for Transplant supports: https://www.aetna.com/health-care-professionals/patient-care-programs/aetna-institutes.html

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Transplant Travel and Lodging Services

When Member or non-covered living donor lives more than 50 miles from the transplant center, the Plan covers travel and lodging expenses for:

- The Member
- One or two parents (if the Member is a child Dependent) or one adult companion (if member is not a child Dependent)
- Non-covered living donor (when living more than 50 miles from center)

Covered expenses include airfare, tolls, parking, gas/mileage, lodging (hotel/apartment rental, short-term home rentals), and meals. Lodging does not include private residences. Lodging reimbursement over $50 per person per day may be taxable income.
Travel and lodging expenses are limited to a maximum benefit of **$10,000 per transplant episode** for the recipient and one companion.

Cost-Sharing

Cost-sharing for these services will vary based on the place of service, as specified in this Schedule. The applicable Deductible, Copayment, or Coinsurance will be determined according to whether the services are provided in a Physician's office, an outpatient hospital department, or another covered setting.

Evaluation of Transplant Services for Therapeutic Treatment and Safety

The Plan evaluates Transplant Services for therapeutic treatment and safety. This evaluation continues at least annually or as new information becomes available and results in specific guidelines about Benefits for Transplant Services. You can call Gravie Care® for information about these guidelines.

Limitations and Exclusions for Transplant Services

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific conditions, limitations, and exclusions apply to Transplant Services:

Limitations:

- Transplant Services coverage may be subject to periodic review by the Plan.

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- Certain Prescription Drugs used in connection with covered Transplant Services may require Prior Authorization before they will be covered. The specific drugs and requirements are determined by the Pharmacy Benefit Manager and may change from time to time.

Services Not Covered by the Plan:

- Services received at or by a non-Designated Network Provider, unless specifically approved by the Plan.
- Organ, tissue, bone marrow, and stem cell transplants, including peripheral stem cell procedures, are not covered if considered Experimental and/or Investigational for the condition.
- Healthcare Services related to non-human organ implants.
- Healthcare Services related to human organ transplants not specifically approved as Medically Necessary by the Plan.
- Treatment of medical complications to a donor after procurement of a transplanted organ.
- Computer search for donors.
- Private collection and storage of blood and umbilical cord/umbilical cord blood, unless related to scheduled and approved future services.
- Travel services and expenses not listed as covered by this Schedule.
- Healthcare Services for or in connection with fetal tissue transplantation, except for non-Investigational stem cell transplants.
- Organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, excluding surgical implantation of U.S. Food and Drug Administration (FDA) approved ventricular assist devices.

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Gene, Cell, and Related Therapies

In General

The Plan covers FDA-approved Gene, Cell, and Related Therapies provided by a Physician, Hospital, or other Provider.

Covered Services

Covered Services include:

1. Cellular immunotherapies;
2. Genetically modified oncolytic viral therapy;
3. Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions;
4. All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use;
5. Products derived from gene editing technologies, including CRISPR-Cas9; and
6. Oligonucleotide-based therapies.

Cost-Sharing

Cost-sharing for these services will vary based on the place of service, as specified in this Schedule. The applicable Deductible, Copayment, or Coinsurance will be determined according to whether the services are provided in a Physician's office, an outpatient hospital department, or another covered setting.

Designated Networks

Members must get Gene, Cell, and Related Therapy Services from a Designated Network Provider. If there are no Designated Network providers in the network, it is important to contact Gravie Care.

The Designated Network for the Plan is:

> Aetna Gene-based, Cellular and Other Innovative Therapies (GCIT®) Designated Networks: https://www.aetna.com/health-care-professionals/patient-care-programs/aetna-institutes.html

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Limitations & Exclusions for Gene, Cell, and Related Therapies

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific conditions, limitations, and exclusions apply to Gene, Cell, and Related Therapies:

- Services received at or by a non-Designated Network Provider, unless specifically approved by the Plan, will not be covered.
- Services that are Experimental and/or Investigational are not covered.

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Genetic Testing and Molecular Diagnostics

In General

The Plan covers Genetic Testing and Molecular Diagnostics when Medically Necessary and when results will directly impact the diagnosis, treatment, or management of a specific sickness or condition. All genetic testing must be ordered by a Physician or other licensed Healthcare Professional acting within the scope of their license. Prior Authorization may be required.

Covered Services

Examples of covered Genetic Testing and Molecular Diagnostic services include, but are not limited to:

- BRCA1 or BRCA2 testing for hereditary breast and ovarian cancer syndrome.
- Lynch syndrome testing for hereditary nonpolyposis colorectal cancer (HNPCC) Familial hypercholesterolemia gene testing.

Benefits Table: Genetic Testing and Molecular Diagnostics

This table outlines Member Cost-Sharing for Genetic Testing and Molecular Diagnostic services:

Type of Service	In-Network Provider	Out-of-Network Provider
Genetic Testing that is considered a Preventive Service under the ACA.	No Member cost.	50% coinsurance after the OON deductible is met.
Genetic and Molecular Diagnostic Testing received as part of an Office Visit with a Primary Care Physician.	$30 copayment per visit. Deductible does not apply.	50% coinsurance after the OON deductible is met.

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Genetic and Molecular Diagnostic Testing received as part of an Office Visit with a Specialist.	$50 copayment per visit. Deductible does not apply.	50% coinsurance after the OON deductible is met.
Genetic and Molecular Diagnostic Testing received as part of an Outpatient Hospital or Facility visit.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Genetic and Molecular Diagnostic Testing received as part of an Inpatient Hospital or Facility visit.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.

Limitations and Exclusions

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific conditions, limitations, and exclusions apply to Genetic Testing and Molecular Diagnostics:

- Genetic Testing is not covered when performed for non-medical purposes (including ancestry, paternity, or personal curiosity).
- Prior authorization may be required for certain Genetic Testing and Molecular Diagnostic services.
- Genetic Testing and Molecular Diagnostics are not covered when done to predict how an individual may respond to certain medications, including whether a drug may be effective, the appropriate dose, or the risk of side effects. This type of testing is considered Experimental and/or Investigational and is not covered unless required by law or specifically listed as a Covered Benefit under the Plan.

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Pregnancy, Childbirth, and Postpartum Care

General Coverage

The Plan provides comprehensive pregnancy-related care, including prenatal care, labor and delivery, and post-natal care. Coverage includes Physician or midwife services, Hospital services (room and board), anesthesia, laboratory and imaging services, and other Medically Necessary care related to pregnancy and childbirth.

Prenatal Care

The Plan covers prenatal care provided by a licensed Physician, obstetrician, certified nurse midwife, or other Healthcare Professional acting within the scope of their license. Covered services include, but are not limited to:

- Initial and follow-up prenatal office visits
- Routine physical exams and monitoring
- Blood pressure checks and fetal heart monitoring
- Laboratory tests and screenings (e.g., blood work, urine tests, gestational diabetes screening)
- Ultrasound and imaging services
- Gestational diabetes screening
- Folic acid supplementation
- Services related to high-risk pregnancies or pregnancy complications, as Medically Necessary

Labor and Delivery

The Plan covers labor and delivery services for covered Members when provided in a Hospital or other licensed Facility (excluding Freestanding Birthing Centers). Covered services include:

- Facility charges (room and board)
- Professional fees for physicians, obstetricians, or certified nurse midwives
- Anesthesia and surgical services (including cesarean delivery)
- Labor monitoring and support services
- Medications and medical supplies administered during delivery
- Post-delivery inpatient care for mother and newborn

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Length of Hospital Stay

As required by the Newborns' and Mothers' Health Protection Act of 1996, the Plan guarantees minimum hospital stays of:

- 48 hours following vaginal delivery
- 96 hours following cesarean delivery

Longer stays may require Prior Authorization.

Newborn/Postnatal Care

Newborn children receive coverage under the Plan retroactive to the date of birth when enrolled within the specified timeframe (see the **Enrollment** section of this document). Covered newborn/postnatal services include:

- Routine nursery care
- Newborn medical screening
- Medically Necessary treatment for injury or illness
- Well-baby visits
- Immunizations

Postpartum Care

The Plan covers comprehensive postpartum care for mothers, including inpatient services and follow-up outpatient care after discharge. Covered services include:

- Physical recovery assessments (incision checks, bleeding evaluation, uterine involution)
- Management of childbirth-related complications
- Follow-up visits with obstetric Providers
- Mental health evaluations and treatment for postpartum conditions
- Prescribed medications for postpartum recovery
- Other Medically Necessary postpartum care
- Breastfeeding counseling and supplies
- Postpartum depression screening

Benefits Outline: Pregnancy, Childbirth, and Postpartum Care

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Coverage for pregnancy, childbirth, and postpartum care is subject to the Plan's Cost-Sharing requirements based on the type of service and service location. Refer to the following sections for applicable Cost-Sharing information:

- Preventive Services
- Office Visit Services
- Outpatient Hospital and Facility Services
- Inpatient Hospital and Facility Services

Note that many routine prenatal, postnatal, and postpartum services are covered at 100% when received In-Network as required by the ACA for Preventive Services. Examples of prenatal, postnatal, and postpartum services that are considered Preventive Services include:

- Routine prenatal office visits (e.g., checkups during pregnancy)
- Standard prenatal screenings (e.g., gestational diabetes)
- Depression screening during and after pregnancy
- Lactation counseling, support, and supplies
- Breast pump purchase or rental

For questions about specific services and whether they qualify as Preventive Services, please contact Gravie Care®.

Limitations & Exclusions for Pregnancy, Childbirth, and Postpartum Care

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific conditions, limitations, and exclusions apply to Pregnancy, Childbirth, and Postpartum Care:

- The Plan does not cover labor and delivery services at Freestanding Birthing Centers, even if licensed or accredited.
- The Plan does not cover Healthcare Services for maternity, labor, and delivery in the home.

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Mental Health & Substance Use Disorder Treatment

In General

The Plan provides coverage for the treatment of mental health conditions and substance use disorders. This coverage is subject to the same terms and requirements that apply to other covered medical and surgical services under the Plan, including limitations on coverage Cost-Sharing, and any applicable Prior Authorization requirements.

Covered services may include Inpatient care, Outpatient therapy, Intensive Outpatient Programs, Partial Hospitalization, and medication-assisted treatment, among others.

The Plan complies with the Mental Health Parity and Addiction Equity Act (MHPAEA), which means it does not impose more restrictive financial requirements or treatment limitations on mental health or substance use disorder benefits than it does on comparable medical/surgical benefits.

Benefits Table: Mental Health (MH) and Substance Use Disorder (SUD) Treatment Services

This table outlines Member Cost-Sharing for Mental Health and Substance Use Disorder Treatment Services:

Type of Service	In-Network Provider	Out-of-Network Provider
Diagnostic Testing & Evaluation for Mental Health as Part of an Office Visit Services may include psychological testing for diagnostic purposes; neuropsychological assessments; standardized testing related to ADHD, learning	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.

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disorders and psychiatric diagnostic evaluation with testing.		
Office Visit Services - Other MH/SUD Services received as part of an Office Visit with a Primary Care Provider or Specialist.	$30 copayment per visit. Deductible does not apply.	50% coinsurance after the OON deductible is met.
Outpatient Hospital/Facility Services MH/SUD Services received in an Outpatient Hospital or Facility setting, including Intensive Outpatient Programs (IOPs) or Partial Hospitalization Programs (PHPs).	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Inpatient Services MH/SUD Services received in an Inpatient Hospital or Facility Setting.	20% coinsurance after the INN deductible is met.	50% coinsurance after the OON deductible is met.
Telemedicine Services MH/SUD treatment provided through real-time audio and video technology, as a virtual alternative to an in-person Office Visit, Outpatient visit, or Intensive Outpatient Program, or Partial Hospitalization Program.	Telemedicine visits are subject to the same coverage, limitations, and exclusions that apply to in-person Office Visit or Outpatient Hospital/Facility Services.	Telemedicine visits are subject to the same coverage, limitations, and exclusions that apply to in-person Office Visit or Outpatient Hospital/Facility Services.
On-Demand Virtual Care from Teladoc® Health On-demand virtual care	No Member cost.	

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available 24/7 from a network of Teladoc® Health contracted doctors. Clinical Treatment Services Members 18+ have access to board-certified and licensed medical doctors for help with conditions such as ADHD, anxiety, post-traumatic stress disorder, grief, etc. Mental Health Coaching (Non-Clinical) Members 18+ have access to zero-cost mental health coaching. Members 13+ have access to text-based coaching, digital programs, and crisis management tools.	

Limitations and Exclusions for Mental Health and Substance Use Disorder Treatment Services

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific conditions, limitations, and exclusions apply to Mental Health (MH) and Substance Use Disorder (SUD) Treatment Services:

- Inpatient MH/SUD treatment services require Prior Authorization, consistent with all Inpatient Hospital and Facility Services.
- The Plan covers Medically Necessary services for Gender Dysphoria. Exclusions apply for Experimental and/or Investigational services. Healthcare Services and associated expenses for gender reassignment are excluded unless they are performed as part of a treatment protocol for Gender Dysphoria.
- Considerations for MH/SUD services received via Teladoc® Health:

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- Only Teladoc® Health Psychiatrists may prescribe medications. Prescriptions for controlled substances or narcotics may require an in-person visit.

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Infertility Services

In General

The Plan provides coverage for the diagnosis of Infertility and correction of Physiological Abnormalities related to Infertility. All other Infertility treatments, services, procedures, medications, assisted reproductive technologies, and related services are excluded from coverage.

Covered Services

Coverage includes:

- **Diagnosis of Infertility:** Initial evaluation, Medically Necessary lab tests, diagnostic imaging, or diagnostic procedures.
- **Correction of Physiological Abnormalities.** Diagnosis and treatment of underlying medical conditions that result in Infertility when such treatment is medically necessary and intended to correct a Physiological Abnormality. Examples may include surgical correction of endometriosis, removal of uterine fibroids, or treatment of obstructed fallopian tubes.
- **Related Services:** Specialist consultations, lab, radiology, and other necessary diagnostics related to a diagnosis of Infertility or Correction of Physiological Abnormalities.

Cost-Sharing

Cost-Sharing for these services will vary based on the place of service, as specified in this Schedule. The applicable Deductible, Copayment, or Coinsurance will be determined according to whether the services are provided in a Physician's office, an Outpatient Hospital or Facility, or another covered setting.

Limitations & Exclusions for Infertility Services

In addition to the Plan's general exclusions listed in the **General Exclusions** section of this Schedule, the following specific conditions, limitations, and exclusions apply to Infertility Services:

- **Treatment of Infertility.** Services and/or treatment beyond the diagnosis of Infertility

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and correction of Physiological Abnormalities as described above are not covered. Excluded services include but are not limited to the following: fertility medications, artificial insemination, in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), embryo transfer, donor eggs or sperm, surrogate parenting, cryopreservation of eggs/sperm/embryos, and any other procedures or treatments aimed at achieving pregnancy.

- **Reversal of Voluntary Sterilization.** Procedures to reverse Voluntary Sterilization, as defined below, are excluded from coverage, including but not limited to tubal reanastomosis or vasovasostomy.

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Dental Coverage

In General

Dental Services are services rendered by a dentist or dental specialist and are generally not covered under the Plan, except as described below.

Covered Dental Services

Accidental Dental Services

The Plan covers Dental Services to treat damage done to sound, natural teeth damaged by accidental injury that causes external trauma to the face and mouth. Treatment must begin within six (6) months and be completed within twelve (12) months of the injury unless the Plan determines a longer completion time is Medically Necessary.

For purposes of this provision, a sound, healthy tooth is a tooth (including supporting structures) that would function normally for at least one year. Primary teeth must have a one-year life expectancy before natural loss.

Dental Services Required for Treatment of an Underlying Medical Condition.

The Plan covers Dental Services required for treatment of an underlying medical condition, e.g. removal of teeth to complete radiation treatment for cancer of the jaw, cysts, and lesions. Claims must be submitted using the appropriate medical Claim form; submissions on dental Claim forms will not be accepted.

Extraction of Impacted Wisdom Teeth

The Plan covers surgical extraction of impacted wisdom teeth.

Facility and Anesthesia Fees for Dental Procedures Requiring Hospitalization

The Plan covers Hospital or Ambulatory Surgical Center Facility fees and anesthesia fees when Dental Services require hospitalization and the Member:

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1. Is under five years of age; or
2. Has a severe disability; or
3. Has a medical condition—unrelated to the dental procedure—that requires hospitalization or anesthesia in order to receive dental treatment

Important: While Facility and anesthesia services are covered; the Plan does not cover the Dental Services itself or any professional fees associated with a hospitalization.

Dental Services Required for Treatment of an Underlying Medical Condition

The Plan covers Dental Services required for treatment of an underlying medical condition, e.g. removal of teeth to complete radiation treatment for cancer of the jaw, cysts, lesions, or confirmed, existing temporomandibular disorder (TMD) and craniomandibular disorder (CMD).

Oral Surgery

The Plan covers oral surgery for: 1) treatment of oral neoplasm and non-dental cysts; 2) fracture of the jaws; and 3) trauma to the mouth and jaws.

Claim Submission Requirement for Dental Services Covered Under the Medical Benefit

Dental services that are covered under the Plan's medical benefit as described above must be submitted using the standard **medical Claim form (CMS-1500 or UB-04, as applicable)**.

Claims for these services **will not be accepted or processed** if submitted on a **dental claim form (e.g., ADA form)**. Providers must use the appropriate medical coding (CPT/HCPCS and ICD-10 diagnosis codes) when submitting Claims for reimbursement under the medical benefit.

This requirement applies to all providers, including oral surgeons and dental providers performing medically covered services.

Cost-Sharing

Cost-sharing for these services will vary based on the place of service, as specified in this Schedule. The applicable Deductible, Copayment, or Coinsurance will be determined according to whether the services are provided in a Physician's office, an outpatient hospital department, or another covered setting.

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Limitations and Exclusions for Dental Services

The Plan does not cover the following Dental Services, in addition to those listed under general Plan exclusions. Some items may also be subject to specific limitations or conditions:

- Any Dental Services covered under a Member's dental plan.
- Preventive dental procedures.
- Healthcare Services or Dental Services for cracked or broken teeth that result from biting, chewing, disease, or decay.
- Dental implants.
- Healthcare Services or Dental Services related to periodontal disease.
- Occlusal adjustment or occlusal equilibration (i.e., bite adjustment).
- Treatment of bruxism (teeth grinding and/or jaw clenching).
- Healthcare Services or Dental Services, Orthodontia, and all associated expenses, except as stated in this section.

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Routine Patient Costs Associated with Clinical Trials

In General

The Plan covers Routine Patient Costs associated with a Clinical Trial and may not: 1) deny your participation in a Clinical Trial; 2) deny (or limit or impose additional conditions on) the coverage of Routine Patient Costs for items and Healthcare Services furnished to you in connection with participation in the Clinical Trial; or 3) discriminate against you on the basis of your participation in a Clinical Trial.

Requirements for Clinical Trials

To be covered under this Plan, a Clinical Trial must meet all of the following:

Purpose and Phase

The trial is a Phase I, II, III, or IV study focused on the prevention, detection, or treatment of cancer or another life-threatening condition (a condition likely to cause death without treatment).

Type of Clinical Trial

The Clinical Trial must be one of the following:

- Federally funded trial approved or supported by agencies such as the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare & Medicaid Services (CMS), Department of Defense (DoD), or Department of Veterans Affairs (VA), or by a cooperative group or research entity recognized under NIH guidelines.
- Trial conducted by the VA, DoD, or Department of Energy (DOE) that has undergone an independent, unbiased scientific review process comparable to NIH standards.
- Trial conducted under an FDA Investigational new drug (IND) application.
- Drug trial exempt from an FDA Investigational new drug application.

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Cost-Sharing

Cost-Sharing for these services will vary based on the place of service, as specified in this Schedule. The applicable Deductible, Copayment, or Coinsurance will be determined according to whether the services are provided in a Physician's office, an outpatient hospital department, or another covered setting.

Participating Provider Requirement

If one or more Participating Providers are participating in a Clinical Trial, the Plan will cover Routine Patient Costs only if you participate in the Clinical Trial through a Participating Provider if the Provider will accept you in the Clinical Trial. This requirement is waived if the approved Clinical Trial is conducted outside the state in which you reside. However, the Plan will not cover Routine Patient Costs if you are in a Clinical Trial with a Non-Participating Provider and you do not have coverage for Non-Participating Provider Benefits.

Limitations/Exclusions for Clinical Trials:

In addition to any other general Plan exclusions, the following specific conditions, limitations, and exclusions apply to Routine Patient Costs associated with Clinical Trials.

- The Plan does not cover costs associated with Clinical Trials that are not Routine Patient Costs.

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Prescription Drug & Pharmacy Benefit

The Plan uses a Prescription Drug Formulary to determine which Prescription Drugs, including Generic equivalents, are covered. The Formulary is subject to periodic review and modification. For information, you may contact Gravie Care® or Express Scripts to locate In-Network pharmacies.

General Coverage Provisions

ACA Preventive Drugs & Supplies

The Plan covers Prescription Drugs that are designated as ACA Preventive Services under the Affordable Care Act (ACA), with no Cost-Sharing (e.g., no Deductible, Copayment, or Coinsurance) when obtained from a Participating Pharmacy. These are referred to throughout this document as “ACA Preventive Drugs and Supplies.”

Covered ACA Preventive Drugs and Supplies include, but are not limited to:

- FDA-approved contraceptive methods for women, as described in more detail below.
- Tobacco cessation medications
- Bowel preparation medications used for colorectal cancer screening (e.g., PEG-electrolyte solutions), when prescribed in advance of a preventive colonoscopy.
- Breast cancer risk-reduction drugs, when prescribed for women at increased risk (e.g., tamoxifen, raloxifene, aromatase inhibitors such as anastrozole or exemestane).
- Certain Over-the-Counter (OTC) Drugs such as aspirin and Vitamin D.

ACA Preventive Drugs and Supplies are subject to the Plan's Formulary, quantity limits, and other utilization management programs, provided these are applied consistently with ACA requirements.

Contraceptive Coverage

In accordance with federal ACA Preventive Services guidelines, the Plan covers contraceptive services and FDA-approved contraceptive methods without Cost-Sharing (no Deductible, Copayment, or Coinsurance).

The Plan will:

- Cover at least one form of contraception in each category listed in the HRSA-supported Women’s Preventive Services Guidelines.

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- Cover any contraceptive services or FDA-approved, -cleared, or -granted products that you and your Provider determine to be medically appropriate, even if not specifically listed in one of the HRSA categories or typically included on the Plan's Formulary or otherwise subject to restrictions.

If you need a contraceptive method that is not typically covered or is subject to restrictions, your Provider can submit an exception request. Once your Provider's determination of medical appropriateness is verified by the Plan, the Plan will cover that method without Cost-Sharing. No additional approvals are required from the Plan beyond this verification. More information on the Plan's exceptions process for contraceptives may be found by contacting Express Scripts.

Specialty Medications

The Plan covers a supply of up to thirty (30) days for retail or mail-order Specialty Medications. These drugs must be obtained through Accredo, a Specialty Pharmacy, unless distribution is restricted. Specialty Medications can be oral or injectable. As designated on the formulary, Specialty Medications must be filled at a Specialty Pharmacy. For further details, you can reach the dedicated Member helpline for Specialty Medications at: 877-605-2001.

The Plan offers Copay assistance for certain Specialty Medications through the SaveOnSP program. These medications are not considered Essential Health Benefits, so if you choose not to enroll and pay out-of-pocket for them, those costs will not count toward your annual out-of-pocket maximum (OOPM).

Step Therapy

Step therapy manages the use of specific Prescription Drugs for certain medical conditions. This approach ensures that alternative (second line) Prescription Drugs are prescribed only after the initial, preferred drugs have been utilized. Members enrolled in a step therapy program must fulfill the program's requirements before receiving a second-line drug. Step therapy may apply to both Formulary and non-Formulary Prescription Drugs, as well as Brand-Name or Generic Drugs. The Plan periodically reviews and modifies the step therapy list.

Use of Brand-Name Drugs When a Generic Equivalent is Available

Unless an exception applies, such as described above for contraceptive services and supplies, if a Brand-Name Drug is required when an FDA-approved Generic Drug alternative is available,

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Members will pay the Brand-Name Drug Cost-Sharing plus the price difference between the Brand-Name Drug and Generic Drug.

Special Cost-Sharing Rules for Biosimilar Drugs

A Biosimilar Drug is a biological product highly similar to an existing FDA-approved biological product (often called a “Brand Reference Product”). It functions identically and is expected to produce the same clinical effect.

If you or your Provider request a Specialty Medication (which is a biological product) for which the Plan has an FDA-approved Biosimilar Drug on its Formulary, you will pay the difference in cost between the requested Specialty Medication and the approved Biosimilar Drug, in addition to your normal Cost-Sharing (any applicable Deductible, Copayment, Coinsurance, or amounts toward your Out-of-Pocket Maximum) for the Specialty Medication, unless a medical exception is approved.

The Plan's Formulary includes several Biosimilar Drugs. You may be required to try an approved Biosimilar Drug before the Plan will cover the Brand Reference Product. Please consult your Formulary for current Biosimilar Drug and Brand Reference Product Coverage information.

Off-Label Use of Drugs

Off-Label Use of Drugs, provided that they are not Experimental and/or Investigational, may be covered in either of the following circumstances:

1. A Prescription Drug is recognized as appropriate for cancer treatment in the National Comprehensive Cancer Network Drugs and Biologics Compendium; or
2. A drug is deemed appropriate for its proposed use by any authoritative compendia identified by the Medicare program, and/or in an article from a major peer reviewed medical journal, provided that such article uses generally acceptable scientific standards other than case-reports.

In addition, Off-Label Use of Drugs is only allowed if all of the following are met in addition to one of the above circumstances applying:

1. The off-label prescription follows all appropriate guidelines (e.g. dosage, age, ingestion, etc.) from the National Comprehensive Cancer Network Drugs and Biologics

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Compendium, applicable authoritative compendia, or applicable major peer reviewed medical journal article; and
2. The drug is prescribed for the treatment of a diagnosed medical condition and is used consistent with the purpose of the prescription.

As with other Healthcare Services, Off-Label Use of Drugs must be Medically Necessary.

Compound Drugs

The Plan covers Compound Drugs only if they are obtained from a Participating Pharmacy and contain at least one active ingredient that is a Prescription Drug.

Coverage for Compound Drugs is subject to the following conditions:

- **Commercially Prepared Alternatives:** If a commercially prepared product (a Prescription Drug available in its final, usable form from a pharmacy without compounding) is identical or similar to the Compound Drug requested, the Plan will only consider coverage for the Compound Drug after documented failure of the commercially prepared product(s).
- **Exclusions:** Compound Drugs containing any product that is otherwise excluded by the Plan will not be covered. This includes dosages and routes of administration that have not been approved by the FDA.

Prescription Drug & Pharmacy Benefit Claims, and Appeals

Prior Authorization Requirements

Certain prescription drugs require Prior Authorization before they will be covered under the Plan. Prior Authorization helps ensure that prescribed medications are Medically Necessary, clinically appropriate, and cost-effective.

When Prior Authorization is Required

In general, Prior Authorization must be obtained before the Plan will cover:

- Specialty medications
- High-cost or brand-name drugs when a generic alternative is available
- Drugs with significant potential for misuse or overuse
- Medications prescribed outside of standard dosage guidelines
- Certain drugs used for cosmetic or lifestyle purposes (e.g., hair growth, weight loss)

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A complete list of medications requiring prior authorization is available by contacting Express Scripts or visiting esrx.com/PA.

How to Request Prior Authorization

Your Provider should visit the Express Scripts online portal at esrx.com/PA or call Express Scripts on or after to request a Prior Authorization (also known as a Coverage Review).

Express Scripts will notify you and your Provider of the decision, typically within 72 hours for standard requests or 24 hours for urgent situations, and will provide written notification of the decision.

Failure to Obtain Prior Authorization

If Prior Authorization is **not obtained** before the drug is dispensed, the Claim may be **denied**, and you may be responsible for the full cost of the medication.

Prescription Drug & Pharmacy Benefit Claims

Claims may be submitted to:

Express Scripts
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Prescription Drug & Pharmacy Benefit Appeals

Express Scripts handles all appeals related to the Prescription Drug & Pharmacy Benefit. It offers a two-level internal appeals process, except for urgent appeals which are handled on an expedited, single-level basis. It will also facilitate any external reviews requested upon exhaustion of the internal appeals process. Appeals should be submitted by following the instructions in the denial letter, or by submitting the appeal to:

Express Scripts
Attn: Appeals
PO Box 14711
Lexington, KY 40512-4711

Operational Delegation to PBM

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For purposes of any clinical programs, Claims, and/or appeals under the Prescription Drug & Pharmacy Benefit, Express Scripts' definitions, policies, procedures, and clinical processes apply, and the following sections of this Schedule (Clinical Programs (Medical Benefit) and Medical Claims and Appeals Procedures) do not apply.

(Note: This operational delegation of authority to the PBM does not override, modify, or conflict with any other provision of this SPD regarding Plan fiduciary responsibilities or the delegation of authority under the Plan.)

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Benefits Table: Pharmacy/Prescription Drug Benefits

This table outlines Member Cost-Sharing for Prescription Drug coverage:

Formulary Tier	In-Network Provider	Out-of-Network Provider
ACA Preventive Drugs	Plan covers 100%. No Member Cost-Sharing.	Not covered.
Tier 1 (Generic Drugs)	**Retail 30-Day Supply:** $10 copayment. **Retail 90-Day Supply:** $20 copayment. **Mail Order (90-Day Supply):** $20 copayment.	Not covered.
Tier 2 (Preferred Brand-Name Drugs)	**Retail 30-Day Supply:** $50 copayment. **Retail 90-Day Supply:** $100 copayment. **Mail Order (90-Day Supply):** $100 copayment.	Not covered.
Tier 3 (Non-Preferred Brand-Name Drugs)	**Retail 30-Day Supply:** $100 copayment. **Retail 90-Day Supply:** $200 copayment. **Mail Order (90-Day Supply):** $200 copayment.	Not covered.
Tier 4 (Non-Formulary Drugs)	No charge after the OOPM.	Not covered.

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Specialty Medications	0% coinsurance after the INN deductible is met.	Not covered.
Specialty Medications covered by the SaveOnSP Copay Assistance Program	Members who enroll in the SaveOnSP Copay Assistance Program will pay $0 for Specialty Medications covered by the program. Members who do not enroll will be responsible for 30% Coinsurance for the applicable Specialty Medication, and these costs will not count toward the Out-of-Pocket Maximum (OOPM).	Not covered.

Limitations and Exclusions for Pharmacy/Prescription Drugs

In addition to the limitations described in this Section and any other general **Plan exclusions**, the following specific conditions, limitations, and exclusions apply to **Prescription Drugs**:

SaveOnSP: Amounts paid out-of-pocket for SaveOnSP Specialty Medications do not count toward the annual OOPM.

Maintenance Medications: You may be required to obtain a 90-day supply of a Maintenance Medication.

Additionally, the Plan does not cover the following:

- Compound Prescription Drugs used for Bioidentical Hormone Replacement Therapy (BHRT), unless otherwise covered.
- Prescription Drugs received from a Non-Participating Provider.
- Replacement of a Prescription Drug due to loss, damage, or theft.
- Over-the-Counter (OTC) drugs, whether dispensed by a Provider or with a Provider's prescription, unless covered under the ACA Preventive Services mandate or as otherwise indicated in this Schedule.
- Over-the-Counter (OTC) home testing products, unless otherwise indicated in this Schedule.

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- Non-prescribed Over-the-Counter (OTC) contraceptives, including condoms, spermicides, and emergency contraceptives.
- Take-home drugs when dispensed by a Physician.
- Prescription Drugs used for cosmetic purposes.
- Unit dose packaging (medications packaged individually by dose) when solely by request of the Member.
- Drugs not approved by the Food and Drug Administration (FDA), including non-FDA approved mechanisms of delivery (e.g., a drug approved for oral use being applied topically).
- Drugs that are given or administered as part of a drug manufacturer's study.
- Off-label Use of Drugs, except as described in the "Off-Label Use of Drugs" section or when the Plan Administrator, at its sole discretion, includes the drug on its Formulary or approves coverage for that specific use.
- Prescribed or non-prescribed vitamins or minerals, including OTC vitamins or minerals, unless covered as an ACA Preventive Service.
- Drugs, medical devices, or therapies that are approved only for Compassionate Use by the U.S. Food and Drug Administration.
- Homeopathic or naturopathic medicine, including dietary supplements.
- Holistic medicine and services, including dietary supplements.
- Weight loss drugs, including Off-Label Use of Drugs for weight loss unless in accordance with the "Off-Label Use of Drugs" section.
- Cannabis/Marijuana, except medical cannabis/marijuana when provided by Providers licensed by applicable state law to sell it.

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Clinical Programs (Medical Benefit)

Overview

The Plan's Clinical Programs for the Medical Benefit include Utilization Management, Case Management, and Care Navigation programs help ensure that you receive medically appropriate care in a cost-effective manner. These programs are designed to:

- Evaluate Healthcare Services for Medical Necessity and appropriateness
- Evaluate alternative level-of-care opportunities
- Coordinate care needs
- Identify applicable benefit limitations
- Identify Members for Case Management programs where applicable

Utilization Management

The Plan's Utilization Management programs includes:

- Prior Authorization
- Medical Review Services
- Case Management

These programs are not designed to practice medicine or substitute for the medical judgment of your treating Provider.

Please note: Prescription drug and pharmacy-related clinical processes (such as Prior Authorization, step therapy, or quantity limits) may differ from those described in this section and are addressed separately in the **Prescription Drug & Pharmacy Benefit** section of this Schedule.

1 - Prior Authorization Requirements (Medical)

When Prior Authorization is Required: To ensure coverage, it is important to obtain Prior Authorization from the Plan before certain Healthcare Services are provided.

Specifically, Members and/or their Providers must obtain Prior Authorization before receiving the following Healthcare Services:

- Inpatient Hospital/Facility admissions
- Non-emergency services delivered in a Hospital or Facility

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- Outpatient Hospital/Facility surgery
- Outpatient surgery by a Physician when performed as part of an Office Visit
- Outpatient Diagnostic Services
- In-Office Diagnostic Services
- All transplants and services for Gene, Cell, and Related Therapies
- Injections or infusions administered in an Outpatient Hospital/Facility, home, or office/clinic setting.
- Services that are potentially considered Experimental and/or Investigational

How to Request Prior Authorization: Prior Authorization requests must be submitted as described in the "Other Key Partners" table above in the **Introduction** section of this Schedule.

To process a medical Prior Authorization request, the following information will be required:

- The identity of the Member and Provider of Services.
- The date(s) of Services.
- A specific medical diagnosis.
- A specific treatment, Healthcare Service, or procedure code for which approval (or extended treatment) is requested.

Non-urgent Prior Authorization requests should be made at least seven (7) days before services are provided.

Prior Authorization Does Not Guarantee Coverage: Obtaining Prior Authorization does not guarantee that the Plan will cover the service or pay Benefits. Your eligibility for services and payment of Benefits remain subject to all terms in the Schedule of Benefits and Summary Plan Description. The UM Administrator only certifies that requested Healthcare Services are Medically Necessary.

Consequences of Not Obtaining Required Prior Authorization: If Members and/or their Providers fail to obtain required Prior Authorization, the Plan may reduce or deny payment for Benefits related to those services.

Review Prior Authorization List for Updates: To prevent potential Claim denials and unexpected out-of-pocket costs, Members and Providers should always check the most current Prior Authorization list before any services are scheduled or rendered. The up-to-date list can be found by visiting https://www.gravie.com/providers/claims/ or by contacting Gravie Care®.

2 - Medical Review Services

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Site of Care Program: The Plan works collaboratively with you and your Providers to identify the most appropriate, convenient, and cost-effective location for receiving certain injectable and infusible medications. The goal of this policy is to ensure that these medications are administered in the most clinically appropriate and cost-effective setting while maintaining or improving the quality of care and patient experience. The Plan evaluates multiple factors including your individual preferences and circumstances, your Provider's clinical recommendations, and the medical appropriateness of each care setting to ensure you receive high-quality treatment in the optimal environment for your needs. If an Outpatient Hospital setting is not Medically Necessary, Prior Authorization may be denied in favor of a more cost-effective site, such as a doctor's office or home.

Concurrent Care Reviews: The Plan may review ongoing services or treatment while you are receiving Inpatient Services at a Hospital or Facility, Outpatient or Home Health services, or while taking Prescription Drugs that were approved through Prior Authorization. If a Member's treating Provider recommends additional services, continued prescription coverage, or a longer Inpatient Hospital or Facility stay than originally authorized, the Provider must request additional Authorization.

Medical Necessity Reviews: The Plan pays only for Healthcare Services that are Medically Necessary and not Experimental and/or Investigational. This means the service must be appropriate for the diagnosis or treatment of the condition, meet accepted standards of medical practice, and be clinically proven to produce positive health outcomes.

When a Provider submits a Claim, the Plan may request additional information to evaluate whether the service qualifies for coverage under these criteria.

In addition, Prior Authorization also involves a Medical Necessity review. Before the service is provided, the Provider (or Member) must submit clinical information to the Plan. The Plan then evaluates whether the requested service meets its definition of Medical Necessity.

If it does not, the Plan may deny coverage even before the service is rendered. This process helps ensure that Covered Services are not only appropriate and effective, but also consistent with evidence-based standards of care.

For Healthcare Services that do not require Prior Authorization, Members and/or their Providers may request a Medical Necessity review before services are provided. This voluntary review determines whether the proposed services meet the Plan's Medical Necessity criteria.

3 – Medical Case Management Program

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Case Management: The Plan provides access to a voluntary Case Management Program designed to assist members with complex or ongoing healthcare needs. This program is a value-added service and does not affect your eligibility or guarantee payment.

The program offers individualized support for a range of medical needs, including medical and surgical diagnoses, as well as short-term and catastrophic case management. Registered Nurse case managers work with Members, families, and Providers to coordinate care, develop individualized care plans, and navigate the healthcare system effectively.

Members may be identified for case management during the utilization management process, including precertification, or through a referral from a physician or other healthcare provider. You may also self-refer to the program by contacting Gravie Care®. Participation is entirely voluntary and can be declined or discontinued at any time.

Enhanced Support and Expert Guidance

Your Plan may also include support to help you navigate complex health issues:

- **Care Navigation (Cancer, and Chronic Conditions):** The Plan offers personalized Care Navigation services for common, complex, and chronic conditions like cancer. You can access this service through a provider referral, a Claims trigger, or by simply self-referring through a call to Gravie Care®.

- **Expert Medical Opinion / Second Opinion Program (MSK and Oncology):** For musculoskeletal conditions or before considering surgery, this program provides access to virtual second opinions from top specialists. An expert second opinion clarifies treatment options, recommends alternative tests, and guides your next steps in care.

Contact Information

For more information about the Plan's Clinical Programs, contact Gravie Care® using one of the following methods:

- **Phone:** You can reach us Monday through Friday, 8 AM – 5 PM Central Time, using the number on your Member ID card.
- **Online:** Visit us at member.gravie.com.

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Medical Claims and Appeals Procedures

In General

The Plan is administered by several administrators, including Gravie as the Claims Administrator and the UM Administrator. The specific entity handling your Claim or Appeal will depend on the nature of the Benefit and the services involved.

Anti-Assignment

Benefits under the Plan, including the right to file a Claim, submit an Appeal, or pursue legal action related to a benefit claim, may not be assigned to an Out-of-Network Hospital, Facility, or other Healthcare Provider without the written approval of the Plan.

The Plan may, at its discretion, choose to make direct payment to an Out-of-Network Provider on behalf of a Member. However, any such payment does not constitute an assignment of rights or Benefits and does not waive or alter the Plan's anti-assignment policy for that Member or for any other Member.

Understanding Claim Types

What is a Claim?

A Claim is a Request for Benefits under the Plan for Healthcare Services a Member has received or is about to receive. There are four (4) main categories of Claims that can be made under the Plan, each with specific rules and timeframes for processing and Appeal.

Claim Type 1: Pre-Service Claims

A Pre-Service Claim is a Claim where the Plan requires advance approval before you receive the Healthcare Service or Benefit. This means you must get approval *before* the Service is provided for it to be covered, in whole or in part.

Benefits under the Plan that typically require advance approval include:

- Benefits subject to Prior Authorization.
- Requests for Network Gap Exceptions.

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- Requests for Continuity of Care when a Provider is no longer participating in the Plan's network (i.e., is no longer a Participating Provider).

Important Note: Not all requests made in advance of services being rendered are considered Pre-Service Claims. If a Benefit does not require Prior Authorization or other advance approval, any inquiries or requests for advance review will generally not be treated as a Claim. (However, an Adverse Benefit Determination will still give rise to Appeal rights.)

Claim Type 2: Concurrent Care Claims

A Concurrent Care Claim occurs when the Plan has approved an ongoing course of treatment (e.g., an Inpatient Hospital stay) to be provided over a period of time, and a request is made to extend that treatment beyond the initially approved period or number of Services.

Examples of Concurrent Care Claims include:

- A request for extension of an Inpatient Hospital stay beyond the number of approved days, made by a Provider following the Prior Authorization process with the UM Administrator.
- A request for additional Skilled Home Health Hours of Service beyond the number of approved days, made by a Provider following the Prior Authorization process with the UM Administrator.
- The continuation of a previously approved Network Gap Exception request.

Claim Type 3: Urgent Care Claims

An Urgent Care Claim is a type of Pre-Service or Concurrent Care Claim that requires an expedited decision due to the medical urgency of your situation. A Claim will be treated as an Urgent Care Claim if applying the usual timeframes could:

- Seriously jeopardize your life or health.
- Seriously affect your ability to get better or regain maximum function.
- Lead to severe pain that cannot be adequately managed without the requested care, as determined by a Physician familiar with your medical condition.

When the Plan receives a Pre-Service or Concurrent Care Claim, it will determine if it qualifies as an Urgent Care Claim based on these criteria. A Claim will also be treated as an Urgent Care Claim if a Physician with knowledge of your medical conditions indicates that the Claim involves urgent or critical care.

Claim Type 4: Post-Service Claims

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A Post-Service Claim is a Request for Benefits made after services have been provided. Under this Plan, a post-service request for payment/Benefits is considered a “Claim for Benefits” when it is submitted by or on behalf of a Member and relates to Benefits for which the Member may have a right or interest under the Plan.

Filing a Claim

To receive Benefits under the Plan, you (or your Authorized Appeals Representative) or your Provider must file a Claim in accordance with the procedures described below.

Filing Pre-Service Claims

Prior Authorization Requests

Prior Authorization requests for medical services should be submitted using the processes outlined above under the **Medical Benefit Clinical Programs** section.

Network Gap Exception and Continuity of Care Requests

To submit a Network Gap Exception or Continuity of Care request, please contact Gravie Care® for assistance. You will need to complete the applicable form and upload it to your Member Portal.

Submitting Concurrent Care Requests

Submissions of Concurrent Care Claims/Requests follow the same process as Prior Authorizations.

Filing Post-Service Claims

A Post-Service Claim for Plan benefits is made when a Member (or Authorized Representative) or Provider submits a written Claim form to the address below. Claim forms may be obtained by contacting Gravie Care®.

A Post-Service Claim must be filed by Participating Providers within 180 days and by Non-Participating Providers within 365 days following receipt of the medical service, treatment or product to which the Claim relates. Claims should be submitted to the following address:

Gravie Administrative Services

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P.O. Box 211543
Eagan, MN 55121

Incorrectly Filed Claims

The Plan's Claims Procedures do not apply to any request for Benefits that is not made in accordance with the above filing requirements, except that:

1. In the case of an incorrectly filed non-urgent Pre-Service Claim, the Plan will notify the Provider or Member as soon as possible, but no later than five (5) days following receipt by the Plan of the incorrectly filed Claim; and
2. In the case of an incorrectly filed Urgent Care Claim, the Plan will notify the Member or requesting Provider as soon as possible but no later than twenty-four (24) hours following receipt of the incorrectly filed Claim.

The notice shall explain that the request has not been filed correctly and describe the proper procedures for filing a Claim. The notice may be oral unless written notice is specifically requested by the requestor.

Initial Benefit Determination

The Plan will make initial benefit determinations according to the following timeframes, which start upon a receipt of a properly filed Claim:

Type of Claim	**Turnaround Time**
Pre-Service (Non-Urgent)	Within a reasonable period, but no later than **15 days** after receipt of the Claim. A one-time extension of up to **15 days** is permitted.
Pre-Service (Urgent)/Urgent Care Claim	As soon as possible, but no later than **72 hours** after receipt of the Claim. If verbal notification is provided, it will be followed by written notification within three (3) days of the verbal notice.
Concurrent Care Request	For urgent requests ("Urgent Care Claims") involving ongoing treatment, as soon as possible and within **24 hours**, as long as the request is made at least 24 hours before the current treatment ends. Requests made later will still be handled urgently, with notice as soon no later than **72 hours** from receipt. For non-urgent requests involving ongoing treatment, the standard timeframes that apply to Pre-Service Non-Urgent or Post-Service

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	Claims will apply. Notice of any Adverse Benefit Determination arising from the Plan's routine review of ongoing care, as opposed to a request for additional services, will be provided in time to permit an Appeal and resolution before treatment ends or is reduced.
Post-Service	Within a reasonable period, but no later than **30 days** after receipt of the Claim. A one-time extension of up to **15 days** is permitted.

Extension of Timeframes If additional time is needed to process your Pre-Service (Non-Urgent) or Post-Service Claim, the Plan may extend the original timeframe once (15 or 30 days depending on Claim type). You will receive written notice before the original decision deadline explaining the reason for delay and the new decision date.

Notice of Adverse Benefit Determination

An Adverse Benefit Determination is any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit. This includes but is not limited to the following:

- A determination of an individual's eligibility to participate in the plan;
- A utilization review decision;
- A determination that a treatment is Experimental and/or Investigational; or
- A determination that the treatment is not medically necessary or appropriate.
- A rescission of coverage, whether or not there is an adverse effect on any particular Claim, except when the rescission is due to the nonpayment of premiums or contributions.

If your Claim is denied (in whole or in part), or for any type of Adverse Benefit Determination, you will receive a written notice including:

- Specific reason(s) for the denial;
- Reference to Plan provisions relied upon;
- Description of any additional information needed to complete the Claim;
  Explanation of your right to appeal and how to do so;
- Information about your right to request external review, if applicable; and
  If applicable, the clinical rationale or policy used in the denial.

Appeal Rights

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You are entitled to a full and fair review of any adverse benefit determination, including a full or partial denial of a Claim for benefits. Your rights Include:

Right to Appeal: You or your Authorized Representative have **180 days** from the date you received an Adverse Benefit Determination to file an appeal. Except for Appeals involving Urgent Care Claims, your appeal must be submitted in writing and should include your name, Member identification number, details about the Claim or service in question, and why you believe the Claim or service should be paid or approved.

Right to Review Documents: You have the right to request, free of charge, reasonable access to all documents, records, and other information relevant to your Claim. This includes any internal rule, guideline, protocol, or criterion relied upon in making the Adverse Benefit Determination.

Expedited Appeals: In urgent care situations where the normal Appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function, you may request an expedited Appeal process.

Filing an Appeal

Medical Necessity Appeals

The UM Administrator handles all **Medical Necessity Appeals** for Adverse Benefit Determinations. You, your Authorized Representative, or your Provider can submit a Medical Necessity Appeal to the UM Administrator within **180 days** of the denial. You can send the appeal by mail to:

Gravie Administrative Services, P.O. Box 211543, Eagan, MN 55121.

A new Healthcare Professional with appropriate experience will be consulted during the Appeal. This professional will not be the same person who made the initial determination.

Appeals will be reviewed and resolved in accordance with the UM Administrator's internal appeal process and applicable regulatory requirements, including timelines established under ERISA where applicable.

Administrative and Other Appeals

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This category of Appeals is handled by Gravie and includes Appeals that are primarily administrative in nature, such as:

- Denials related to Plan rules or coverage requirements.
- Network Gap Exception requests.
- Continuity of Care requests.

Some of these appeals may also involve Medical Judgment (except for any Medical Necessity determinations) but they are handled under the “Administrative and Other Appeals” process. Such appeals will be reviewed by a professional with appropriate training and experience.

Members have the right to two (2) levels of internal Administrative and Other Appeals. Appeals must be submitted within 180 days of receiving a denial. You, your Provider, or your Authorized Representative can submit your Appeal in one of two ways:

- **Online:** Log in to your member portal at https://member.gravie.com and select "Submit an Appeal."
- **By mail:** Send your appeal to:
  Gravie Appeals Department P.O. Box 211543 Eagan, MN 55121

Appeal Forms may be requested from Gravie Care®.

Right to Request External Review

If your internal Appeal is denied, you may be eligible to request an External Review by an Independent Review Organization (IRO). External Review is available for certain types of denials involving Medical Judgment (such as Medical Necessity or Experimental and/or Investigational treatment decisions), or for a Rescission of Coverage. You must request an External Review within four (4) months of receiving your final denial letter following the internal Appeals process.

A preliminary review will determine whether your request is complete and eligible. If your request is incomplete or ineligible, you will receive a written notice, and you may correct or complete your request within the later of: 1) Four (4) months; or 2) Forty-Eight (48) hours after notice. If your case involves urgent medical circumstances, you may request an expedited external review.

The IRO is a third-party entity with no connection to the Plan. It will determine whether your Claim qualifies for external review and will conduct a full, independent evaluation. You may submit additional information for the IRO to consider. There is no cost to you for this review.

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For standard reviews, the IRO will issue a written decision within forty-five (45) days. For expedited reviews, a decision will be made within seventy-two (7)2 hours. The IRO’s decision is binding on the Plan.

Judicial Review

Upon completion of the Plan's internal review procedures or the external review procedures, either the Claimant or the Plan may request judicial review of the final decision on the Claim. Any action brought by, or on behalf of, a Claimant for Plan benefits must be filed not later than twenty-four (24) months after completion of the Plan's internal Claims and Appeals process (including, if applicable, external review).

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General Exclusions

In addition to any specific limitations and/or exclusions described under individual Benefit descriptions above, the Plan will not cover charges incurred for any of the following services.

Please Note: Exclusions listed in this section are not an exhaustive list of all exclusions under the Plan. Exclusions described in any Benefit section apply based on the nature of the service, even if the exclusion is not restated in this General Exclusions section.

1. Services that are not considered Medically Necessary. This exclusion may not apply to some services provided by Participating Providers, depending on their specific contract.
2. Healthcare Services ordered or provided any individual or entity that is not licensed, certified, registered, or otherwise authorized under applicable state law to provide such services.
3. Educational services that are not directly related to improving or managing health, such as classes that focus on personal enrichment or education not linked to medical conditions (e.g., cooking classes, fitness classes etc.), and general-purpose group wellness workshops.
4. Tobacco cessation intervention programs and services, except when covered as ACA Preventive Services.
5. Nutritional counseling, except when provided during a confinement; or in an office or Hospital/Facility setting: a) for the diagnosis and treatment of diabetes; b) to a Member who has been diagnosed by a Physician with a chronic medical condition; or c) as counseling that is treated as an ACA Preventive Service.
6. Professional sign language and foreign language interpreter services in a Provider's office, except when arranged by the Provider's office at the time of scheduling.
7. Exams, other evaluations and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this Schedule or as a Preventive Services.
8. Charges for duplicating and obtaining medical records from Non-Participating Providers, unless requested by the Plan Administrator.
9. Hypnosis and chelation therapy, except chelation therapy will be covered when Medically Necessary for the treatment of heavy metal poisoning.
10. Reversal of sterilization procedures.
11. Orthoptics.
12. Refractive surgery (e.g. Lasik) for ophthalmic conditions that are correctable by contacts or glasses.

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13. Healthcare Services and associated expenses for gender reassignment, except when performed as part of a treatment protocol for Gender Dysphoria.
14. Autopsies.
15. Treatment for compulsive gambling.
16. Healthcare Services when the sole purpose is to monitor, hold, or confine a Member who is under the influence of alcohol or drugs, if no Medically Necessary treatment is required. This applies no matter where the services are received (for example, in a Hospital, detoxification center, or other Facility).
17. Nutritional and food supplements, unless specifically listed as covered under this Schedule.
18. Routine foot care, unless required due to blindness, diabetes, or peripheral vascular disease.
19. Vision therapy.
20. Marital counseling, relationship counseling, family counseling except as otherwise covered in this Schedule, or other similar counseling or training services.
21. Counseling, studies, Healthcare Services, or confinements ordered by a court or law enforcement officer that are not determined to be Medically Necessary by the Plan Administrator.
22. Biofeedback.
23. Surgical treatments and procedures to treat one-sided deafness.
24. Acupuncture.
25. Abortion, except when a provider operating within the scope of their license determines that: (a) the pregnancy is a result of rape or incest; or (b) the life or health of the mother would be endangered if the fetus is carried to full term.
26. Bariatric surgeries, including preoperative procedures, initial procedures, surgical revisions, and subsequent procedures.
27. Growth hormone therapy prescribed for children due to short stature only, or for adults with no documented significant deficiency of growth hormone.
28. Healthcare Services for any sickness or injury that results from:
    - Committing or attempting to commit a felony, even if you are not charged or convicted. However, this exclusion does not apply to sickness or injury from domestic violence or from a medical condition such as substance use disorder.
    - Voluntarily taking part in a riot, insurrection, or civil disobedience.
    - War, or any act of war, which includes both declared and undeclared war and acts of terrorism.
29. Healthcare Services for any sickness or injury that results from self-inflicted Injury (other than suicide or attempted suicide). This exclusion does not apply to any sickness or injury that is a result of an act of domestic violence or results from a medical condition, such as depression.
30. In-person therapy visits provided in your home solely for convenience.

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31. Therapy for conditions that are self-correcting.
32. Therapy for treatment of stuttering.
33. Voice training and voice therapy.
34. Secretin infusion therapy.
35. Sensory integration therapy when used for a reason other than the treatment of feeding disorders.
36. Therapy or items primarily educational in nature, or for vocation, comfort, convenience, or recreation. This includes recreational therapy provided solely for the purpose of recreation (e.g., physical or occupational therapy to improve athletic ability, or braces/guards to prevent sports injuries).
37. Vocational rehabilitation.
38. Healthcare Services for homeopathy, immunoaugmentative therapy, aromatherapy, and reflexology.
39. Massage therapy services.
40. Healthcare Services provided by massage therapists, doulas, and personal trainers.
41. Health club memberships.
42. Healthcare Services provided by an audiologist that are not provided in a clinical/healthcare setting.
43. Electronic cigarettes, e-cigarettes, personal vaporizers, and similar forms of nicotine delivery systems.
44. Tobacco cessation intervention programs and Healthcare Services, except as otherwise covered under the Schedule.
45. Healthcare Services related to surrogate pregnancy for a person who is not a Member.
46. Vision lenses, eyeglasses, frames, and their related fittings.
47. Routine eye examinations, except as covered under ACA Preventive Services or Expanded Preventive Services.
48. Routine hearing examinations, except as covered under ACA Preventive Services or Expanded Preventive Services.
49. Any weight loss programs and related Healthcare Services that are not otherwise covered as an ACA Preventive Service. For purposes of this Plan, “weight loss programs” are services or programs that are primarily intended for general weight reduction or weight management and are not provided to treat an underlying medical condition. This definition does not include Medically Necessary services provided to diagnose or treat an eating disorder, obesity, or any other medical condition, when such services are otherwise covered under the Plan.
50. Custodial Care.
51. Healthcare Services received before coverage under this Plan begins or after your coverage under this Plan ends.
52. Healthcare Services that the Plan Administrator determines are Experimental and/or Investigational and associated expenses unless the specific terms of a Participating

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Provider's network contract applicable to the Plan precludes application of the exclusion.

53. Healthcare Services not directly related to your care.
54. Healthcare Services that are: a) not given in a cost-effective setting, meaning a place or manner that is appropriate for your condition based on standard medical practices in your area; or 2) performed with a frequency not accepted by the medical community as medically appropriate.
55. Healthcare Services, supplies, or procedures that are cosmetic in nature or provided for convenience or comfort reasons.
56. Charges for Healthcare Services determined to be duplicate services by the Plan.
57. Charges that exceed the Allowed Amount for Healthcare Services received from Non-Participating Providers.
58. Healthcare Services prohibited by law or regulation, or illegal under applicable laws.
59. Charges for Healthcare Services that are eligible for payment under any insurance policy, including auto insurance, that covers the Member or for which the Member is required by law to enroll, or under a Workers' Compensation law, employer liability law or any similar law.
60. Any Healthcare Services provided by a relative (i.e., a Spouse, or a parent, brother, sister, or child of the Covered Employee or of the Covered Employee's Spouse) or anyone who customarily lives in the Covered Employee's household.
61. Hospitalization, transportation, supplies, or medical services, including Physicians' services furnished by the U.S. Government or by an institution operated by the U.S. Government, unless payment is required in accordance with applicable law.
62. Healthcare Services provided by Providers who have not completed professional level education and licensure as determined by the Plan.
63. Charges billed by Providers that are not in compliance with generally accepted guidelines established by the Centers for Medicare & Medicaid Services (CMS) and/or the TPA's policies.
64. Healthcare Services, including drug testing, and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure, and employment, and when such services are not preventive care or otherwise Medically Necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for driving under the influence/driving while intoxicated, competency evaluations, and adoption studies.
65. Services provided to a Member if the Member also has other primary insurance coverage for those services and does not provide the Plan with the necessary information to pursue coordination of benefits, as required under this Schedule.
66. Costs, charges, fees, and other losses for non-Healthcare Services.

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67. Services or costs associated with Non-Covered Services under the Plan. Non-Covered Services include, but are not limited to, cosmetic surgery, bariatric surgery, Infertility treatments, and Experimental and/or Investigational procedures. This exclusion also applies to follow-up care or complications arising from with Non-Covered Services except in cases of an Emergency Medication Condition requiring Emergency Services.
68. Services provided during a telehealth and/or virtual visit for the sole purpose of: scheduling appointments; filling or renewing existing prescriptions; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; services that would similarly not be charged for in an onsite medical office visit; telephone conversations, e-mails, or facsimile transmissions between Providers; or e-mails, or facsimile transmissions between a Provider and a patient.
69. Healthcare Services, including consumer direct testing, and supplies not ordered by a Provider, such as but not limited to, cholesterol testing, glucose testing and mammograms unless specifically listed in the **Preventive Services** section of this Schedule or provided by a Participating Provider.
70. Healthcare Services or items for personal comfort or convenience.
71. Non-Emergency Services performed directly in connection with the performance of a Non-Covered Healthcare Service.
72. Non-Emergency Services received outside the United States.
73. Private Duty Nursing, except as specifically permitted by this Schedule.
74. Travel services and travel/living expenses not listed as covered by this Schedule.
75. Adoption costs.
76. Healthcare and other services that do not require medical training and can be performed by a non-medical person or by the individual receiving the service.
77. Orthognathic surgery, which includes surgical manipulation of the elements of the facial skeleton to restore the proper anatomic and functional relationship in patients with dentofacial skeletal anomalies.

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Health Plan Definitions

To help you understand your benefits, here are important terms used in this document:

A

ACA Preventive Services - Certain evidence-based items or services that the Plan is required to cover without Cost-Sharing when delivered by an In-Network Provider, as required under the Affordable Care Act (ACA). These services include:

1. Evidence-based items or services with a rating of “A” or “B” from the U.S. Preventive Services Task Force (USPSTF);

2. Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);

3. Preventive care and screenings for infants, children, and adolescents, as provided in guidelines supported by the Health Resources and Services Administration (HRSA); and

4. Preventive care and screenings for women, including pregnant women, as provided in comprehensive guidelines supported by HRSA.

Coverage is subject to applicable guidelines in effect as of the date the service is provided and may be limited to certain age groups, risk factors, or frequencies as specified by the relevant recommending body.

Activities of Daily Living (ADLs) - The basic tasks individuals perform to care for themselves on a daily basis. For purposes of the Plan, ADLs include: (1) Bathing - washing oneself by sponge bath, or in a tub or shower, including getting in and out; (2) Dressing - putting on and taking off clothing and necessary braces or prosthetics; (3) Eating - feeding oneself by mouth, including the use of utensils or assistive devices; (4) Toileting - getting to and from the toilet, using it, and managing personal hygiene; (5) Transferring - moving into or out of a bed, chair, or wheelchair; (6) Continence - controlling bladder and bowel function or performing related hygiene if incontinent.

Acute Care Facility - A Facility that provides care to a Member who is in the acute phase of an illness or injury and who will have a stay of fewer than thirty (30) calendar days.

Administrative and Other Appeals - Appeals of Adverse Benefit Determinations that are not based on the Plan’s definition of Medical Necessity. These Appeals may involve administrative,

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eligibility, contractual, or Benefit design issues, and may also involve the application of Medical Judgment other than Medical Necessity. Administrative and Other Appeals include, but are not limited to, determinations regarding eligibility, enrollment, coverage limits, network participation, benefit calculations, referral or authorization requirements, continuity of care, network or gap exceptions, and other similar benefit determinations.

Air Ambulance Service - Medical transport by helicopter or airplane for patients.

Ambulatory Surgical Center (ASC) - A distinct entity, licensed by the state, that provides surgical services and procedures to a Member on an Outpatient basis, without requiring an overnight stay.

Appeal - A request to the Plan to review and reconsider a decision it has made about Benefits. This review is conducted within the Plan itself before any external review or other legal remedies, and it can include denials based on Medical Necessity, coverage rules, or other Plan provisions.

B

Balance Billing/Balance Bill - Occurs when a provider bills you for the difference between the provider's billed charges and the Allowed Amount recognized by the Plan for a Covered Service. If you receive care from an In-Network Provider, Balance Billing is not permitted for Covered Services. If you receive care from an Out-of-Network Provider, the Provider may bill you for any amount that exceeds the Plan's Allowed Amount, in addition to your applicable Cost-Sharing.

Benefits - The Healthcare Services, supplies, or expenses that are covered under the Plan, subject to the terms, limitations, and exclusions described in this document.

Billed Amount - The full, undiscounted amount charged by a Provider or Facility for a Healthcare Service or supply before any adjustments, discounts, or payments from the Plan or other sources are applied.

Biosimilar Drug - A medication that is highly similar to an already approved Brand-Name biologic drug (called the reference product). Biosimilars have no clinically meaningful differences from the reference product in terms of safety, effectiveness, and quality. They are approved by the FDA and used to treat the same conditions as the original biologic.

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Blended Services - Healthcare Services that include both Skilled and non-skilled components. When Blended Services are provided, only the Skilled Care portion of the Service is covered under the Plan.

Brand-Name Drug - A prescription drug that is marketed under a proprietary, trademark-protected name by a specific manufacturer. Brand-name drugs are typically developed and patented by the manufacturer and may be more expensive than their generic equivalents.

Brand Reference Drug/Product – The original, FDA-approved biologic medication against which a proposed biosimilar product is compared.

C

Calendar Year - The period from January 1 through December 31 of the same year.

Claim - A request for a Benefit determination under the Plan, made by or on behalf of a Member, for Healthcare Services that have been received (Post-Service Claim) or that require Prior Authorization before being received (Pre-Service Claim) or continued (Concurrent Care Claim). Pre-Service and Concurrent Care Claims may also be considered Urgent Care Claims if the request requires an expedited decision due to the medical urgency of the situation.

Clinical Trial: A research study that tests a drug, device, procedure, or other medical intervention in humans to evaluate its safety, effectiveness, or proper use.

Cochlear Implants - Small, surgically implanted electronic devices that provide a sense of sound to individuals with moderate-to-profound sensorineural hearing loss. Unlike hearing aids, they bypass damaged parts of the ear to directly stimulate the auditory nerve.

Coinsurance - A percentage of the Covered Charge for a Covered Service a Member pays after any applicable Deductible. For example, if the Covered Charge for a service is $100 and your Plan pays 80% after the Deductible, your Coinsurance is 20% ($20).

Compound Drug - Medicine with different ingredients combined together in order to tailor it for individual needs. Once mixed together, Compound Drugs are not FDA-approved.

Continuous Care (Hospice) - Care provided by a Nurse or home health aide during a period of crisis in order to maintain you in your home when you are terminally ill.

Copayment - A flat dollar amount a Member pays for a Covered Service each time it is received. Copayments do not count toward the Deductible and continue to apply even after your Deductible has been met.

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Cost-Sharing - The portion of healthcare expenses that you are responsible for paying when you receive Covered Services under the Plan. Cost-Sharing includes Deductibles, Copayments, Coinsurance, and any other amounts you are required to pay toward the cost of Covered Services. Cost-Sharing does not include premiums, charges for Non-Covered Services, or amounts that exceed the Plan's Allowed Amount (except where prohibited by law). References in this document to “no Member cost” or “no member cost-share” mean that no Cost-Sharing applies for that Covered Service — that is, you are not responsible for any Deductible, Copayment, or Coinsurance amount for those services.

Cost-Sharing Amount - The specific dollar amount or percentage that you are responsible for paying for a Covered Service under the Plan, such as Deductibles, Copayments, Coinsurance.

Covered Charge - The amount the Plan recognizes for a Covered Service. For In-Network services, this is the Negotiated Rate. For Out-of-Network services, this is the Allowed Amount as determined by the Plan.

Covered Dependent - A Dependent who is enrolled in the Plan in accordance with its terms and is receiving benefits under the Plan.

Covered Employee - An Employee who meets the eligibility requirements of the Plan, has properly enrolled in the Plan, and for whom required contributions have been paid. A Covered Employee is the primary enrollee or subscriber under the Plan and may also enroll eligible Dependents for coverage.

Covered Service - Services and supplies for which the Plan provides Benefits, as described in this document, and your other Plan documents. To be considered a Covered Service, the service or supply must be Medically Necessary, provided by an Eligible Provider, and meet all other terms and conditions of the Plan.

Critical Medical Situation - A medical condition where a patient's vital signs are unstable, their condition is life-threatening or could rapidly deteriorate, and they require immediate, intensive, or specialized medical intervention to prevent serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or death. (This is different from an Emergency Medical Condition, which means a sudden and serious health problem that needs immediate care to stop it from getting worse.)

Custodial Care - Services to assist in Activities of Daily Living and personal care that do not seek to cure or do not need to be provided or directed by a skilled medical professional.

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D

Deductible - The annual amount of Allowed Amounts a Member needs to pay before the Plan begins to share costs. Your Plan has an Individual Deductible and a Family Deductible. You'll also see separate In-Network and higher Out-of-Network Deductibles in your Medical Benefits Schedule.

Dependent (or Eligible Dependent) - An individual, including a Spouse, who meets the Plan's eligibility requirements for Dependent coverage, as outlined in the **Eligibility** section of this SPD**.**

Disabled Child - An individual who meets all of the following criteria and may be eligible for continued coverage beyond the Plan's standard age limit: (1) became disabled before reaching age 26; (2) was a Covered Dependent under the Plan prior to reaching age 26; (3) is incapable of self-sustaining employment due to a physical disability, developmental mental disability, mental illness, or mental health disorder expected to last at least two continuous years; (4) is unmarried; and (5) is financially dependent on the Covered Employee for more than half of their support and maintenance.

Domestic Partner - An individual who meets the criteria established by the Employer for domestic partner status, as documented in the Employer's policies or as otherwise determined by the Employer.

Durable Medical Equipment (DME) - Equipment such as wheelchairs, walkers, hospital beds, oxygen equipment, and other devices that can withstand repeated use, are primarily used for a medical purpose, are generally not useful to a person in the absence of illness or injury, and are appropriate for use in the home.

E

Electronic PHI (ePHI) - PHI that is transmitted by or maintained in electronic media.

Eligible Employee - An individual who meets the Plan's eligibility criteria for coverage, as described in the *Eligibility and Enrollment* sections of this SPD.

Eligible Provider - A Healthcare Professional or Facility that is legally licensed or certified to provide medical services and is acting within the scope of their license or certification. For In-Network Benefits to apply, the Eligible Provider must also be a Participating Provider in the Plan's network.

Embedded Deductible - For Members enrolled in a family tier of coverage, each covered family member has an Individual Deductible amount, and the family also has an overall Family

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Deductible. Once an individual Member meets their Individual Deductible, the Plan begins to pay Benefits for that person—even if the Family Deductible has not been met.

Emergency Medical Condition - A medical condition, including a mental health condition or substance use disorder, manifesting itself through acute symptoms of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place the individual's health in serious jeopardy, impair bodily functions, or result in serious dysfunction of bodily organ or part.

Emergency Transportation Services - Ground or air ambulance transportation provided to an individual experiencing an Emergency Medical Condition, when such transport is medically necessary to obtain emergency medical care. These services are intended to transport the individual to the nearest appropriate facility capable of providing Emergency Services.

Emergency Services - Medical screening, examination, and stabilization services provided in a Hospital Emergency Department or comparable Facility, as needed to evaluate and treat an Emergency Medical Condition. Emergency Services are covered regardless of where they are provided, and regardless of whether the provider is participating or non-participating, when sought for an Emergency Medical Condition.

Employee - A common-law employee of the Employer, as determined solely from the employment records of the Employer.

Employer - The company that sponsors and administers the Plan, unless otherwise stated. In this document, the Employer may also be referred to as the Plan Sponsor and/or the Plan Administrator.

Essential Health Benefits (EHBs) - Essential Health Benefits mean, under section 1302(b) of the Affordable Care Act, those health benefits that include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Expanded Preventive Services - Certain services the Plan covers at 100% when received In-Network that are not considered ACA Preventive Services. These services are covered at the Plan's discretion and may be subject to different terms and conditions than ACA-Preventive Services.

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Experimental and/or Investigational - As determined by the Plan, a drug, device or medical treatment or procedure is Experimental and/or Investigational if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The Plan will consider the following categories of reliable evidence, none of which shall be determinative by itself:

1. Whether there is a final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the FDA; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared to standard means of treatment or diagnosis; and
2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in any authoritative compendia as identified by the Medicare program such as, the National Comprehensive Cancer Network Drugs and Biologics Compendium, as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility, studying the same drug, device, medical treatment, or procedure.

For Prescription Drug and Pharmacy Benefits, the Plan delegates all clinical determinations, utilization management, and appeals to the PBM. The PBM's clinical policies, definition of Experimental and/or Investigational, and determinations with respect to Prescription Drugs shall govern for purposes of pharmacy benefits under the Plan.

External Review - An impartial, independent review of the Plan's final Adverse Benefit Determination, conducted by an accredited External Review Organization, after the Plan's internal Appeal process has been exhausted. It is available for eligible Claims involving Medical Judgment or Rescissions of Coverage and is carried out in accordance with applicable regulatory protections and timelines. The decision of the external reviewer is binding on the Plan, except to the extent otherwise permitted by law.

F

Facility - A licensed institution or agency, other than a Member's home, that provides Healthcare Services. This includes Hospitals, Ambulatory Surgical Centers, freestanding outpatient surgical centers, diagnostic imaging centers, laboratories, skilled nursing facilities, rehabilitation centers, and specialized clinics.

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Facility Fee - A charge billed by a Hospital, Ambulatory Surgical Center, or other Facility for the use of their premises, equipment, and supporting personnel that enable the delivery of Healthcare Services.

Family Deductible - The total amount that all covered family members must pay combined in a Plan Year before the Plan begins to pay for Covered Charges not yet applied to an Individual Deductible.

Formulary - A list of Prescription Drugs covered by the Plan under the Prescription Drug & Pharmacy Benefit. Also called a drug list.

Fraud - Any intentional act or omission made with the knowledge that it could result in unauthorized or inappropriate benefits being paid under the Plan. This includes but is not limited to knowingly providing false information, failing to notify the Plan of changes affecting eligibility, submitting Claims for services not received, altering medical records, allowing another person to use a Member ID card, or participating in schemes to inflate charges.

Freestanding Birthing Center - A Healthcare Facility that provides maternity services, including labor and delivery, in an outpatient setting and operates independently of a Hospital. A Freestanding Birthing Center is not licensed as a Hospital and does not have immediate access to inpatient Hospital care or surgical services. It is typically staffed by midwives, with or without Physician oversight. The Plan does not cover labor and delivery services provided in a Freestanding Birthing Center, including facility charges and professional fees, regardless of Provider licensure.

G

Gene, Cell, and Related Therapies - Services that are: 1) Gene-based; 2) Cellular and innovation therapeutics; and 3) Based in genetic/molecular medicine and not covered under the Institutes of Excellence™ (IOE) programs.

Generic Drug - A prescription medication that:

- Is approved by the FDA as a chemically equivalent substitute for a Brand-Name Drug;
- Has the same active ingredients, dosage form, strength, route of administration, and intended use as the Brand-Name Drug;
- May differ in color, shape, or inactive ingredients (such as fillers or preservatives); and
- Is typically sold under its chemical name rather than a brand name.

Grandfathered Health Plan - A health plan that was in existence on March 23, 2010, and has not undergone certain prohibited design changes since then.

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H

Healthcare Professional - An individual who is licensed, certified, or otherwise authorized by law to provide Healthcare Services within the scope of their professional practice. This includes Physicians, therapists, physician assistants, and other licensed medical or allied health personnel.

Healthcare Services - Services or supplies provided to diagnose, prevent, treat, or manage a disease, injury, illness, or health condition. This includes medical, surgical, diagnostic, therapeutic, behavioral health, preventive care, and prescription drug services or supplies, when provided by a licensed or certified Healthcare Professional, Facility, or pharmacy.

Homebound - A person who is unable to leave their home without considerable and taxing effort due to a medical condition or illness. This may include the need for assistance from another person or the use of mobility aids. Lack of transportation alone does not qualify as being Homebound.

Home Infusion Therapy - The administration of medications into the body through intravenous (IV), subcutaneous, intramuscular, or other parenteral routes in the home setting under the direction of a Physician or other qualified Healthcare Professional.

Hospice Center - A licensed Facility, other than a Hospital or Skilled Nursing Facility, that provides palliative and supportive care to terminally ill patients and their families under the direction of a licensed Hospice Program.

Hospital - An institution that primarily provides diagnostic, medical, surgical, or psychiatric care and treatment for sick or injured Members, on either an Inpatient or Outpatient basis. The institution must be licensed by the state and maintain facilities for diagnosis and major surgery, with a permanent staff of Physicians and nurses available 24 hours a day.

Hour of Service - Each full hour (sixty consecutive minutes) of Medically Necessary care provided by a covered Provider as part of approved Home Health Care, Hospice Care, or Skilled Nursing Care.

I

Individual Deductible - The amount a Member must pay each plan year for Covered Services before the Plan begins to pay benefits for that individual.

Infertility - A disease, condition, or status characterized by: (1) a failure to establish a pregnancy or to carry a pregnancy to live birth after an appropriate trial of egg-sperm contact;

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(2) a person's inability to reproduce either as a single individual or with a partner without medical intervention; or (3) a licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Inpatient - Refers to services provided during a formal admission to a Hospital or Facility that includes an overnight stay or longer, for medical, surgical, mental health, substance use disorder, or other Covered Services.

Inpatient Services - Healthcare Services provided when you are formally admitted to a Hospital, Skilled Nursing Facility, or other licensed health care Facility as an Inpatient. These services generally require at least one overnight stay and include room and board, nursing care, medical care, and other services provided during the admission.

In-Network Provider (Participating Provider/Facility) - A healthcare professional, hospital, or facility that has a contract with your plan to provide services at a negotiated, typically lower, rate. Using In-Network Providers usually results in lower out-of-pocket costs.

In-Network Services - Medical services you receive from an In-Network Provider or Facility. These services typically have lower Cost-Sharing Amounts and count towards your In-Network Out-of-Pocket Maximum.

Intensive Outpatient Hospitalization Services - Programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring.

L

Licensed Hospice Program - An organization that provides hospice care services to terminally ill patients and their families. It must be licensed and operated in accordance with applicable state and federal laws, and approved by the appropriate regulatory authority to provide coordinated, multidisciplinary care under the direction of a licensed Physician or other qualified Provider.

Long-Term Care - Care provided to individuals who have chronic illnesses, disabilities, or functional impairments that require assistance with Activities of Daily Living (ADLs) or supervision for an extended period—typically months or years. This includes custodial or personal care services and is usually Non-Skilled Care.

M

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Maintenance Medication - A Prescription Drug taken regularly and on an ongoing basis to treat chronic or long-term health conditions, such as high blood pressure, diabetes, asthma, or high cholesterol.

Material Misrepresentation - Providing false, incomplete, or misleading information, or failing to provide information, whether intentionally or negligently, that the Plan relies on to determine eligibility for coverage, enrollment, or benefits, and where the correct information would have resulted in a denial of coverage, termination of coverage, or a change to the terms of coverage.

Medical Benefit - A Benefit covered under the Plan's medical coverage, as opposed to the Prescription Drug Benefit. Medical Benefits include services and supplies such as office visits, Hospital care, diagnostic testing, Preventive Services, and medical equipment and supplies, unless otherwise covered under the Prescription Drug Benefit.

Medical Judgment - Decisions made by the Plan about the Medical Necessity, appropriateness, or setting of a health care service, based on clinical standards and individual circumstances. A Claim may involve medical judgment if it includes decisions such as:

- Whether a treatment should be provided in a Hospital, Outpatient setting, or at home;
- Whether it is Medically Necessary to be treated by a Specialist;
- Whether care qualifies as Emergency Services or Urgent Care;
- Whether a generally excluded service is covered due to a specific medical condition;
- How often or in what way a Preventive Service should be provided, if not clearly defined in guidelines.

Medical Necessity/Medically Necessary - Healthcare services, supplies, or medications provided to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, condition, or its symptoms, in a manner that is:

- Required to diagnose or treat an illness, injury, disease, condition, or its symptoms;
- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site, and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes and representative of best practices in the medical profession;
- Not primarily for the convenience of the enrollee, patient, physician, or other health care provider;
- Not more costly than an alternative service(s), medication(s), or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile; and
- Rendered in the least intensive setting appropriate for the delivery of the services, supplies, or medications.

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The applicable UM Vendor will make a determination of Medical Necessity based on its internal clinical review criteria, policies, and procedures.

For Prescription Drug and Pharmacy Benefits, the Plan delegates all clinical determinations, utilization management, and appeals to the PBM. The PBM's clinical policies, definition of Medical Necessity, and determinations with respect to Prescription Drugs shall govern for purposes of pharmacy benefits under the Plan.

Important note regarding Prescription Drug & Pharmacy Benefits: While the above definition of Medical Necessity applies to medical Benefits, the Plan defers to the clinical definitions, policies, and determinations of the Plan's Pharmacy Benefit Manager (PBM) as applied to medications, for the Pharmacy and Prescription Drug Benefit (including coverage determinations, utilization management, and appeals).

Medical Necessity Appeal - A request for the Plan to review a denial of a health care service or treatment based on the Plan's determination that it was not Medically Necessary. This type of Appeal focuses specifically on whether the service should have been considered clinically appropriate and required under generally accepted medical standards.

Member - An individual who is enrolled in this health Plan and is eligible to receive Benefits.

Mental Health/Substance Use Disorder (MH/SUD) Provider - A Provider who diagnoses, treats, and manages mental health (MH) conditions and substance use disorders (SUDs). For purposes of office visits, these Providers are considered Primary Care Providers.

N

Negotiated Rate (In-Network Only) - The rate or fee that has been agreed upon between the Plan and a Participating (In-Network) Provider for covered Healthcare Services. The Negotiated Rate is the amount the Participating Provider has agreed to accept as payment in full for such services, subject to any applicable Deductible, Copayment, or Coinsurance.

No Surprises Act (NSA) - A federal law that protects Members from unexpected medical bills (surprise bills) for certain emergency and non-emergency services provided by Out-of-Network Providers.

Non-Emergency Services - Medical care that is not required to evaluate or stabilize an Emergency Medical Condition. Non-Emergency Services provided in an Emergency Department are generally not covered (or may be subject to higher Cost-Sharing), except as otherwise required by law.

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Non-Grandfathered Health Plan - A plan that is not a Grandfathered Health Plan.

Non-Participating Provider (Out-of-Network Provider) - A Physician, Provider, Hospital, or Facility that does NOT have a contract with your Plan. Using Out-of-Network Providers generally results in higher out-of-pocket costs because they do not have Negotiated Rates with the Plan.

Non-Skilled Care - Healthcare Services that do not require the training, clinical judgment, or direct supervision of a licensed nurse or other qualified Health Care Professional. These services can typically be safely and effectively performed by an individual without specialized medical training or can be self-administered. Non-Skilled Care is generally not covered by the Plan.

Nurse - A person who is licensed and authorized to practice as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.) under applicable state law and who is acting within the scope of their license.

O

Observation Care/Observation Hours - Services provided for short-term monitoring, assessment, or treatment to determine whether a patient needs inpatient admission.

Off-Label Use of Drugs - The prescription or administration of a drug for a purpose, population, dosage, or route of administration that is not included in the FDA-approved labeling for that drug.

Orthodontia - Dental Services and procedures for the diagnosis, prevention, and correction of mispositioned teeth and jaws, including the use of braces, aligners, retainers, or other orthodontic appliances. Services may include treatment for functional bite correction and alignment of teeth.

Orthotics - Externally applied devices (like braces, splints, or custom shoe inserts) used to support, align, prevent, or correct the function of a body part, particularly related to the musculoskeletal system. They aid existing body parts without replacing them.

Outpatient Services - Healthcare Services received by a Member without being admitted to a Hospital or Facility for an overnight stay. Services provided on an outpatient basis generally allow the Member to return home the same day. Outpatient Services include, but are not limited to, outpatient laboratory, diagnostic, and imaging services, and other outpatient procedures including outpatient surgery.

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Out-of-Network Services - Medical services you receive from an Out-of-Network Provider. These services generally result in higher Cost-Sharing Amounts and typically do not count towards your In-Network Out-of-Pocket Maximum.

Out-of-Pocket Maximum (OOPM) - The annual total amount a Member will be responsible for paying in Deductibles, Copayments, and Coinsurance for Covered Services. Once this maximum is reached, the Plan typically pays 100% of the Allowed Amount for most Covered Services for the remainder of that year.

Over-the-Counter (OTC) Drug - A medication that:

- Is approved by the FDA for sale without a prescription; and
- Can be purchased directly by a consumer without a written or electronic prescription from a Provider.

P

Palliative Care - A specialized type of medical care provided to an individual with a serious illness. These services focus on providing relief from the symptoms, pain, and stress of the illness, with the goal of improving the quality of life for both the individual and their family. These services can be received at any age and at any stage of a serious illness.

Partial Hospitalization - Medically directed intensive, or intermediate short-term mental health and/or substance use disorder treatment provided for a period of less than twenty-four (24) hours but more than four (4) hours in a day for five (5) to seven (7) days per week in a licensed or certified Facility or program.

Physician - A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of their license.

Physiological Abnormality - A functional or structural abnormality of the reproductive system that prevents the natural conception of a pregnancy or the ability to carry a pregnancy to term. The abnormality must be diagnosed through recognized clinical evaluation or testing and supported by medical evidence.

Plan - Refers to this health plan document and Benefits.

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Post-Stabilization Services - Services provided by an Out-of-Network Provider or Emergency Facility after an individual's Emergency Medical Condition is stabilized. These services must be provided as part of Outpatient observation, an Outpatient stay, or an Inpatient stay.

Prescription Drug - A medication, product, or biological that:

- Is approved by the U.S. Food and Drug Administration (FDA);
- Requires a prescription by law; and
- Is dispensed by a licensed pharmacist following a written or electronic order from a licensed prescriber (such as a physician, dentist, or other authorized healthcare provider).

Prescription Drugs may include brand-name drugs, generic drugs, and specialty medications, as determined by the Plan or Pharmacy Benefit Manager.

Prescription Drug & Pharmacy Benefit - A Benefit administered by the Plan's Pharmacy Benefit Manager (PBM). Prescription Drug & Pharmacy Benefits generally include outpatient prescription medications and other pharmacy items, as specified in the Plan's Formulary or drug list.

Preventive Services - Healthcare Services provided to help prevent illness, detect conditions early, and support overall health and well-being. These services may include screenings, immunizations, exams, and counseling that are intended to identify health issues before symptoms appear or to reduce the risk of future health problems. Preventive Services may be covered under the Plan as **ACA Preventive Services** or as described in **the Expanded Preventive Services** section of this Schedule, depending on the type of service.

Primary Care Provider (PCP) - For Office Visits, a Provider who practices in family medicine, general medicine, internal medicine, pediatrics, or obstetrics/gynecology (OB/GYN), or mental health (MH)/substance use disorder (SUD).

Prior Authorization - A review conducted by the Plan's designated Utilization Management Vendor or PBM before certain services, supplies, or medications are provided, to determine whether they meet the Plan's requirements for Medical Necessity, appropriateness, and eligibility for coverage. Prior Authorization **is not a guarantee of benefits or payment**. Final benefit determinations are made only after the Claim is submitted and processed in accordance with the terms of the Plan.

Private Duty Nurse/Private Duty Nursing - One-on-one, continuous nursing care provided by a Nurse (Registered Nurse or Licensed Practical Nurse) for an individual patient, typically in the

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home. This type of care is ordered by a Physician and is intended to manage complex, ongoing medical needs that require individualized, extended nursing attention—often for several hours per day or overnight.

Professional Fee - A charge billed by Physicians, surgeons, anesthesiologists, radiologists, pathologists, or other Providers for the services they personally render during a Hospital or Facility visit or for Inpatient Services.

Prosthetics - Artificial devices that replace a missing body part, such as a limb (e.g., an artificial leg or arm), an eye, or an internal joint. They restore either function or appearance, or both.

Protected Health Information (PHI) - Information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. PHI includes information of persons living or deceased. PHI does not include health information about an employee that is held in the Plan Sponsor's employment records in its role as an employer.

Provider - A Healthcare Professional or Facility that is licensed, certified, or otherwise authorized to provide Healthcare Services and is acting within the scope of their license, certification, or accreditation as required by law.

Q

Qualifying Medical Child Support Order (QMCSO) - A medical child support order that: 1) creates or recognizes the right of an alternate recipient to receive benefits under the Plan for which a Member or beneficiary is otherwise eligible, or assigns to an alternate recipient the right of a Member or beneficiary to receive benefits under the Plan; and 2) is recognized by the Plan as "qualified" because it includes the information and meets the requirements set forth in the QMCSO provisions under applicable law.

A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO under the Plan.

Qualifying Payment Amount (QPA) - A benchmark rate, based on the Plan's median contracted rate, used to calculate your Cost-Sharing Amount for certain services protected under the No Surprises Act. It also helps determine payments to Out-of-Network Providers if a dispute resolution process is initiated.

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Qualifying Reason (HIPAA Special Enrollment): A Qualifying Reason for loss of coverage includes: termination of employment, reduction in work hours, divorce or legal separation, loss of Dependent status (e.g., due to age), death of the Covered Employee, exhaustion of COBRA coverage, or termination of Plan Sponsor contributions.

R

Recognized Amount - For purposes of determining your Cost-Sharing Amount under the No Surprises Act (NSA), the amount used by the Plan to calculate your cost-sharing for certain Out-of-Network items and services that are subject to NSA protections, including emergency services, non-emergency services at in-network facilities, and air ambulance services.

Reconstructive Surgery - Medically Necessary surgery needed due to an illness, injury, or congenital (birth) condition. This includes: 1) surgery that is part of, or follows, treatment for the affected body part; 2) surgery for a Covered Dependent child when a congenital condition has caused a functional problem, as determined by the attending Physician; or 3) surgery following a mastectomy, in accordance with the coverage requirements of the Women's Health and Cancer Rights Act (WHCRA).

Relative (Eligibility) - For the purposes of the eligibility provisions of this Plan, an individual who is the Participant's parent or grandchild, whether by blood, adoption, or step-relationship.

Residential Treatment Facility - A Facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of individuals diagnosed with alcohol, drug or substance use disorders or mental illness.

Request for Benefits – Any request for a Benefit(s) made by a Claimant in accordance with the Plan's procedure for filing Claims.

Rescission of Coverage - A retroactive cancellation or termination of a Member's coverage under the Plan due to Fraud or a Material Misrepresentation. Any Rescission of Coverage will be implemented only as permitted by law and will include advance notice of at least thirty (30) days to the affected Member.

Reversal of Voluntary Sterilization - A surgical or medical procedure to reverse a previous sterilization procedure that was undertaken at the request of the individual for the purpose of permanently preventing pregnancy.

Routine Home Care - Basic hospice care provided in the patient's home or other place of residence.

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Routine Patient Costs: The cost of any Healthcare Services that would typically be covered if the Member were not enrolled in an approved Clinical Trial. Routine Patient Costs do not include:

1. The cost of the Investigational item, device, or Healthcare Service that is the subject of the approved Clinical Trial;
2. Items and Healthcare Services provided solely to satisfy data collection and analysis needs and not used in direct clinical management.
3. A Healthcare Service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

S

Skilled Care - Care that requires the training, clinical judgment, and direct supervision of a licensed or registered nurse or other qualified Healthcare Professional, and meets the criteria established by the Centers for Medicare and Medicaid Services (CMS) for skilled care.

Skilled Home Health Care - Skilled Care provided to a patient in their home by a qualified Healthcare Professional under the direction of a Physician or other authorized Provider. These services require the expertise and training of medical professionals and go beyond basic personal care or assistance with daily activities.

Skilled Nursing Facility Services - Skilled Care provided in a Skilled Nursing Facility for the management, observation, and evaluation of a patient's care, or for the performance of complex nursing procedures. Skilled Nursing Facility Services are covered only when they are Medically Necessary and are not primarily for the convenience of the patient or caregiver. Services that do not require the skills of a Nurse, or that are primarily custodial in nature, are not considered Skilled Nursing Facility Services.

Specialist - A Provider other than a Primary Care Provider, regardless of any subspecialty in which the Provider is trained or practicing. Specialists may include cardiologists, dermatologists, orthopedic surgeons, and other Healthcare Professionals who focus on specific diseases, conditions, or patient populations.

Specialty Care Services - Medical services provided by a Specialist whose practice is limited to a particular field of medicine, or services that require specialized equipment or expertise not typically found in a primary care setting.

Specialty Medication – Generally, medication used to treat chronic, complex conditions like multiple sclerosis, hepatitis C and cancer. Specialty Medications can include oral solids, or can be injected, infused or inhaled and may require special handling, such as refrigeration.

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Specialty Pharmacy - A pharmacy that focuses on dispensing, managing, and supporting the use of complex, high-cost, and often high-touch medications for patients with chronic, rare, or serious health conditions.

Spouse - An individual who is treated as a Spouse for federal tax purposes. A common-law Spouse shall be eligible for coverage if the foregoing requirement is met and the Covered Employee submits a written notarized statement affirming the person as their Spouse and naming the state of marriage.

Stand-Alone Services - Basic or advanced laboratory testing, imaging, pathology, or genetic testing/molecular diagnostics, as described in the Outpatient Hospital and Facility Services section of this Schedule, when such services are billed separately and not in conjunction with any other Facility, professional, procedural, or ancillary service. Any services other than those expressly listed above are not eligible for coverage or reimbursement as a Stand-Alone Service.

Summary Health Information - Information (1) that summarizes the Claims history, Claims expenses, or type of Claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

T

Tax Dependent – An individual who qualifies as the Member's dependent for federal income tax purposes under the Internal Revenue Code, including but not limited to: 1) a "qualifying child" as defined in Internal Revenue Code §152(c); or 2) a "qualifying relative" as defined in Internal Revenue Code §152(d); provided that the individual satisfies all requirements under applicable IRS rules to be claimed as a dependent on the Member's federal income tax return.

Transplant Services - Transplantation (including retransplants) of human organs or tissue, including all related post-surgical treatment and drugs and multiple transplants for related care.

U

Urgent Care Center - A Healthcare Facility whose primary purpose is to provide immediate, short-term medical care for minor illnesses or injuries that require prompt attention but are not life-threatening. Services are provided on an unscheduled, walk-in basis and are not intended for regular or routine care.

V

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Voluntary Sterilization - A surgical or medical procedure undertaken at the request of the individual for the purpose of permanently preventing pregnancy, not due to an underlying medical condition. Examples include tubal ligation, salpingectomy for sterilization purposes, and vasectomy.

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