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

By: Gale GALLEGOS (Feb 20, 2025 14:48 MST) **Date:** Feb 20, 2025

The North Conejos School District RE1-J Group Health Plan

Summary Plan Description

July 01, 2024

QUICK REFERENCE GUIDE

Questions?	**Gravie Administrative Services Customer Service staff is available to answer questions about your coverage Monday through Friday from 8AM to 5PM Central Time.** **Customer Service: 866.863.6232**
	When contacting Customer Service, please have your identification card available. If your questions involve a bill, we will need to know the date of service, type of service, the name of the Provider and the charges involved.
Telephone Numbers for Utilization Management Vendor for Pre-certification and Pre-Service/Concurrent Care Claims	**Monday through Friday 7 AM to 7 PM Central Time** **Customer Service: 855.451.8365** **CVS Caremark: 833.847.8881** **Aetna: 855.451.8365**
Website	**Gravie member website:** https://member.gravie.com **Aetna Provider directory:** www.aetna.com/asa
Mailing Address	**Claims, appeal requests, and written inquiries should be mailed to:** **Customer Service Department** **Gravie Administrative Services** **P.O. Box 211543** **Eagan, MN 55121**
Prescription Drugs **CVS Caremark**	**Telephone: 833.847.8881** **Website: www.gravie.com**
Identification Cards	The Third-Party Administrator (TPA) issues an identification (ID) card containing important coverage information. Please verify the information on the ID card and notify Customer Service if there are errors. If any ID card information is incorrect, Claims for Benefits under the Plan or bills and/or invoices for your health care may be delayed or temporarily denied. You will be asked to present your ID card whenever you receive services. If any Covered Person permits the use of their Identification Card by any other person, such card may be retained by this Plan, and all rights of such Covered Person pursuant to this Plan may be terminated.

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I. Introduction

A. Your Employer (Plan Administrator)

Your Employer, which also serves as the Plan Sponsor and the Plan Administrator, has established an employee welfare Benefit Plan (the Plan) to provide health care Benefits. This Plan is self-insured, which means that the Plan Sponsor pays the Claims for Covered Services from its general assets.

The Plan Administrator retains all fiduciary responsibilities with respect to the Plan and has the exclusive and final binding discretionary authority to interpret and administer the Plan, resolve any ambiguities that exist and make all factual determinations to the fullest extent permitted by law.

The Plan Sponsor, by action of its governing body or an authorized officer or committee, reserves the right to change or terminate the Plan. This includes, but is not limited to, changes to Contributions, Copayments, Deductibles, Coinsurance, and Out-of-Pocket Limits and any other terms or conditions of the Plan. The decision to change the Plan may be due to changes in federal laws governing welfare Benefits, or for any other reason.

B. Gravie Administrative Services (Gravie, TPA)

Your Employer has contracted with Gravie, as an external Third-Party Administrator (TPA), to provide certain administrative services, including Claim processing services, subrogation, utilization management, and complaint resolution assistance. Please note that your Employer is solely responsible for payment of your eligible Claims. Gravie has no power to change or delete any of the terms of the Plan, or to waive or fail to apply any eligibility requirements for a Benefit under the Plan without direction from the Plan Administrator.

C. Summary Plan Description (SPD)

Please read this entire SPD and review its attachments carefully. Many of its provisions are interrelated, so reading just one or two provisions may give you incomplete information regarding your rights and responsibilities under the Plan. **The Schedule of Benefits and State-Specific Benefit Addendum attached to this SPD have specific information on covered Benefits, exclusions, and cost-sharing amounts.**

Capitalized words used in this SPD have special meanings and are defined at the back of this SPD in Section XI. Keep this SPD in a safe place for future reference.

This document serves as the Summary Plan Description and includes important information about your benefits under the Plan. The Plan Administrator has, to the fullest extent permitted by law, the sole, final, and exclusive discretion to determine Benefits available under the Plan. Amendments that are included with this SPD or adopted by the Plan Sponsor are fully made a part of this SPD.

II. When Am I Eligible?

A. Eligibility

You are eligible to enroll for coverage if you are:

1. Classified by the Plan Sponsor as a full-time employee whose standard hours are a minimum of 30 hours per week.

2. An Eligible Dependent of the employee. An employee must elect coverage for themselves if they want to enroll eligible dependents. If both parents are covered as employees under this Plan, a child may be covered as a dependent of either parent, but not both.

B. Enrollment and Coverage Commencement

New Enrollment. The eligible employee must apply to enroll themselves and any dependents they wish to enroll within 31 calendar days after the date the employee first becomes eligible. Coverage will commence on the first of the month after a waiting period of 0 days.

Annual Enrollment. Subject to all eligibility and enrollment provisions, the employee may elect to enroll themselves and any eligible dependents during the Employer's annual enrollment period. Coverage will commence on the date indicated by your Employer during the annual enrollment period.

III. Are There Other Times When I Can Add or Drop Coverage?

Special Enrollment Period

If you are an eligible employee, but not enrolled for coverage under this Plan, you may enroll yourself and your eligible dependents for coverage under the terms of this Plan if the following conditions apply:

1. You were covered under a group health Plan , covered under a state public health program, or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. You experienced a qualifying life event such as marriage, birth, adoption, or placement for adoption.

3. The eligible employee stated in writing at the time that coverage was previously offered that the other health coverage was the reason for declining enrollment.

4. Your coverage described in paragraph 1 above was:
   a. Terminated under a COBRA or state continuation provision and the coverage under such provision was exhausted; or
   b. Terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer Contributions toward such coverage were terminated; or
   c. Terminated as a result of loss of eligibility for a state public health program; or
   d. Coverage under a group health plan with a plan year that differs from the plan year applicable to coverage under this SPD and such coverage ended either at the close of such other group health plan's plan year in relation to an open enrollment period or upon the occurrence of one or more of the following qualifying change in status events experienced by the eligible employee or dependent, but only to the extent such event is recognized under this employer's Section 125 cafeteria plan, if applicable:

i. A significant reduction in benefits available under the other group health plan; or

ii. A significant increase in the cost charged to the eligible employee or dependent for coverage under the other group health plan; or

iii. A reduction in working hours that caused a significant increase in the cost charged to the eligible employee or dependent for coverage under the other group health plan; or

iv. A covered dependent is eligible to enroll in an individual health insurance plan through the Marketplace. An employee is allowed to drop group health plan coverage and reduce their pre-tax election amount for group medical premiums mid-year from family to self-only coverage if the following conditions are met:

1. One or more of the employee's dependents are eligible for a special or open enrollment period in the Marketplace, and
2. The change to the employee's election is related to their dependent(s) intended enrollment in individual health insurance coverage through the Marketplace. The Marketplace health insurance coverage must be effective beginning no later than the day immediately following the last day they are covered under the employee's employer plan; and

5. The eligible employee requested such enrollment not later than 30 calendar days after the date of the event described in paragraphs 4.a, 4.b or 4.d above, or not later than 60 calendar days after the date of loss of eligibility for a state public health program described in paragraph 4.c above.

Special Enrollment Period for Medicaid and Children's Health Insurance Program (CHIP) Participants.

If an eligible employee and/or the eligible employee's eligible dependents are covered under a state Medicaid Plan or a state CHIP (if applicable) and that coverage is terminated as a result of loss of eligibility, then such employee may request enrollment in the Plan on behalf of the eligible employee and/or eligible dependents. Such request shall be submitted to the Plan not later than 60 calendar days after the eligible employee's and/or the eligible employee's dependent's coverage ends under such state plans.

If an eligible employee and/or the eligible employee's eligible dependents become eligible for coverage under a state Medicaid Plan or a state CHIP (if applicable), and the Employer has not opted out of the premium assistance subsidy offered by the state, then such employee may request enrollment in the Plan on behalf of the eligible employee and/or such eligible dependents. The eligible employee shall request such enrollment in the Plan no later than 60 calendar days after the date the employee and/or the eligible employee's eligible dependents are determined to be eligible for coverage under such state plans.

Special Enrollment Period for Covered Persons due to the Acquisition of New Dependents. New dependents may enroll if all the following conditions are met:

1. A group health plan makes coverage available to a dependent of an employee; and

2. The employee is eligible for coverage under this Plan; and

3. They become dependents of the employee through marriage, birth, adoption, placement for adoption, or legal guardianship. This Plan shall provide a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the employee, and in the case of the birth, adoption, children placed for adoption, or the legal guardianship of a child, the employee may enroll and the spouse of the employee may be enrolled as a dependent of the employee if such spouse is otherwise eligible for coverage. The eligible employee, if not previously enrolled, is required to enroll when a dependent enrolls for coverage under this Plan. In the case of marriage, the employee, the spouse, and any new dependents resulting from the marriage may be enrolled, if otherwise eligible for coverage; and

4. Application must be received within 31 calendar days of the date the employee first acquires the dependent and coverage will be effective on the date of the marriage, birth, adoption, placement for adoption, or legal guardianship as described in paragraph 3 above.

Notwithstanding paragraph 4 above, if a Covered Employee has a spouse and/or dependent child/children covered under this Plan and subsequently acquires an eligible dependent child through birth or adoption, the newly acquired dependent child will be considered covered under the Plan effective on the date of the birth or adoption, provided that the employee enrolls the newly acquired dependent child within 60 days of the birth or adoption.

Note: Other dependents (such as siblings of a newborn child) are entitled to special enrollment rights upon the birth or adoption of a child.

Coverage will commence on the date of the event described above.

IV. When Does My Coverage End?

Your coverage will terminate on the earliest of the following dates:

- The date the Plan is terminated;
- The end of the month in which the Covered Employee retires;
- The end of the month in which your eligibility under the Plan ends;
- The end of the month in which your written request is received to terminate coverage due to your enrollment in Medicare or another group health Plan;
- For a dependent, the end of the month due to the dependent's enrollment in Medicare or another group health Plan;
- When you do not make your required Contribution for coverage under the Plan. Termination will be retroactive to the last day for which your required Contribution has been timely received; or
- The date you performed an act that constitutes fraud, made an intentional misrepresentation or omission of material fact, under the terms of the Plan.
- The end of the month following the date you enter active military duty for more than 31 days.
- The date of the death of the Covered Person. Coverage for the Covered Employee's dependents will terminate the end of the month in which the death occurred.
- For a spouse, the end of the month following the date of divorce.
- For a dependent domestic partner (if covered), the end of the month in which the individual no longer meets the criteria to be a dependent domestic partner.
- When the maximum period for coverage under COBRA Continuation Coverage expires for a Covered Person.
- For a child who is entitled to coverage through a National Medical Support Notice (NMSN), the end of the month in which the earliest of the following occurs:
    a. The NMSN ceases to be effective; or
    b. The child is no longer a child as that term is used under state law; or
    c. The child has immediate and comparable coverage under another Plan; or
    d. The Covered Employee who is ordered by the NMSN to provide coverage is no longer eligible as determined by the Employer; or
    e. The Employer terminates family or dependent coverage; or
    f. The relevant premium or Contribution toward the premium is last paid.

For a Covered Dependent child, coverage will terminate the end of the month in which the child is no longer eligible as a Covered Dependent. If your Covered Dependent child is disabled, coverage will end the end of the month in which the Covered Dependent child marries or is no longer disabled.

V. How Do I Submit a Claim For Payment?

D. Bills from Participating Providers

When you present your identification card at the time of requesting services from Participating Providers, paperwork and submission of post-service Claims relating to services will be handled for you by your Participating Provider. You may be asked by your Provider to sign a form allowing your Provider to submit Claims on your behalf. If you receive an invoice or bill from your Provider for services, simply return the bill or invoice to your Provider, noting your enrollment in the Plan. Your Provider will then submit the post-service Claim under the Plan in accordance with the

terms of its participation agreement. Your Claim will be processed for payment according to the Employer's coverage guidelines. The TPA must receive Claims within 365 calendar days after the date services were Incurred or a longer time period, if any, specifically set forth in the Participating Provider's agreement or the national network agreement, except in the absence of your legal capacity. Claims received after the deadline will be denied.

B. Bills from Non-Participating Providers

The process described in this section pertains only to medical services. Out-of-network pharmacy services are not covered. To locate an in-network pharmacy, please visit www.gravie.com.

Claim Submission. You must submit a completed Claim form in writing, together with an itemized bill for the services Incurred, on the Claim form provided and in accordance with the filing procedures for post-service Claims outlined in the next section. The TPA must receive Claims within 180 calendar days after the date services were Incurred, except in the absence of your legal capacity. If the Plan is discontinued, the deadline for the receipt of Claims is 180 calendar days. Claims received after the deadline will be denied. If you need Claim forms, please contact Customer Service.

Payment of Claims. Claims for Benefits will be paid promptly upon receipt of written proof of loss. Benefits which are payable periodically during a period of continuing loss will be paid on a periodic basis. All or any portion of any Benefits provided by the Plan may be paid directly to the Provider rendering the services. Payment will be made according to the Employer's coverage guidelines.

C. Initial Benefit Determinations of Post-Service Claims

Post-service Claims are Claims that are filed for payment of Benefits under the Plan after medical care has been received and submitted in accordance with the post-service Claim filing procedures for the Plan.

Filing Procedure for Post-Service Claims. To file a post-service Claim, you or your attending Provider must submit an itemized bill in writing and in accordance with the procedures and within the deadlines described above. To be considered a properly filed post-service Claim under the Plan, your completed Claim form, together with an itemized bill and the essential data elements, must be submitted in writing to Customer Service at the mailing address noted inside the cover page of this SPD. Your post-service Claim must include at least the following essential data elements:

- The identity of the Covered Person and Provider of services;
- The date(s) of services;
- A specific medical diagnosis; and
- Specific treatment, health care service, or procedure codes for which Benefits or payment is requested.

An explanation of these essential data elements will be provided to you, upon request and free of charge, by calling Customer Service. If you or your attending Provider have not submitted the post-service Claim in accordance with these filing procedures, including a failure to submit all essential data elements, your post-service Claim will be treated as incorrectly filed. Please note that the time periods for making an initial Benefit determination begin when Customer Service receives a written post-service Claim submitted in accordance with the Plan's filing procedures.

If your attending Provider files a post-service Claim on your behalf, the Provider will be treated as your authorized representative under the Plan for purposes of such Claim and associated appeals unless you provide the TPA with specific direction otherwise within three business days or as required under state law from the Plan Administrator's notification that an attending Provider was acting as your authorized representative. Your direction will apply to any remaining appeals.

A request or inquiry that is not made in accordance with the Plan's Claim procedures will not be treated as a Claim under the Plan.

Initial Benefit Determination. If your post-service Claim is denied, the TPA will communicate such denial within 30 calendar days after receipt of a post-service Claim submitted in accordance with the Plan's filing procedures. If the

TPA does not have all information it needs to make an initial Benefit determination, it may extend the time period for the initial Benefit determination by 15 calendar days. The TPA will notify you of the extension within the initial 30 calendar day period. You will then have 45 calendar days, or longer time as granted to you in the extension notification, to provide the requested information. The TPA will notify you of its initial Benefit determination within 15 calendar days after the earlier of the TPA's receipt of the requested information or the end of the time period specified for you to provide the requested information. If you do not provide the requested information within the time period specified, your Claim will be denied. If you and your authorized representative then submit the requested information within 180 calendar days after the date services were Incurred (except in the absence of your legal capacity), the Plan Administrator may, but is not required to, reconsider the submitted information, and will not consider information it receives more than 365 calendar days after the date your services were Incurred.

The time period for the initial Benefit determination may also be extended for 15 calendar days for circumstances beyond the TPA's control.

If your post-service Claim is denied, notification will be provided to you. This notice will explain:

- Information sufficient to identify the Claim involved and any information required by law.
- The reason for the denial;
- The part of the Plan on which it is based;
- Any additional material or information needed to make the Claim acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

VI. How Do I Submit An Appeal?

Please refer to the State-Specific Benefit Addendum for information on submitting an appeal.

Prescription Drug Appeals

Plan Sponsor delegates to CVS Caremark (CVS) the authority to perform administrative and/or clinical initial prescription drug coverage determinations and appeals (whether first level, second level or urgent) filed by or on behalf of Covered Persons. In the event CVS issues a denial in connection with the final level of internal (Plan) appeal, CVS will, on Plan Sponsor's behalf, provide the Covered Person access to a panel of Independent Review Organizations (IROs) for the purpose of obtaining an external review if desired. CVS may offer the services of different IROs, or otherwise change the composition of the panel, during the term of the Agreement. CVS offers access to such IROs as a convenience to Plan Sponsor, and Plan Sponsor at all times retains the responsibility and authority to determine the IROs that will perform external reviews for the Plan.

CVS Information:

Website: www.caremark.com
Telephone: 833-847-8881
Address: CVS Caremark Claims Department
PO Box 52136
Phoenix, AZ 85072-2136

VII. Coordination of Benefits

As a Covered Person, you agree to permit the Plan to coordinate obligations under this SPD with payments under any other health Benefit plans as specified below, which cover you as an employee or dependent. You also agree to provide any information or submit any Claims to other health Benefit plans necessary for this purpose. You agree to authorize billing to other health plans for purposes of coordination of Benefits.

This Plan does not coordinate your prescription drug Benefits under this SPD with any other health plan's prescription drug Benefits.

Unless applicable law prevents disclosure of the information without the consent of the Covered Person or the Covered Person's representative, each Covered Person claiming Benefits under this Plan must provide any fact needed to pay the Claim. If the information cannot be disclosed without consent, the Plan will not pay Benefits until the information is given.

A. APPLICATION: This Coordination of Benefits provision applies when you have health care coverage under more than one plan.

B. ORDER OF BENEFIT DETERMINATION RULES: The plan that covers the Covered Person as the Covered Employee is the primary plan. The plan that covers the Covered Person as a dependent is the secondary plan. A secondary plan pays after the primary plan and may reduce the Benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

A plan that does not contain a Coordination of Benefits provision that is consistent with this section is always primary.

A plan may consider the Benefits paid or provided by another Plan in determining its Benefits only when it is secondary to that other Plan.

This Plan will not pay more than it would have paid had it been the Primary Plan. This Plan determines its order of Benefits by using the first of the following that applies:

1. **Nondependent/Dependent**: The plan that covers the person as an employee, subscriber, or retiree is the primary plan; and the plan that covers the person as a dependent is the Secondary Plan.

   Exception: If the person is a Medicare beneficiary and federal law makes Medicare:
   a. Secondary to the plan covering the person as a dependent; and
   b. Primary to the plan covering the person as a nondependent (e.g., a retired employee); then the order is reversed, so the plan covering that person as a nondependent is secondary and the other plan is primary.

2. **Child Covered Under More Than One Plan**: The order of Benefits when a child is covered by more than one plan is:
   a. If the parents are married, the following rules apply:
      - The primary plan is the plan of the parent whose birthday is earlier in the year;
      - If both parents have the same birthday, the plan that covered either of the parents for a longer time is primary.
   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms; then that plan is primary.
   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of Benefits is the plan of the:
      - Custodial parent;
      - Spouse of the Custodial Parent;
      - Noncustodial parent; and then
      - Spouse of the noncustodial parent.
   d. For a child covered under more than one plan by persons who are not the parents of such child, the order of Benefits shall be determined under paragraph 2.a of this section as if those persons were parents of such child.
   e. For a dependent child who has coverage under either or both parents' plans and who also has coverage as a dependent under a spouse's plan , the rule in paragraph 5 of this section 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' plans, the order of Benefits shall be determined by applying the birthday rule in paragraph 2.a of this section to the dependent child's parent(s) and the dependent's spouse.

3. **Active/Inactive Employee**: The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan that covers the person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits; then this rule is ignored.

4. **Continuation Coverage**: If a person whose coverage is provided under a right of continuation provided by the federal or state law and is also covered under another plan , then:
   a. The plan covering the person as an employee, Covered Person, subscriber, or retiree (or as a dependent of an employee, Covered Person, subscriber, or retiree) is the primary plan.
   b. The continuation coverage is the secondary plan.

5. **Longer/Shorter Length of Coverage**: The plan that covered the person as an employee, dependent or retiree for a longer time is primary.

C. THE EFFECT ON THE BENEFITS OF THIS PLAN: When this Plan is secondary, it may reduce its Benefits at the time of processing, so that the total Benefits paid or provided by all plans for each Claim are not more than 100% of total Allowable Expenses for such Claim. The reduction in this Plan's Benefits is equal to the difference between:

1. The Benefit payments that this Plan would have paid had it been the primary plan; and
2. The Benefit payments that this Plan actually paid or provided.

When the Benefits of this Plan are reduced as described above, each Benefit is reduced in proportion to any applicable limit, such as a visit limit under this Plan.

D. RIGHT TO RECEIVE AND RELEASE INFORMATION: Certain facts about health care coverage and services are needed to apply Coordination of Benefit rules and to determine Benefits payable under this Plan and other plans. The TPA 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 this Plan. Each person claiming Benefits under this Plan must give the Plan any facts it needs to apply those rules and determine Benefits payable.

E. FACILITY OF PAYMENT: A payment made under another plan may have included an amount that should have been paid under this 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.

F. 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:

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

G. COORDINATING WITH MEDICARE:

If a Provider has accepted assignment of Medicare, this Plan determines Allowable Expenses based upon the amount allowed by Medicare. This 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. This 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. This Plan pays the difference between what Medicare pays and the Plan's allowable expenses.

If you are eligible for Medicare Part A on the basis of ESRD but you defer Medicare entitlement beyond the 30-month coordination period, we will cover the ESRD-related health care services provided to you during the period of deferment immediately following the 30-month coordination period only to the extent we would cover such ESRD-related health care services had you not deferred Medicare entitlement beyond the 30-month

coordination period (but we will not otherwise differentiate between you and other members with respect to coverage for non-ESRD-related health care services).

VIII. Subrogation and Reimbursement

Please refer to the State-Specific Benefit Addendum for information on subrogation and reimbursement.

IX. Information About Your Plan

A. Conflict with Existing Law

If any provision of this SPD conflicts with any applicable law, only that provision is hereby amended to conform to the minimum requirements of the law.

B. Binding Arbitration

Any dispute or Claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any Claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small Claims court. Any dispute regarding a Claim for damages within the jurisdictional limits of the small Claims court will be resolved in such court.

C. Anti-Assignment

Without limiting the foregoing, no Claim for Benefits under the Plan, and no rights related directly or indirectly to any such Claim (including, without limitation, the right to pursue an internal Claim or appeal, the right to pursue litigation for payment of Benefits, the right to pursue litigation for breach of fiduciary duty, the right to pursue litigation to recover any statutory penalties, or the right to assign payment), may be assigned to an out-of-network hospital, facility, or other health care Provider without the Plan Administrator's written consent. In its discretion, the Plan Administrator may voluntarily pay (or cause to be paid) Benefits directly to an out-of-network hospital, facility, or other health care Provider on behalf of a Covered Individual, and such payment will not constitute an assignment of rights or Benefits and will not be deemed a waiver of this anti -assignment provision as to that Covered Individual or any other Covered Individual.

D. Rights of Covered Persons

Continue Group Health Plan Coverage

Continue health care coverage for yourself and/or Covered Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage rights.

Enforce Your Rights

If your Claim for Benefits under the Plan is denied or ignored, in whole or in part, within certain time schedules you have a right to:

- Know why this was done;
- Obtain copies of documents relating to this decision without charge; and
- Appeal any denial.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

Your Rights and Responsibilities

You have the following rights and responsibilities:

1. A right to receive information about Gravie Administrative Services, its services, its Participating Providers and your member rights and responsibilities.
2. A right to be treated with respect and recognition of your dignity and right to privacy.
3. A right to available and accessible services, including emergency services, 24 hours a day, 7 days a week.
4. A right to be informed of your health problems and to receive information regarding treatment alternatives and risks that are sufficient to assure informed choice.
5. A right to participate with Providers in making decisions about your health care.
6. A right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or Benefit coverage.
7. A right to refuse treatment.
8. A right to privacy of medical, dental, and financial records maintained by your Plan Administrator and its Participating Providers in accordance with existing law.
9. A right to voice complaints and/or appeals about your Plan Administrator's policies and procedures or care provided by Participating Providers.
10. A right to file a complaint with Gravie Administrative Services.
11. A right to make recommendations regarding member rights and responsibilities policies.
12. A responsibility to supply information (to the extent possible) that Participating Providers need in order to provide care.
13. A responsibility to supply information (to the extent possible) that your Plan Administrator requires for health Plan processes such as enrollment, Claims payment and Benefit management, and providing access to care.
14. A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
15. A responsibility to follow plans and instructions for care that you have agreed on with your Providers.
16. A responsibility to advise your Plan Administrator of any discounts or financial arrangements between you and a Provider or manufacturer for health care services that alter the charges you pay.

X. Specific Information About Your Plan

The federal government requires that the following information be furnished for the North Conejos School District RE1-J Medical Option of the Plan:

Name of the Plan:	This Plan shall be known as North Conejos School District RE1-J Group Health Plan.
Address of the Plan:	North Conejos School District RE1-J 17887 US HWY 285 La Jara, CO 81140
Type of Plan:	Welfare Benefit Plan providing group health Benefits
Group Number, as assigned by the TPA:	KSNZW
Employer Identification Number:	84-6001052
IRS Plan Identification Number:	501
Plan Year:	July 01 2024 through June 30 2025
Third Party Administrator or TPA: The company that provides certain administrative services in connection with the Plan. TPA shall not be deemed an employer with respect to the administration of or provision of Benefits under Plan Sponsor's Plan.	Gravie Administrative Services P.O. Box 211543 Eagan, MN 55121
Plan Sponsor and Sponsor's Address:	North Conejos School District RE1-J 17887 US HWY 285 La Jara, CO 81140
Plan Administrator and Administrator's Address: Plan Administrator retains all fiduciary responsibilities with respect to the Plan, except to the extent it has delegated one or more such responsibilities to others.	Benefits Committee North Conejos School District RE1-J 17887 US HWY 285 La Jara, CO 81140
Named Fiduciary:	North Conejos School District RE1-J 17887 US HWY 285 La Jara, CO 81140
Participating Provider:	Aetna
Agent for Service of Legal Process:	Attention: Human Resource Department North Conejos School District RE1-J 17887 US HWY 285 La Jara, CO 81140
Funding:	This is a self-funded Plan , not insured by the TPA or an insurance carrier; the Employer provides funds from its general assets to pay Claims under the Plan.

Contributions and Other Cost Sharing:	The Employer and the Covered Employee share the cost of coverage. This cost sharing involves Contributions, Deductibles, Copayments, and Coinsurance. Your Employer funds and provides contributions for the cost of coverage and will inform you of your share of the contribution, which will be used to reimburse the Employer for the cost of coverage it provided. Your share of Deductibles, Copayment and Coinsurance are described elsewhere in this SPD.
COBRA Administrator:	Basic PO Box 14015 Madison, WI 53708 866-857-6351 Provider.Services@basiconline.com

XI. Definitions of Capitalized Terms

Allowable Expenses	Means a health care service or expense, including deductibles, Coinsurance, and Copayments, that is covered at least in part by any of the plans covering the person. When a Plan provides Benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a Benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense.
Benefits	The health care services covered under the Plan as approved by the Plan Administrator as Covered Services, as explained in this SPD and any amendments.
Claim	A request for Benefits made by a Covered Person or the Covered Person's authorized representative in accordance with the procedures described in this SPD. It includes pre-certification requests
Coinsurance	A portion of eligible charges from Non-Participating Providers that is paid by you. Your Coinsurance is a percentage of those eligible charges that are: 1) calculated at the time the Claim is processed, 2) subject to the Usual and Customary Amount or (3) the amount you must pay after satisfying your Deductible for emergency services provided by a Non-Participating Provider.
Contribution	The payment your Employer requires to be paid on behalf of or for Covered Persons for the provision of Covered Services. Your Employer will inform you of your share of the Contribution.
Copayment	The fixed amount of eligible charges you must pay to the Provider for covered health care services received. The Copayment may not exceed the charge billed for the covered health care service.
Covered Dependent	A Covered Employee's Eligible Dependent as described in the section "When Am I Eligible? " who is enrolled under the Plan.
Covered Employee	The person: 1. On whose behalf Contribution is paid; and 2. Whose employment is the basis for membership; and 3. Who is enrolled under the Plan.
Covered Person	A Covered Employee or Covered Dependent.
Covered Services	Health care services that are provided by your Provider or clinic and are covered by the Plan, subject to all of the terms, conditions, limitations, and exclusions of the Plan.
Custodial Parent	Means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

Effective Date	July 01, 2024
Eligible Dependent	An Eligible Dependent include a Covered Employee's: 1. Lawful spouse whose marriage to the Covered Employee is valid under applicable state law. 2. Children, from birth through end of the month in which the child reaches age 26, including: i. Natural child; ii. Child who is legally adopted by or placed with Covered Employee for legal adoption; iii. Stepchild; iv. Child for whom Covered Employee is designated a foster parent by an authorized social services agency or by a court of law; v. Child for whom Covered Employee is the legal guardian appointed by a court of law; vi. Child covered under a valid National Medical Support Notice (NMSN). 3. Same-sex or Opposite-sex domestic partner solely for the purpose of eligibility for coverage under this SPD but excluding eligibility for COBRA Continuation Coverage. 4. Dependent children who are disabled. Application for extended coverage and proof of incapacity must be furnished to the Plan Administrator within 31 calendar days after the dependent child reaches age 26. A dependent child may be eligible for coverage if coverage has not otherwise terminated under this Plan and if the dependent child meets all of the following criteria: i. Became disabled before age 26; ii. Was a Covered Dependent under the Plan prior to reaching age 26; iii. Is incapable of self-sustaining employment, because of a physical disability, developmental mental disability, mental illness, or mental health disorder that is expected to be ongoing for a continuous period of at least two years from the date initial proof is supplied to the Plan; iv. Is dependent on Covered Employee for a majority of financial support and maintenance; and v. Is unmarried.
Fiduciary	The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for Benefits or to construe the terms of the Plan and may delegate such discretion to other individuals or entities.
Gravie	Gravie Administrative Services, which is a Third-Party Administrator (TPA) providing administrative services to your Employer in connection with the operation of the Plan.
Incurred	Health care services rendered to you shall be considered to have been Incurred at the time or date the health care service was actually purchased or provided.
Non-Participating Provider	1. A physician or other health care Provider who, when providing health care services, is acting within the scope of practice of that Provider's license or certification under applicable State law; or 2. A facility, like a clinic or hospital; That is not a Participating Provider.

Out-of-Pocket Limit	The maximum amount of money you must pay for health care services from Participating Providers before this Plan pays your eligible charges at 100%. If you reach Benefit, day, or visit maximums, you are responsible for amounts that exceed the Out-of-Pocket Limit. Expenses you pay for Copayments will apply to the Out-of-Pocket Limit.
Participating Provider	1. A physician or other health care Provider who is acting within the scope of practice of that Provider's license or certification under applicable State law; or 2. A facility, like a hospital or clinic: That is directly contracted to participate in the specific TPA Participating Provider network designated by Plan Administrator to provide Benefits to Covered Persons enrolled in this SPD. The participating status of providers may change from time to time. Participating providers may also be offered from other Preferred Provider Organizations that have contracted with TPA.
Plan	The North Conejos School District RE1-J Group Health Plan, as amended from time to time.
Plan Administrator	North Conejos School District RE1-J. The Plan Administrator retains ultimate authority for this Plan including final appeal determinations.
Plan Sponsor	North Conejos School District RE1-J.
Plan Year	The period following the Effective Date of the Plan and each subsequent 12-month period this Plan remains in force.
Provider	A health care professional, physician, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide health care services to you.
Summary Plan Description (SPD)	The document describing, among other things, the Benefits offered under the Medical Option of the Plan and your rights and obligations under such Benefit option as required by the Plan.
Third Party Administrator (TPA)	Gravie Administrative Services.
Usual and Customary Amount	The average amount for each covered service or supply that by discretion of the Plan Administrator is customary in the geographic area in which the health care service is provided.

For more information about Plan benefits and required annual Notices, please reference the following documents, which are incorporated herein by reference:

Attachment A: Schedule of Benefits

Attachment B: Annual Compliance Notices

Attachment C: State-Specific Benefit Addendum

Gravie ComfortFit $6,350 OOPM
Schedule of Benefits

July 01, 2024

QUICK REFERENCE GUIDE

Questions?	**Gravie Administrative Services Customer Service staff is available to answer questions about your coverage Monday through Friday from 8AM to 5PM Central Time.** **Customer Service:** **866.863.6232** **When contacting Customer Service, please have your identification card available. If your questions involve a bill, we will need to know the date of service, type of service, the name of the provider and the charges involved.**
Telephone Numbers for Utilization Management Vendor for Pre-certification and Pre-Service/Concurrent Care Claims	**Monday through Friday 7 AM to 7 PM Central Time** **Customer Service: 855.451.8365** **CVS Caremark: 833.847.8881** **Aetna: 855.451.8365**
Website	**Gravie member website:** https://member.gravie.com **Aetna provider directory:** www.aetna.com/asa
Mailing Address	**Claims, appeal requests, pre-certification, and written inquiries should be mailed to:** **Customer Service Department** **Gravie Administrative Services** **P.O. Box 211543** **Eagan, MN 55121**
Prescription Drugs **CVS Caremark**	**Telephone: 833.847.8881** **Website: www.gravie.com**
Identification Cards	The TPA issues an identification (ID) card containing important coverage information. Please verify the information on the ID card and notify Customer Service if there are errors. If any ID card information is incorrect, Claims for Benefits under the Plan or bills and/or invoices for your health care may be delayed or temporarily denied. You will be asked to present your ID card whenever you receive services. If any Covered Person permits the use of their Identification Card by any other person, such card may be retained by this Plan, and all rights of such Covered Person pursuant to this Plan may be terminated.

gravie

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I. About This Schedule of Benefits

This Schedule of Benefits ("Schedule") lists the Deductibles, Copayments, or payment percentage, if any apply to the covered services you receive under the Plan. You should review this Schedule to become aware of these and any limits that apply to these services. Benefits are not covered for excluded services and exclusions include, but are not limited to, health care

services that are not Medically Necessary as determined by the Plan Administrator. Be sure to review the list of exclusions as well. A provider recommendation or performance of a service, even if it is the only service available for your particular condition, does not mean it is a covered service. Benefits are not available for Medically Necessary services unless such services are also covered services. **Benefits are limited to the most cost effective and medically necessary alternative**.

How your cost share works

You are required to pay any Deductible, Coinsurance and/or Out-of-Pocket Limit. Benefits listed in this Schedule are according to what the Plan pays. Benefits are limited to the most cost effective and Medically Necessary alternative. Any amount of Coinsurance you must pay to the Provider is based on 100% of Eligible Charges less the percentage covered by the Plan. Plan payment begins after you have satisfied any applicable Deductible, Coinsurance and/or Out-of-Pocket Limit.

Discounts negotiated by or on behalf of the TPA with Providers may affect your Coinsurance cost-sharing amount. This Plan may pay higher Benefits if you choose a Participating Provider. If you use a Non-Participating Provider, in addition to any Deductible and Coinsurance, you pay all charges that exceed the Usual and Customary Amount, when applicable.

II. Benefits Summary

A. BENEFIT DEDUCTIBLE

	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Covered Employee Once you have incurred Eligible Charges equal to the Deductible shown below, the Plan will pay Benefits for the rest of the Plan Year. You must submit copies of bills for Eligible Charges used to satisfy the Deductible to the TPA. Expenses you pay for Copayments and any amount in excess of the Usual and Customary Amount will not apply to the Deductible. Except as described below, a separate Deductible applies for Health Care Services from Non-Participating Providers. **Note:** Any manufacturer coupon or manufacturer copay assistance funds can be used towards member cost share for qualifying service, however, these coupon and assistance funds will not accumulate towards the member Deductible or Out of Pocket totals.	$6,350 per Covered Person	$10,000 per Covered Person per Plan Year for Eligible Charges received from Non-Participating Providers.
Family (Covered Employee and Covered Dependents) The family must satisfy the family Deductible per Plan Year for Health Care Services before the Plan will pay Benefits for the family in that Plan Year. There is an embedded Deductible shown in the table below that applies for each Covered Person within the family. If any Covered Person within the family satisfies such embedded Deductible, the Plan will pay Benefits for such Covered Person before the family Deductible is met. Copies of bills for Eligible Charges used to satisfy the Deductible must be submitted to the Plan. The Plan will not pay benefits for the Eligible Charges applied toward the family Deductible. Expenses you pay for Copayments and any amount in excess of the Usual and Customary Amount will not apply to the family Deductible.	$12,700 per family ($6,350 per Covered Person)	$20,000 per family ($10,000 per Covered Person) per Plan Year for Eligible Charges from Non-Participating Providers.

Note: Any manufacturer coupon or manufacturer copay assistance funds can be used towards member cost share for qualifying service, however, these coupon and assistance funds will not accumulate towards the member Deductible or Out of Pocket totals.		

B. BENEFIT OUT-OF-POCKET LIMIT

	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Covered Employee The Out-of-Pocket Limit applies to Health Care Services received from Participating Providers. Except as described below, if you receive services from a Non-Participating Provider, the Out-of-Pocket Limit does not apply. After the Covered Employee has met the Out-of-Pocket Limit per Plan Year for Health Care Services from Participating Providers, the Plan covers the remaining Eligible Charges incurred from Participating Providers for the remainder of the Plan Year. It is the Covered Employee's responsibility to demonstrate to the Plan that the Out-of-Pocket Limit is satisfied, and to pay any amounts greater than the Out-of-Pocket Limits if any benefit, day, or visit maximums are exceeded. Expenses you pay for Copayments will apply to the Out-of-Pocket Limit. **Note:** Any manufacturer coupon or manufacturer copay assistance funds can be used towards member cost share for qualifying service, however, these coupon and assistance funds will not accumulate towards the member Deductible or Out of Pocket totals.	$6,350 per Covered Person	None.
Family (Covered Employee and Covered Dependents) The family Out-of-Pocket Limit applies to Health Care Services received from Participating Providers. There is an embedded Out-of-Pocket Limit shown in the table below that applies for each Covered Person within the family. If any Covered Person within the family satisfies such embedded Out-of-Pocket Limit, the Plan will pay benefits for such Covered Person before the family Out-of-Pocket Limit is met. If you or your Covered Dependents receive services from a Non-Participating Provider, the Out-of-Pocket Limit does not apply. After the family has met the family Out-of-Pocket Limit per Plan Year for Health Care Services from Participating Providers, the Plan covers the remaining Eligible Charges incurred from Participating Providers for the remainder of the Plan Year. It is the family's responsibility to demonstrate to the Plan the family Out-of-Pocket Limit has been satisfied and to pay any amounts greater than the family Out-of-Pocket Limit if any benefit, day, or visit maximums are exceeded. Expenses you pay for Copayments will apply to the family Out-of-Pocket Limit. **Note:** Any manufacturer coupon or manufacturer copay assistance funds can be used towards member cost share for qualifying service, however, these coupon and assistance	$12,700 per family ($6,350 per Covered Person)	None.

funds will not accumulate towards the member Deductible or Out of Pocket totals.		

NOTE: Your coverage is either "Covered Employee only" or "family." Therefore, only one of the following sections ("Covered Employee only" or "Family") applies to you, unless the Plan expressly provides otherwise. If you have questions about which section applies to you, contact TPA or your employer.

Deductible and Out-of-Pocket Limits are for Eligible Charges from Participating Providers, charges calculated for Non-Participating Providers of Emergency Services, charges calculated for Non-Participating Providers of air ambulance services, and charges calculated for Non-Participating Providers of non-Emergency Services at a hospital or ambulatory surgical center which is a participating provider*.

Cost Sharing. The amount of the flat fee Copayments is calculated on Provider allowed charges. The amount of Copayments vary as described later in this Schedule. The calculation of the Coinsurance is based on the least of the Provider's allowed charge, the Fee Schedule negotiated by the TPA with the Participating Provider, or the Usual and Customary Amount, except for: (1) the calculation of the Coinsurance for Emergency Services provided by a Non-Participating Provider, in which case, the calculation of the Coinsurance will be based on the Recognized Amount; (2) the calculation of the Coinsurance for air ambulance services provided by a Non-Participating provider, in which case, the calculation of the Coinsurance will be based on the lesser of the Qualified Payment Amount and billed charges; and (3) the calculation of the Coinsurance for Non-Participating Providers of non-Emergency Services at a Hospital or ambulatory surgical center which is a Participating Provider, in which case, the calculation of the Coinsurance will be based on the Recognized Amount.* If you have a Deductible, it is first subtracted from the allowed charge, Fee Schedule, or the Usual and Customary Amount, the Recognized Amount, or the amount calculated for air ambulance services provided by a Non-Participating Provider whichever is applicable, then the Coinsurance percentage is applied to the remainder.

* If a Non-Participating Provider provides non-Emergency Health Care Services at a Hospital or ambulatory surgical center which is a Participating Provider and the Non-Participating Provider has satisfied the notice and consent requirements described in the Annual Compliance Notices document entitled Balance Billing Under the No Surprises Act, then the Plan will pay for charges for such non-Emergency Health Care Services according to the terms of the Non-Participating Provider Benefit in this Schedule and any amounts paid by you toward the Deductible for charges for such non-Emergency Health Care Services will count toward the Deductible for Non-Participating Providers.

Note: For Non-Participating Providers, in addition to any Deductible and Coinsurance, you pay all charges that exceed the Usual and Customary Amount.

C. MEDICAL BENEFIT COST-SHARING

Covered Service	Participating Provider Plan Payment	Non-Participating Provider Plan Payment
Ambulance Services • Ambulance services for emergency • Non-emergency transportation	• 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges after the Deductible.	• Same as the Participating Provider Benefit for emergency ambulance services. • 50% of Eligible Charges after the Deductible for Non-Participating Provider.
Chiropractic Services	100% of Eligible Charges. Deductible does not apply.	50% of Eligible Charges after the Deductible for Non-Participating Provider.
Dental Services	See "Office Visits" and "Hospital Services".	See "Office Visits" and "Hospital Services".
Durable medical equipment (DME)	100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider.
Emergency Services Note: Includes urgent care clinics within a hospital and ER urgent care.	100% of Eligible Charges for emergency services after a $750 Copayment per visit. Deductible does not apply.	100% of the Out-of-Network rate after a $750 Copayment per visit. Deductible does not apply.
Home Health Services	100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider.
Hospice Care	100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider.
Hospital Services • Outpatient Hospital Services, Ambulatory Surgical Center, or other Freestanding Outpatient Surgical Center • Outpatient Hospital, Partial Hospital, and Rehabilitation Services in a Day Hospital Program for Mental and Substance Use Related Disorders • Telehealth and/or Virtual Visits • Inpatient Hospital Services • Inpatient Hospital and Residential Treatment Facility Services for Mental and Substance Use Related Disorders • Non-Routine Prenatal and Postnatal care.	• 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges. Deductible does not apply. • 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider.
Infertility Services • Diagnostic Services • Surgical Correction of Physiological Abnormalities causing Infertility • Prescription drugs for the treatment of Infertility	• See "Office Visits" and "Hospital Services". • See "Office Visits" and "Hospital Services". • See Pharmacy Benefit Cost-Sharing Below.	• See "Office Visits" and "Hospital Services". • See "Office Visits" and "Hospital Services". • See Pharmacy Benefit Cost-Sharing Below.
Office Visits	100% of eligible charges. Deductible does	50% of Eligible Charges after the Deductible.

• **Primary Care Visit** • **Specialty Care Visit** • **Urgent Care Visit** • **Telemedicine Visits** Office visits include: Sickness or Injury; allergy testing and injections; surgical services; telehealth and/or virtual visits; convenience care; non-routine prenatal and postnatal care.	not apply.	
Office Visits • Laboratory and Pathology • X-Ray • Enhanced Radiology **Note:** Combined costs over $500 for non-hospital labs, pathology, x-ray and enhanced radiology will be applied to the out-of-pocket. These services are no cost after the Deductible is met.	No charge for first $500 per Covered Person; then 100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider.
Office Visits • Chemotherapy • Radiation therapy • Dialysis	100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider.
Organ and Bone Marrow Transplant Services	See "Office Visits" and "Hospital Services."	See "Office Visits" and "Hospital Services."
Physical Therapy, Occupational Therapy, And Speech Therapy	See "Office Visits" and "Hospital Services".	See "Office Visits" and "Hospital Services".
Preventive Health Care Services Includes certain routine services such as: • Counseling for certain conditions. • Routine immunizations. • Routine laboratory tests, pathology, and radiology. • Routine physical examinations. • Routine screenings for certain cancers and certain other conditions. • Prescribed preventive medications required under the Affordable Care Act. • Tobacco cessation intervention program Prescription Drugs and prescribed over the counter (OTC) medications	100% of Eligible Charges. Deductible does not apply.	50% of Eligible Charges after the Deductible for Non-Participating Provider. **Note:** Out-of-network pharmacy services are not covered.
Reconstructive Surgery	See "Office Visits" and "Hospital Services".	See "Office Visits" and "Hospital Services".
Skilled Nursing Facility Services	100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider.

D. PHARMACY BENEFIT COST-SHARING

Covered Service	Participating Provider Plan Payment	Non-Participating Provider Plan Payment
Retail • Up to a 30-calendar day supply. • 100% of Eligible Charges after Copayment for Generic and Preferred	**Generic drugs designated as Tier 1**: 100% of Eligible Charge per prescription unit or refill. **Preferred Brand drugs designated as Tier 2**:	Not covered.

Brand drugs; Deductible does not apply.	If no generic equivalent exists, 100% of Eligible Charges after a $75 Copayment. If generic exists, 100% of Eligible Charges after the Deductible. **Non-Preferred Brand drugs designated as Tier 3**: 100% of Eligible Charges after the Deductible. **Non-Formulary drugs**: Not covered.	
Mail Order • Up to a 90-calendar day supply. • 100% of Eligible Charges after Copayment for Generic and Preferred Brand drugs; Deductible does not apply.	**Generic drugs designated as Tier 1**: 100% of Eligible Charge per prescription unit or refill. **Preferred Brand drugs designated as Tier 2**: If no generic equivalent exists, 100% of Eligible Charges after a $150 Copayment. If generic exists, 100% of Eligible Charges after the Deductible. **Non-Preferred Brand drugs designated as Tier 3**: 100% of Eligible Charges after the Deductible. **Non-Formulary drugs**: Not covered.	Not covered.
90-Day Retail/Maintenance Drug • Up to a 90-calendar day supply. • 100% of Eligible Charges after Copayment for Generic and Preferred Brand drugs; Deductible does not apply.	**Generic drugs designated as Tier 1**: 100% of Eligible Charge per prescription unit or refill. **Preferred Brand drugs designated as Tier 2**: If no generic equivalent exists, 100% of Eligible Charges after a $150 Copayment. If generic exists, 100% of Eligible Charges after the Deductible. **Non-Preferred Brand drugs designated as Tier 3**: 100% of Eligible Charges after the Deductible. **Non-Formulary drugs**: Not covered.	Not covered.
Specialty Drugs* • Up to a 30-calendar day supply for retail or mail order. • Specialty Drugs may be oral or injectable • Must be purchased through a CVS specialty pharmacy unless distribution is limited (see list at www.gravie.com) Note: Prescription Drugs which CVS Caremark determines are Specialty Drugs may not be covered at the generic, preferred brand, non-preferred brand, mail order, or non-formulary benefit level. *Excludes insulin	100% of Eligible Charges per prescription if enrolled in the PrudentRx Solution for Specialty Drugs and filled at a CVS pharmacy. Note: if you are enrolled in the PrudentRx Solution and choose to disenroll, your cost for the Specialty Drug will be 30% of the Eligible Charges. Deductible does not apply. For Specialty Drugs that are not eligible for the PrudentRx Solution, your cost will be $0 after the Deductible has been met.	Not covered.

Women's Preventive Contraceptive Methods received at a retail or mail order pharmacy • Generic oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law up to a 30-calendar day supply from a retail pharmacy, up to a 90-calendar day supply from a mail order pharmacy, and up to a 90-calendar day supply from a retail/maintenance drug pharmacy; and • Brand name oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists up to a 30-calendar day supply from a retail pharmacy, and up to a 90-calendar day supply from a mail order pharmacy, and up to a 90-calendar day supply from a retail/maintenance drug pharmacy.	**Retail pharmacy:** 100% of Eligible Charges. Deductible does not apply. **Mail order pharmacy:** 100% of Eligible Charges. Deductible does not apply. **Retail/maintenance drug pharmacy:** 100% of Eligible Charges. Deductible does not apply.	Not covered.
Women's Preventive Contraceptive Methods received at a retail or mail order pharmacy Brand name oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists up to a 30-calendar day supply from a retail pharmacy, and up to a 90-calendar day supply from a mail order pharmacy, and up to a 90-calendar day supply from a retail/maintenance drug pharmacy.	**Retail pharmacy:** **Preferred Brand drugs designated as Tier 2**: If no generic equivalent exists, 100% of Eligible Charges after a $75 Copayment. If generic exists, 100% of Eligible Charges after the Deductible. **Non-Preferred Brand drugs designated as Tier 3**: 100% of Eligible Charges after the Deductible. **Non-Formulary drugs**: Not covered. **Mail order pharmacy:** **Preferred Brand drugs designated as Tier 2**: If no generic equivalent exists, 100% of Eligible Charges after a $150 Copayment. If generic exists, 100% of Eligible Charges after the Deductible. **Non-Preferred Brand drugs designated as Tier 3**: 100% of Eligible Charges after the Deductible. **Non-Formulary drugs**: Not covered. **Retail/maintenance drug pharmacy:**	Not covered.

	Preferred Brand drugs designated as Tier 2: If no generic equivalent exists, 100% of Eligible Charges after a $150 Copayment. If generic exists, 100% of Eligible Charges after the Deductible. **Non-Preferred Brand drugs designated as Tier 3**: 100% of Eligible Charges after the Deductible. **Non-Formulary drugs**: Not covered.	
Women's preventive contraceptive methods, sterilization procedures, and education received at a provider's office: • Generic injectable, implantable, and insertable contraceptives that require a prescription under applicable law; and • Brand name injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists. • Brand name injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists. • Sterilization procedures, excluding the reversal of sterilization procedures. • Covered Person education and counseling about contraceptive methods.	• 100% of Eligible Charges. Deductible does not apply. • 100% of Eligible Charges. Deductible does not apply. • 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges. Deductible does not apply. • 100% of Eligible Charges. Deductible does not apply.	50% of Eligible Charges after the Deductible.

III. Covered Benefits

A. Ambulance Services

Air ambulance services. Covered air ambulance services provided by a Non-Participating Provider are subject to the same Deductible requirements that would apply if the services were provided by a Participating Provider of air ambulance services. The Deductible requirements must be calculated as the lesser of the qualifying payment amount and the billed amount for the services.

The Plan covers ambulance service to the nearest Hospital or medical center where initial care can be rendered for a medical emergency. Air ambulance transport to the nearest Hospital that is able to render medically necessary care, is covered only when the condition is an acute medical emergency and is authorized by a physician.

The Plan also covers emergency ambulance (air or ground) transfer from a Hospital not able to render the Medically Necessary care to the nearest Hospital or medical center able to render the Medically Necessary care only when the condition is a critical medical situation and is ordered by a Physician and coordinated with a receiving physician.

Pre-certification is recommended for:

- Non-emergency ambulance service, from Hospital to Hospital when care for your condition is not available at the Hospital where you were first admitted; and
- Non-emergency transfers by ambulance from a Hospital to other facilities for subsequent covered care or from home to Physician offices or other facilities for outpatient treatment procedures or tests when medical supervision is required en route.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

B. Chiropractic Services

Note: Some services that may be provided during an office visit may be subject to the Deductible (e.g. x-ray)

Coverage includes chiropractic services to treat acute musculoskeletal conditions, by manual manipulation therapy. Diagnostic services are limited to Medically Necessary radiology. Treatment is limited to conditions related to the spine or joints.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

C. Dental Services

The Plan Administrator considers dental procedures to be services rendered by a dentist or dental specialist to treat the supporting soft tissue and bone structure.

Accidental Dental Services. Treatment and repair for services required due to an accidental Injury must be started within six months and completed within twelve months of the date of the Injury. The Plan covers services to treat and restore damage done to a sound, natural tooth as a result of an accidental Injury. Coverage is for external trauma to the face and mouth only. A sound, natural tooth is a tooth, including supporting structures, that is healthy and would be able to continue functioning for at least one year. Primary (baby) teeth must have a life expectancy of one year before loss.

Medically Necessary Dental Services. The Plan covers dental services, limited to 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. The Plan covers surgical extraction of impacted wisdom teeth.

Medically Necessary Hospitalization for Dental Care. Eligible Charges are those Incurred by a Covered Person who: (1) is a child under age five; (2) is severely disabled; or (3) has a medical condition, unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a Physician, dentist, or dental Specialist.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

D. Durable Medical Equipment (DME), Services, and Prosthetics

Wigs for hair loss resulting from a medical condition are limited to a maximum of one wig per Covered Person per plan year.

Diabetic supplies: Coverage includes over-the-counter diabetic supplies, syringes, blood and urine test strips and other diabetic supplies as Medically Necessary.

Note: See "Preventive Health Services" section for coverage of glucose meters. If you require a blood glucose meter as part of your treatment for diabetes, you may obtain a PREFERRED meter free of charge from CVS Caremark by visiting Caremark.com/ManagingDiabetes or calling the number on the back of your ID card.

Note: Non-participating providers must have a Medicare provider number for their charges to be eligible for coverage.

The Plan covers certain equipment and Health Care Services, nutritional formulas, and enteral feedings, which may include; amino acid-based formulas, other oral nutritional, and electrolyte substances; and special dietary treatment for phenylketonuria (PKU); ordered or prescribed by a Physician and provided by DME/prosthetic vendors. For verification of eligible equipment and supplies, call Customer Service. 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 has determined that the item is appropriate for rental only. The Plan Administrator reserves the right to determine if an item will be approved for rental or purchase.

The Plan also covers the following:

- Custom molded foot orthotics.
- Medically Necessary durable medical equipment, orthotics, and prosthetics.
- When Medically Necessary, therapeutic shoes for diabetes, prosthetic shoes, rehabilitative foot orthotics following surgery or trauma.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

E. Emergency Services

The emergency room Copayment is waived if you are admitted within 24 hours for the same emergency condition treated in the emergency room.

Note: Services other than Emergency Services received in an emergency room are not covered. If you choose to receive non-Emergency Services in an emergency room, you are solely responsible for the cost of these services.

If you have an Emergency that requires immediate treatment, call 911 or go to the nearest emergency facility. If possible under the circumstances, you should telephone your Physician or the clinic where you normally receive care. A Physician will advise you how, when, and where to obtain the appropriate treatment.

Notwithstanding anything in this Schedule to the contrary, the Plan shall cover emergency services, whether provided by a Participating Provider or a Non-Participating Provider, without the need for any pre-certification.

In the case of Emergency Services provided by a Non-Participating Provider, your Copayment, Deductible and Coinsurance will be calculated as if the total amount charged for such Emergency Services were equal to the Recognized Amount.

Covered services, whether provided by a Participating Provider or a Non-Participating Provider, are subject to all of the Benefit limitations set forth in this Schedule. You should provide notice to the Utilization Management vendor of an admission to an inpatient facility within 48 hours or as soon as reasonably possible.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

F. Home Health Services

Home health care is available as an alternative to facility or clinic-based care.

Services are limited to 100 visits (4 hours of service = 1 visit) per Covered Person per plan year for home health services.

Services are also limited to 100 visits for palliative care (4 hours of service = 1 visit) per Covered Person per plan year if you are eligible to receive palliative care in the home but you are not homebound.

The Plan covers skilled home health services that are directed by a Physician and received from a licensed Home Health Care Agency. Services may include: Skilled Care; physical therapy; occupational therapy; speech therapy; respiratory therapy; home health care as an alternative to facility or clinic-based care and other Medically Necessary therapeutic services that are rendered in your home.

In order for services to be received in your home, you must be Homebound, or the Plan Administrator must determine the services are medically appropriate and the most cost effective to the Plan.

A Health Care Service shall not be considered Skilled Care merely because it is performed by, or under the direct supervision of, a licensed registered nurse. Where a Health Care Service (such as tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person, or self-administered, without the direct supervision of a licensed registered nurse, the Health Care Service shall not be regarded as Skilled Care, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of "blended" services (i.e., services that include skilled and non-skilled components) is covered under the Plan.

The Plan covers palliative care benefits if you are not homebound up to the visit limit stated above. Palliative care includes symptom management, education, and establishing goals of care.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

G. Hospice Care

The Plan covers hospice services for terminally ill patients in a hospice program. The patient must meet the eligibility requirements of the program and elect to receive services through the hospice program. The services will be provided in the patient's home or hospice center, with inpatient care available when Medically Necessary. Hospice services are in lieu of curative or restorative treatment.

Eligibility. In order to be eligible to be enrolled in the hospice program, you must:

- Be terminally ill with Physician certification of six months or less to live; and
- Have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than restorative treatment or treatment attempting to cure the disease or condition).

You may withdraw from the hospice program at any time.

Hospice services include the following services provided in accordance with an approved hospice treatment plan:

- Care provided in your home by an interdisciplinary hospice team (which may include a Physician, nurse, social worker, and spiritual counselor) and home health aide services;
- One or more periods of continuous care provided in your home or in a setting that provides day care for pain or symptom management by a registered nurse, licensed practical nurse, or home health aide, when Medically Necessary as determined by the Plan Administrator;
- Medically Necessary inpatient services;
- Respite care for caregivers in your home or in an appropriate setting. Respite care must be authorized in advance to give your primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain you at home;
- Medically Necessary medications for pain and symptom management;
- Durable medical equipment when authorized in advance and determined by the Plan Administrator to be Medically Necessary.

Continuous care is defined as two to 12 hours of service per calendar day provided by a registered nurse, licensed practical nurse, or home health aide during a period of crisis in order to maintain you in your home when you are terminally ill.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

H. Hospital Services

Note: For inpatient Hospital services, each Covered Person's confinement, including that of a covered newborn child, is separate and distinct from the confinement of any other Covered Person.

If you have Covered Employee only coverage, on the date of birth of a newborn, you, and your new Covered Dependent(s), when enrolled, become subject to the terms and conditions of family coverage.

In the case of Health Care Services (other than Emergency Services) furnished by a Non-Participating Provider with respect to a visit at a Hospital or ambulatory surgical center which is a Participating Provider:

a) Unless the Non-Participating Provider has satisfied the notice and consent requirements:

   i. Your Deductible and Coinsurance will be calculated as if the total amount charged for such non-Emergency Health Care Services were equal to the Recognized Amount; and

   ii. The coinsurance percentage applied to such charges is 100% .

   iii. The Plan will pay 50% of the Out-of-Network rate after the Deductible.

b) If the Non-Participating Provider has satisfied the notice and consent requirements, then the Plan will pay according to the terms of the Non-Participating Provider Benefit in the table above.

Notify the Utilization Management vendor of an admission to an inpatient facility within 48 hours or as soon as reasonably possible.

Some outpatient Hospital services that are commonly performed in an office visit may be covered under the Plan as an office visit. Contact Customer Service if you have a question about your Plan.

Outpatient Hospital, Ambulatory Surgical Center, or other Freestanding Outpatient Surgical Center Services, Partial Hospital or Day Treatment Services. The Plan covers Health Care Services authorized by a Physician for the diagnosis or treatment of Sickness or Injury on an outpatient basis:

- Use of operating rooms or other outpatient departments, rooms, or facilities;
- General nursing care, anesthesia, radiation therapy or other medications administered during treatment, blood, and blood plasma and other diagnostic or treatment related outpatient services;
- Mental health and substance use related disorder services, such as:
  - An initial court-ordered exam for a covered dependent age 18 and under;
  - Outpatient professional services for evaluation and diagnostic services, crisis intervention, therapeutic services including psychiatric services and treatment of mental and nervous conditions;
  - Diagnosis and treatment of substance-related conditions including evaluations, diagnostic services, therapeutic services, and psychiatric services;
  - Outpatient individual and group therapy;
  - Outpatient family therapy that is recommended by a designated Provider treating a minor Covered Dependent child; and
  - Medication management.
  - Telehealth and/or Virtual Visit services may include interactive audio, messaging, and video communications, permitting real time or asynchronous communication between a distant site Provider of Health Care Services and the Covered Person.
- Laboratory tests, pathology, and radiology; and
- Physician and other professional medical and surgical services rendered while an outpatient.
- Medically necessary genetic testing determined by TPA to be covered services if it is determined that: 1) the Covered Person displays clinical features, or is at direct risk of inheriting the mutation in question

(presymptomatic); and 2) the result of a Covered Person's screening test during prenatal care is abnormal, or the Covered Person has a high-risk pregnancy; and 3) the result of the test will directly impact the current treatment being delivered to the Covered Person; and 3) after history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.

The Plan also covers Preventive Health Care Services. These preventive services will be covered as shown in the Preventive Health Care Services, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this Schedule.

Inpatient Services. The Plan covers Health Care Services authorized by a Physician for the treatment of acute Sickness or Injury that requires the level of care only available in an Acute Care Facility, Hospital, or Residential Treatment Facility. Inpatient services include, but are not limited to:

- Room and board;
- The use of operating rooms, intensive care facilities, newborn nursery facilities;
- General nursing care, anesthesia, radiation therapy or other medications administered during treatment, blood, and blood plasma, and other diagnostic or treatment related inpatient services;
- Physician and other professional medical and surgical services;
- Mental health and substance use related disorder services;
- Laboratory tests, pathology, and radiology; and
- For a ventilator-dependent patient, up to 120 hours of services provided by a private-duty nurse or personal care assistant solely for the purpose of communication or interpretation for the patient.
- Inpatient private-duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.) when Medically Necessary and not custodial in nature and the Hospital's Intensive Care Unit (ICU) is filled or the Hospital has no ICU.

The Plan covers a semi-private room. Benefits for a private room are available only when the private room is Medically Necessary for a Sickness or Injury or if it is the only option available at the admitted facility. If you choose a private room when it is not Medically Necessary, Plan payment toward the cost of the room shall be based on the average semi-private room rate in that facility.

Emergency Services that Lead to an Inpatient Admission

If you were incapacitated in a manner that prevented you from providing the notice described under "Emergency Services," or if you are a minor and your parent (or guardian) was not aware of your admission, then the time period begins when the incapacity no longer exists or when your parent (or guardian) is made aware of the admission. You are considered incapacitated only when: (1) you are physically or mentally unable to provide the required notice; and (2) you are unable to provide the notice through another person.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

I. Infertility Services

This Plan covers the professional services necessary to diagnose Infertility and the related tests, facility charges, and laboratory work related to eligible services. Unless covered under your Plan, services for the treatment of Infertility are not eligible for coverage. Certain Prescription Drugs for the treatment of Infertility and charges for surgical correction of physiological abnormalities causing Infertility may be covered**.**

Contact your Employer to determine if Infertility treatment is covered under your plan. Please refer your Plan's Infertility Rider for coverage details.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

J. Office Visits

Note: Some services that may be provided during an office visit may be subject to the Deductible, such as, but not limited to, laboratory, enhanced diagnostic imaging, pathology, and radiology.

The Plan covers office visits and urgent care center, telemedicine, and designated convenience care center visits related to diagnosis, care, or treatment of medical, mental health, and substance use related conditions, Sickness, or Injury:

- Outpatient professional services for evaluation, diagnosis, crisis intervention, therapy, including Medically Necessary group therapy, psychiatric services, and treatment of mental and nervous disorders; and
- Diagnosis and treatment of substance use related disorders, including evaluation, diagnosis, therapy, and psychiatric services.
- Laboratory tests, pathology, and radiology.
- Allergy injections.
- Contact lenses prescribed as Medically Necessary for the treatment of keratoconus. The lenses and fitting are Eligible Charges under the Durable Medical Equipment (DME) Benefit. Covered Persons must pay for lens replacement.
- Surgical service performed during an office visit.
- Oral surgery is covered for: 1) treatment of oral neoplasm and non-dental cysts; 2) fracture of the jaws; and 3) trauma to the mouth and jaws.
- Treatment of confirmed, existing temporomandibular disorder (TMD) and craniomandibular disorder (CMD). Dental services required to directly treat TMD or CMD are eligible. TMD splints are Eligible Charges under the Durable Medical Equipment (DME) Benefit.
- Port wine stain elimination or maximum feasible treatment to lighten or remove the coloration.
- Diabetic outpatient self-management training and Educational services.
- An Emergency examination of a child ordered by judicial authorities.
- Telehealth and/or virtual visit services may include interactive audio and video communications, permitting real time communication between a distant site Provider of Health Care Services and the Covered Person.
- Medically Necessary genetic testing determined by TPA to be Covered Services if it is determined that: 1) the Covered Person displays clinical features, or is at direct risk of inheriting the mutation in question (presymptomatic); and 2) the result of the test will directly impact the current treatment being delivered to the Covered Person; and 3) after history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.

The Plan also covers Preventive Health Care Services. These preventive services will be covered as shown in the Preventive Health Care Services, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this Schedule.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

K. Organ and Bone Marrow Transplant Services

The Plan covers eligible Transplant Services that are pre-certified and determined by the Plan Administrator to be Medically Necessary and not Investigative. Transplant Services must be received at a designated transplant network provider. Certain drugs or Gene Therapies may require pre-certification prior to the procedure to see if those are covered under your plan.

Coverage for organ transplants, bone marrow transplants and bone marrow rescue services is subject to periodic review. The Plan Administrator evaluates Transplant Services for therapeutic treatment and safety. This evaluation continues at least annually or as new information becomes available and it results in specific guidelines about Benefits for Transplant Services. You may call the TPA at the telephone number listed inside the front cover for information about these guidelines.

Benefits may be available for the following transplants when the transplant meets the definition of a Covered Service and is not Investigative:

- Bone marrow transplants and peripheral stem cell transplants with or without high dose chemotherapy.
- Heart transplants.
- Heart/lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.
- Liver transplants.
- Pancreas transplants.
- Small bowel transplants.

Transplant coverage includes a private room and all related post-surgical treatment and drugs. The transplant related treatment provided shall be subject to and in accordance with the provisions, limitations, and other terms of this Schedule.

Medical and Hospital expenses of the donor are covered only when the recipient is a Covered Person and the transplant has been authorized in advance by the Plan Administrator. Treatment of medical complications that may occur to the donor are not covered.

Travel services are paid for by the Plan under the following circumstances:

- The Covered Person or the non-covered living donor must live more than 50 miles from the transplant center.
  - The Plan will pay for the travel and housing up to the maximum listed on the Transplant Services Rider.
  - Expenses will be paid for the following individuals:
    - The Covered Person who lives more than 50 miles from the transplant center.
    - One or two parents of the Covered Person if the Covered Person is a Covered Dependent child.
    - An adult to accompany the Covered Person if the Covered Person is not a Covered Dependent child.
    - The non-covered living donor who lives more than 50 miles from the transplant center.

Covered travel and housing expenses include the following:
- Airfare.
- Tolls and parking fees.
- Gas/mileage.
- Lodging at or near the transplant center including:
  - Apartment rental.
  - Hotel rental.
  - Applicable taxes.
  - Meals

Lodging for purposes of this Plan does not include private residences. Lodging reimbursement that is greater than $50 per person per day, may be subject to IRS codes for taxable income.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

L. Physical Therapy, Occupational Therapy and Speech Therapy

The Plan covers office visits and outpatient physical therapy (PT), occupational therapy (OT) and speech therapy (ST) for Rehabilitative Care rendered to treat a medical condition, Sickness, or Injury. The Plan also covers outpatient PT, OT, and ST Habilitative Therapy for medically diagnosed conditions that have significantly limited the successful initiation of normal motor or speech development. PT, OT, and ST must be provided by or under the direct supervision of a licensed physical therapist, occupational therapist, or speech therapist for appropriate services within their scope of practice. OT and ST must be ordered by a Physician, physician assistant or a certified nurse practitioner. Coverage is limited to Rehabilitative Care or Habilitative Therapy that demonstrates measurable functional improvement within a reasonable period of time.

Digital Physical Therapy. You may be eligible to participate in the programs and services of Gravie's digital physical therapy partner at no additional cost. More information is available by contacting Customer Service.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

M. Prescription Drug Services

Coverage includes Prescription Drugs dispensed at a pharmacy.

Note: This section does not cover or provide benefits for oral, injectable, or Prescription Drugs and insertable devices that are Preventive Health Care Services described in the "Preventive Contraceptive Methods and Counseling for Women" section of this Schedule.

With the exception of contraceptive drugs for women, benefits for Specialty Drugs and/or injectable drugs, are as described in this section, regardless of the place of service where the Specialty Drug and/or injectable drug is dispensed or administered.

The Usual and Customary Amount for Prescription Drugs obtained from a Non-Participating Provider pharmacy is the cost of the generic equivalent of the Prescription Drug and the dispensing fee, or if a generic equivalent does not exist, the charge that the Plan Administrator determines is customary for such Prescription Drugs.

If you or your provider request a brand name drug when there is an FDA-approved generic alternative drug available then you may be required to pay the brand name drug copayment PLUS the difference in price between the brand name drug and the generic alternative. Many generic drugs are available at no cost; please consult the formulary at www.gravie.com.

The difference in cost between the brand name drug and the generic, if charged, will apply to the Out-of-Pocket Limit that you are responsible for.

Please see the Preventive Health Care Services section for coverage of Prescription Drugs, including biosimilars for injectables like insulin, on the Gravie Basic Formulary Preventive Drug list.

The Plan Administrator uses a drug Formulary to determine which Prescription Drugs, including their generic equivalents, are covered. The Formulary is the Gravie Basic Formulary. The Formulary is subject to periodic review and modification. For information, you may call Gravie at the phone number listed on the inside front cover of this Schedule or on the back of your ID card to locate retail pharmacies participating in the Retail/Maintenance Drug Pharmacy Network.

You may be required to take a 90-day supply of a maintenance medication. For a comprehensive list, please call Customer Service or look at the Maintenance List posted on www.gravie.com. You may contact Gravie at the phone number listed on the inside front cover of this Schedule or on the back of your ID card to locate retail pharmacies participating in the Retail/Maintenance Drug Pharmacy Network.

For certain medical conditions, there is a need to manage the use of specific drugs before alternative (second line) drugs are prescribed for the same medical condition. This is known as step therapy. Covered Persons in a step therapy program will need to meet the requirements of that program prior to receiving the second line drug. For information, you may call Gravie at the phone number listed on the inside front cover of this Schedule or on the back of your ID card. Step therapy can apply to Formulary or non-Formulary drugs and brand or generic drugs. The step therapy list is subject to periodic review and modification by the Plan.

Compounded Drugs will be covered only if obtained from a pharmacy that is Participating Provider provided that at least one active ingredient is a Prescription Drugs. Payment for a Compounded Drugs that has a commercially prepared product available that is identical to or similar to the Compounded Drugs will be considered for coverage after documented failure of the commercially prepared product(s). A commercially prepared product is one that is

available at the pharmacy in its final, usable form and does not need to be compounded at the pharmacy. The applicable Benefit level will be applied. Compounded Drugs containing any product that is excluded by the Plan will not be covered including dosages and route of administration that have not been approved by the FDA. Compounded Drugs will be covered according to the Covered Person's pharmacy network Benefits.

Prescription Drugs covered as Preventive Health Care Services. The Plan covers certain prescription drugs which are required to be covered without cost-sharing as Preventive Health Care Services under the Affordable Care Act. The Plan's Formulary identifies these Prescription Drugs as being included in the "$0 Cost Share" tier and may be obtained by accessing the Gravie website or by calling Gravie. More information regarding Benefits for Prescription Drugs that are Preventive Health Care Services can be found under the "Preventive Contraceptive Methods and Counseling for Women" and "Preventive Health Care Services" sections of this Schedule.

Biosimilar Drugs. If all of the following apply:

1. You or your Provider request a Specialty Drug that is a biological product licensed by the FDA under section 351(a) of the Public Health Service Act (PHS Act), and
2. The FDA has determined another biological product to be biosimilar to the Specialty Drug that has been requested by your Provider, and
3. The Plan Administrator has included such biosimilar product on its list of approved biosimilar drugs in relation to the Specialty Drug that has been requested by your Provider,

Then you must pay any applicable Out-of-Pocket Limit, Copayment, Deductible and Coinsurance for the Specialty Drug requested by your Provider plus the difference in cost between the Specialty Drug requested by your Provider and the biosimilar product that is on the Plan Administrator's list of approved biosimilar drugs.

Off-label use of drugs. Off-label use of drugs, provided that they are not Investigative, may be covered in either of the following circumstances:

1. A 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 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 health care services, off-label use of a drug must be Medically Necessary.

Prior authorization. Certain Prescription Drugs require pre-certification before you can have your prescription filled at the pharmacy. For information, you may call Gravie at the phone number listed on inside cover of this Schedule, on the back of your ID card, or by visiting www.gravie.com.

PrudentRx Solution for Specialty Medications. You may be eligible to participate in the CVS Caremark PrudentRx specialty medication copay assistance program if you are currently taking, or if you begin taking certain Specialty Drugs. This program will help you enroll in financial assistance programs offered by the manufacturer for your eligible Specialty Drug with the goal of helping you avoid most out-of-pocket expenses for your therapy.

Prescription Drug Exclusions:

- Compounded Drugs that are being used for bio-identical hormone replacement therapy, unless otherwise covered.
- Compounded drugs received from a Non-Participating Provider.
- Replacement of a Prescription Drug due to loss, damage, or theft.
- Prescription Drugs or OTC drugs in the same classification of drugs as the following:
  1. Non-Sedating Antihistamines (NSAs).
  2. Non-steroidal Anti-Inflammatory drugs (NSAIDs).
  3. H2 antagonists (H2As).
  4. Proton Pump Inhibitors (PPIs).
- Over-the-counter drugs with or without a Physician's prescription, except as covered under this Schedule.
- Over-the-counter home testing products, except as covered under this Schedule.
- Drugs not approved by the FDA, drugs not approved by the FDA for a particular use (i.e. "off-label" use of drugs), except off-label use of drugs in accordance with the section entitled "Off-label use of drugs" or when the Plan Administrator, at its sole discretion, determines to include the drug on its Formulary or approves coverage of the drug for the particular use.
- Take home drugs when dispensed by a Physician.
- Weight loss drugs, including off-label use of drugs for weight loss unless in accordance with the section entitled "Off-label use of drugs."
- Prescription Drugs and over-the-counter drugs for tobacco cessation, except as covered as a Preventive Health Care Service.
- Drugs used for Cosmetic purposes.
- Unit dose packaging per request of the covered person.
- Prescription Drugs if purchased by mail order through a program not administered by the Plan's pharmacy vendor.
- Non-FDA approved mechanism of delivery (e.g., medication that is FDA approved for oral use, but is being applied topically).
- Drugs that are given or administered as part of a drug manufacturer's study.
- Off-label use of drugs, determined to be Investigative.
- Growth hormone therapy prescribed for children due to short stature only, or for adults with no documented significant deficiency of growth hormone.
- Oral, injectable and insertable contraceptives and contraceptive devices, except as covered as a Preventive Health Care Service in the Preventive Contraceptive Methods and Counseling for Women section of this Schedule.
- Specialty Drugs received from a Non-Participating Provider pharmacy.
- Prescribed or non-prescribed vitamins or minerals including over the counter, unless covered as Preventive Health Care Services.
- 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 section entitled "Off-label use of drugs."
- Cannabis/Marijuana, except medical cannabis/marijuana when provided by Providers licensed by applicable state law to sell medical cannabis/marijuana.
- Prescription Drugs and prescribed OTC drugs for tobacco cessation, except as covered under the Schedule.

N. Preventive Contraceptive Methods and Counseling for Women

The Plan covers preventive contraceptive methods and counseling services by female Covered Persons as described in the Preventive Health Care Services Schedule. The Schedule, which includes preventive contraceptive methods and counseling services for women provided by the Affordable Care Act, is available on the TPA's member website or by calling Customer Service.

This coverage includes the full range of Food and Drug Administration approved contraceptive methods for women with reproductive capacity, including women's contraceptive drugs, devices, and delivery methods obtained from a retail pharmacy, mail order pharmacy, or received at a Provider's office.

If you or your Provider request a brand name women's contraceptive that requires a prescription under applicable law when a generic alternative is available, you are required to pay the difference in cost between the brand name and the generic contraceptive, in addition to any applicable Copayments or Coinsurance.

The difference in cost between the brand name contraceptive and the generic will not apply to the Out-of-Pocket Limit, Deductible or to any Copayments or Coinsurance that you are responsible for. When you have reached the Out-of-Pocket Limit, you must still pay for the difference in the cost between the brand name and the generic contraceptive.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

O. Preventive Health Care Services

The Plan covers preventive services required by the Affordable Care Act. The Schedule may be amended, from time to time, on a prospective basis, and is available by contacting Customer Service.

Female Covered Persons may obtain annual preventive health examinations and prenatal screenings from obstetricians and gynecologists in the Participating Provider Network, without a referral from another Physician or prior approval from the Plan.

Child health supervision services includes pediatric preventive services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations, up to age 18. Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months.

Two designated tobacco cessation intervention program attempts are available per Covered Person per plan year, limited to four counseling sessions per attempt. Tobacco cessation Prescription Drugs and prescribed over the counter (OTC) medications when used in connection with or separate from designated tobacco cessation counseling program attempts, are limited to a maximum of 31-calendar days per prescription or refill per Covered Person and a total 93-calendar day supply per Covered Person per attempt for up to two attempts per Covered Person per plan year. For a complete list of covered medications, please visit www.gravie.com.

Routine Covered Services Required by the Affordable Care Act:

- Counseling for certain conditions. This includes, but is not limited to:
  - Breastfeeding support and counseling, with access to breastfeeding supplies.
  - Breast cancer genetic counseling (BRCA) for women at higher risk.
  - Sexually transmitted infection counseling.
  - Alcohol or drug misuse counseling.
- Routine immunizations. This includes, but is not limited to:
  - Flu (influenza).
  - Hepatitis A and B.
  - Human Papillomavirus (HPV).
  - Shingles.
- Routine screenings for certain cancers and certain other conditions. This includes, but is not limited to:
  - Colorectal cancer screening in adults ages 45 to 75 years.
  - Cholesterol screening for adults of certain ages or at a high risk.
  - Breast cancer screening (mammogram) for average-risk women.
  - Cervical cancer screening average-risk women aged 21 to 65 years.

Preventive Health Care Services that are in Addition to Those Required by the Affordable Care Act:

- Routine eye examination, limited to one exam per Covered Person per plan year.
- Routine hearing examination limited to one exam per Covered Person per plan year.
- Routine prenatal care services.
- One routine postnatal care exam that includes a health exam, assessment, education, and counseling provided during the period immediately after childbirth.
- 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.
- Prostate-specific antigen (PSA) blood tests and digital rectal examinations to screen for prostate cancer for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older.
- Blood pressure monitor for Covered Person diagnosed with hypertension.
- Peak flow meter for Covered Person diagnosed with asthma.
- Glucose meter for Covered Person diagnosed with diabetes. If you require a blood glucose meter as part of your treatment for diabetes, you may obtain a PREFERRED meter free of charge from CVS Caremark by visiting Caremark.com/ManagingDiabetes or calling the number on the back of your ID card.
- Retinopathy screening for Covered Person with diabetes.
- Hemoglobin A1c testing for Covered Person diagnosed with diabetes.
- International Normalized Ratio (INR) testing for Covered Person diagnosed with liver disease or bleeding disorders.
- Low-density Lipoprotein (LDL) testing for Covered Person diagnosed with heart disease.

Notes:

- For a list of prescribed preventive medications that are required under the Affordable Care Act, please refer to the Gravie Basic Formulary at the website located on the inside cover of this Schedule or by calling Customer Service. If you are taking a specialty medication that is also preventive, you must follow the terms of the PrudentRx Solution for specialty medications.
- Non-Preventive Health Care Services are not covered under this section of the Schedule.
- Non-routine Health Care Services, including but not limited to non-routine prenatal services, are not covered under this section of the Schedule.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

P. Reconstructive Surgery

The Plan covers Medically Necessary Reconstructive surgery due to Sickness, accident, or congenital anomaly that is incidental to or follows surgery resulting from injury, Sickness, or other diseases of the involved part, or when such surgery is performed on a Covered Dependent child because of a congenital disease or anomaly which has resulted in a functional defect as determined by the attending Physician. Eligible Charges include eligible Hospital, Physician, laboratory, pathology, radiology, and facility charges. Contact Customer Service to determine if a specific procedure is covered.

Reconstructive surgery following a mastectomy includes the following:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of mastectomy, including lymphedemas.

Health Care Services will be determined in consultation with you and the attending Physician. Such coverage will be subject to Copayments, Out of Pocket Limit, Deductible, Coinsurance, and other Plan provisions.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

Q. Skilled Nursing Facility Services

Coverage is limited to a maximum of 120 days per Covered Person per plan year.

The Plan covers the eligible Skilled Nursing Facility services for post-acute treatment and Rehabilitative Care of a Sickness or Injury. These services must be directed by a Physician and authorized in advance by the Plan Administrator. Please follow the pre-certification procedure described in Section II., Benefits Summary, for the procedure you must follow.

Skilled Nursing Facility services include room and board, daily skilled nursing, and related services. The Plan Administrator determines when care no longer meets criteria for coverage.

The Plan covers a semi-private room. Benefits for a private room are available only when the private room is Medically Necessary for a Sickness or Injury or if it is the only option available at the admitted facility. If you choose a private room when it is not Medically Necessary, Plan payment toward the cost of the room shall be based on the average semi-private room rate in that facility. Only services that qualify as reimbursable under Medicare are eligible charges.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

IV. Pre-certification Requirements

Pre-certification of Health Care Services does not guarantee either payment or the amount of payment. Eligibility for, and payment of, Benefits are subject to all of the terms of this Schedule. Please read the entire Schedule to determine which other provisions may also affect Benefits. The Utilization Management vendor only certifies that the Health Care Services are Medically Necessary.

Pre-certification Requirement: Pre-certification requires that you or your Provider request that certain Health Care Services be authorized as Medically Necessary in advance by your plan's Utilization Management vendor.

Pre-certification by the Utilization Management vendor is required for the following Health Care Services:

- All inpatient admissions including but not limited to Hospital, Skilled Nursing Facility, rehabilitation, and residential treatment facilities;
- Transplant Services, excluding cornea;
- Procedures that could be construed to be Cosmetic;
- The following high dollar outpatient diagnostic services:
  - PET
  - Capsule endoscopy
  - Genetic Testing (including BRCA)
  - Sleep Study
  - CT for non-orthopedic
  - MRI for non-orthopedic
- The following outpatient continuing care services:
  - Chemotherapy (including oral)
  - Radiation Therapy
  - Oncology and transplant related injections, infusions, and treatments (e.g. CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g. antiemetic and antihistamine)
  - Hyperbaric Oxygen
- Dialysis; and
- Durable Medical Equipment (DME), limited to electric/motorized scooters or wheelchairs and pneumatic compression devices exceeding $5,000;
- Home health care;
- Select outpatient surgeries that could be considered experimental or Investigational;
- Sexual dysfunction healthcare services; and
- Certain injections or infusions administered in an outpatient hospital, home infusion, or in a Provider's office.

The Plan reserves the right to deny a claim for services if pre-certification was not obtained.

If you have questions about pre-certification and when you are required to obtain it, please contact Gravie for assistance.

Certain Prescription Drugs may require prior authorization before you can have your prescription filled at the pharmacy. For information, you may call Gravie at the phone number listed on the inside front cover of this Schedule, on the back of your ID card, or search the formulary linked at www.gravie.com.

Pre-Certification Procedure for Non-Acute Care Pre-Service Claims

Non-acute care pre-service Claims are Claims for non-acute care services that require pre-certification and are submitted in accordance with the pre-service Claim filing procedures for the Plan.

Filing Procedure for Non-Acute Care Pre-Service Claims. To request pre-certification and file a non-acute care pre-service Claim, a phone call must be made to the Utilization Management vendor at the telephone number shown on your id card and on the inside cover of this Schedule at least seven business days before the date services requiring pre-certification are provided and all essential data elements must be supplied. An expedited review is available if your attending Provider believes your medical condition warrants it. Please refer to the subsection below entitled "Essential Data Elements for Pre-Service Claims" for the list of essential data elements that are required to file a pre-service Claim. If you or your attending Provider have not submitted the request in accordance with these filing procedures, including a failure to submit all essential data elements, your request will be treated as incorrectly filed, and you will be notified within five calendar days. Please note that the time periods for making an initial Benefit determination begin when the Utilization Management vendor receives a pre-certification request submitted in accordance with the Plan's filing procedures.

If your attending Provider requests pre-certification on your behalf, the Provider will be treated as your authorized representative under the Plan for purposes of such request and the submission of your claim and associated appeals unless you provide the TPA with specific direction otherwise within three business days from the Plan Administrator's notification that an attending Provider was acting as your authorized representative. Your direction will apply to any remaining appeals.

A request or inquiry relating to the availability of Benefits or payment for future services that do not require pre-certification will not be treated as a Claim under the Plan.

Initial Benefit Determination of Non-Acute Care Pre-Service Claims. You and your attending Provider will be notified of the TPA's initial Benefit determination within 15 calendar days (or a shorter time period as required by applicable law) after receipt of a pre-certification request submitted in accordance with the Plan's filing procedures, provided the TPA has all necessary information needed to make an initial Benefit determination.

If the TPA does not have all information it needs to make an initial Benefit determination, or in other circumstances permitted by law, then it may extend the time period for making the initial Benefit determination by 15 calendar days (or a shorter time period as required by applicable law). The TPA will notify you of the extension and the time period to provide the requested information. If you do not provide the requested information within the time period specified, your Claim will be denied.

The initial Benefit determination may be made to your attending Provider by telephone.

If your pre-certification request is denied, written notification will be provided to you and your attending Provider. This notice will explain:

- Information sufficient to identify the Claim involved and any information required by law;
- The reason for the denial;
- The part of the Plan on which it is based;
- Any additional material or information needed to make the Claim acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

Expedited Pre-Certification Procedure for Acute Care Pre-Service Claims

Acute care services are services needed when a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of your attending Provider, could cause severe pain. An expedited initial Benefit determination will be made for Claims for services that require pre-certification and are submitted in accordance with the pre-service Claim filing procedures for the Plan, if your attending Provider believes your medical condition warrants acute care services.

Filing Procedure for Acute Care Pre-Service Claims. To request expedited pre-certification and file an acute care pre-service Claim, a phone call must be made to the Utilization Management vendor before the date services requiring pre-certification are provided and all essential data elements must be supplied. Please refer to the subsection below entitled "Essential Data Elements for Pre-Service Claims" for the list of essential data elements that are required to file a pre-service Claim. If you or your attending Provider have not submitted the request in accordance with these filing procedures, including a failure to submit all essential data elements, your request will be treated as incorrectly filed, and you will be notified within 24 hours. Please note that the time periods for making an expedited initial Benefit determination begin when the Utilization Management vendor receives a pre-certification request submitted in accordance with the Plan's filing procedures.

If your attending Provider requests pre-certification on your behalf, the Provider will be treated as your authorized representative under the Plan for purposes of such request and the submission of your Claim and associated appeals unless you provide the TPA with specific direction otherwise within three business days from the Plan Administrator's notification that an attending Provider was acting as your authorized representative. Your direction will apply to any remaining appeals.

A request or inquiry relating to the availability of Benefits or payment for future services that do not require pre-certification will not be treated as a Claim under the Plan.

Expedited Initial Benefit Determination of Acute Care Pre-Service Claims. An expedited initial Benefit determination will be provided by the TPA to you and your attending Provider as quickly as your medical condition requires, but no later than 72 hours (or such shorter time as required by applicable law) following receipt of a pre-certification request submitted in accordance with the Plan's filing procedures.

If the TPA does not have all information it needs to make an initial Benefit determination, you will be notified within 24 hours. You will then have 48 hours, or longer time as granted to you in the notification, to provide the requested information. If you do not provide the requested information within the time period specified, your request will be denied. You will be notified of the initial Benefit determination within 48 hours after the earlier of the TPA's receipt of the requested information or the end of the time period specified for you to provide the requested information.

The initial Benefit determination may be made to your attending Provider by telephone.

If your pre-certification request is denied, written notification will be provided to you and your attending Provider. This notice will explain:

- Information sufficient to identify the Claim involved and any information required by law;
- The reason for the denial;
- The part of the Plan on which it is based;
- Any additional material or information needed to make the Claim acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

Essential Data Elements for Pre-Service Claims (including Concurrent Care Claims)

You or your attending Provider must submit at least the following essential data elements when calling the Utilization Management vendor to request pre-certification and file a pre-service Claim (or requesting to extend a previously pre-certified treatment and file a concurrent care Claim):

- The identity of the Covered Person and Provider of services;

- The date(s) of services;
- A specific medical diagnosis; and
- A specific treatment, Health Care Service, or procedure code for which pre-certification approval (or extended treatment) is requested.

An explanation of these essential data elements will be provided to you, upon request and free of charge, by calling the Utilization Management vendor. If you or your attending Provider have not submitted the pre-certification (or extended treatment) request in accordance with the Plan's filing procedures for pre-service Claims, including a failure to submit all essential data elements, your request will be treated as incorrectly filed and you will be notified within applicable timeframes.

Procedure for Concurrent Care Claims

Filing Procedure for Concurrent Care Claims. If an ongoing course of treatment was pre-certified by the Plan Administrator for a specified period of time or number of treatments and you or your attending Provider request to extend acute care services, your extension request and concurrent care Claim must be submitted in accordance with the filing procedure for acute care pre-service Claims, as described above. If an ongoing course of treatment was pre-certified by the Plan Administrator for a specified period of time or number of treatments and you or your attending Provider request to extend non-acute care services, your extension request and concurrent care Claim must be submitted in accordance with the filing procedure for non-acute care pre-service Claims, as described above. If you or your attending Provider have not submitted the extension request in accordance with the Plan's filing procedures, including a failure to submit all essential data elements, your request will be treated as incorrectly filed and you will be notified within 24 hours in the case of a request to extend acute care services, and within five calendar days in the case of a request to extend non-acute care services. Please note that the time periods for making an initial Benefit determination begin when the Utilization Management vendor receives an extended treatment request submitted in accordance with the Plan's filing procedures.

If your attending Provider requests extended treatment on your behalf, the Provider will be treated as your authorized representative under the Plan for purposes of such request and the submission of your Claim and associated appeals unless you provide the TPA with specific direction otherwise within three business days from the Plan Administrator's notification that an attending Provider was acting as your authorized representative. Your direction will apply to any remaining appeals.

A request or inquiry relating to the availability of Benefits or payment for future services or extended treatments that do not require pre-certification will not be treated as a Claim under the Plan.

Initial Benefit Determination of Concurrent Claims. If an ongoing course of treatment was previously pre-certified for a specified period of time or number of treatments and you request to extend acute care services, the TPA will make the initial Benefit determination on your extended treatment request within 24 hours following receipt of a properly filed extended treatment request, provided your request is made at least 24 hours before the end of the approved treatment. If a properly filed request for extended treatment is not made at least 24 hours before the end of the approved treatment, your request will be treated as a pre-certification request for acute care services and handled in accordance with the expedited pre-certification procedures outlined above for such services.

If an ongoing course of treatment was previously pre-certified for a specified period of time or number of treatments and you request to extend non-acute care services, your request will be treated as a pre-certification request for non-acute care services and handled in accordance with the pre-certification procedures outlined above for such services.

The initial Benefit determination may be made to your attending Provider by telephone.

If your concurrent care Claim and extended treatment request is denied, written notification will be provided to you and your attending Provider. This notice will explain:

- Information sufficient to identify the Claim involved and any information required by law;
- The reason for the denial;

- The part of the Plan on which it is based;
- Any additional material or information needed to make the Claim acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

V. Additional Benefit Information

A. Provider Directory

You may find Participating Providers on the designated website listed on the inside cover of this Schedule. Coverage may vary according to your provider selection.

The list of Participating Providers frequently changes and the TPA does not guarantee that a listed Provider is a Participating Provider. You should verify that the Provider you choose is a Participating Provider by calling Customer Service at the telephone number listed on the inside cover of this Schedule. If you call Customer Service, the TPA will respond to you as soon as practicable but in no case later than 1 business day after your call is received, through a written electronic communication or, at your request, a hard copy communication.

If You called Customer Service, or used an Internet-based provider directory made available by the TPA to confirm that a Provider was a Participating Provider before you received certain Health Care Services from the Provider, but the Provider which furnished the Health Care Services after you received such information was a Non-Participating Provider:

Then the Plan:

(A) Shall not impose on you a cost-sharing amount (e.g. a Deductible or Copayment) for such Health Care Services furnished by the Non-Participating Provider that is greater than the cost-sharing amount that would apply had such Health Care Services been furnished by a Participating Provider; and

(B) Shall apply the Out-of-Pocket Maximum that would apply if such Health Care Services were furnished by a Participating Provider.

B. Case Management/Alternative Care

In cases where your condition is expected to be or is of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional who understands both medical procedures and health care coverage under the Plan.

Under certain conditions, the Plan Administrator will consider other care, services, supplies, reimbursement of expenses, or payments of your serious Sickness or Injury that would not normally be covered or would only be partially covered. The Plan Administrator and your Physician will determine whether any medical care, treatments, services, supplies, reimbursement of expenses or payments will be covered. Such care, treatment, services, supplies, reimbursable expenses, or payments provided will not be considered as setting any precedent or creating any future liability, with respect to you, or any other Covered Person.

Other care, treatments, services, or supplies must meet both of the following tests:

1. Be determined in advance by the Plan Administrator to be Medically Necessary and cost effective in meeting your long term or intensive care needs in connection with a catastrophic Sickness or Injury; and
2. The charges Incurred would not otherwise be payable or would be payable at a lesser percentage.

Alternative Care

If your attending health care professional advises you to consider alternative care for a Sickness or Injury that includes Health Care Services not covered under the contract, your attending health care professional should contact the Utilization Management Vendor who will contact the Plan Administrator. The Plan Administrator has

full discretionary authority to consider paying for such non-covered Health Care Services and may consider an alternative care plan if the Plan Administrator finds that:

1. The recommended alternative care offers a medical therapeutic value equal to or greater than the current treatment or confinement;
2. The current treatment or confinement is covered under this Schedule;
3. The current treatment or confinement may be changed without jeopardizing your health; and
4. The Health Care Services provided under the alternative care plan will be as cost effective as the Health Care Services provided under the current treatment or confinement plan.

The Plan Administrator will make each alternative care coverage determination on a case-by-case basis and no decision will set any precedent for future claims. Payment of benefits, if any, will be determined by the Plan Administrator.

Any alternative care decision must be approved by you, the attending health care professional, and the Plan Administrator before such alternative care begins.

C. Routine Patient Costs Associated with Clinical Trials

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 Health Care 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.

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.

D. Limited Access to Participating Providers

In the event that the Plan Administrator determines you are receiving Health Care Services, including Prescription Drugs, in a quantity or manner that might be harmful to your health, the Plan Administrator will notify you that your access to Participating Providers is limited. You will have 30 calendar days in which to select one participating Physician, Hospital, and pharmacy to coordinate your health care. If you do not select those Participating Providers within 30 calendar days, the Plan Administrator will choose for you.

Failure to receive Health Care Services through your selected Participating Providers will result in denial of coverage. If your condition requires care or treatment from other providers, you must obtain a written referral from your selected participating Physician.

E. Continuity of Care

1) If you are a continuing care patient and:
   a) The Plan Administrator's contract with the Participating Provider that is providing your continuing care terminates for any reason other than the Participating Provider's failure to meet applicable quality standards or fraud;
   b) Your benefits under this Schedule for the Health Care Services (except Prescription Drugs) provided by the Participating Provider that is providing your continuing care terminate because of a change in the terms of the Plan Administrator contract with such Participating Provider.
2) Then:

a) The Plan Administrator will notify you of the applicable event described in (1) and your right to elect continued transitional care from such Non-Participating Provider (in the event of notice under (1)(A)) or such Participating Provider (in the event of notice under (1)(B));

b) The Plan Administrator will provide you with an opportunity to notify the Plan of your need for transitional care; and

c) The Plan Administrator will allow you to elect to continue to have benefits for transitional care provided under this Schedule, under the same terms and conditions as would have applied under this Schedule had the applicable termination not occurred, as long as such benefits are for the course of treatment provided by such Non-Participating Provider (in the event of notice under (1)(A)) or such Participating Provider (in the event of notice under (1)(B)) relating to your status as a continuing care patient during the period beginning on the date on which the notice in (2)(A) is provided and ending on the earlier of:

i. The 90-day period beginning on such date; or

ii. The date on which you are no longer a Continuing Care Patient of such Non-Participating Provider (in the event of notice under (1)(A)) or such Participating Provider (in the event of notice under (1)(B)).

3) Continuing care patients are defined as individuals who, with respect to a provider or facility, are at least one of the following:

1. Undergoing treatment from the provider or facility for a serious and complex condition, defined as:

a. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.

b. In the case of a chronic illness or condition, a condition that is:

i. Life-threatening, degenerative, potentially disabling, or congenital; and

ii. Requires specialized medical care over a prolonged period of time.

2. Undergoing a course of institutional or inpatient care from the provider or facility.

3. Scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery.

4. Pregnant and undergoing treatment for pregnancy from the provider or facility.

5. Terminally ill and receiving treatment for such illness from the provider or facility.

F. Transition of Care

If a covered person is under the care of a non-participating provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a Non-Participating Provider may be covered at the Participating Provider level of benefits for a limited period of time. The TPA will review and approve or deny such requests.

G. For Non-Emergency Services Received in a Participating Provider Facility from a Non-Participating Provider

If a Participating Provider arranges and/or performs Health Care Services for you at a Participating Provider facility, all related eligible non-facility charges from both Participating Providers and Non-Participating Providers, will be covered at the participating provider level of benefits as shown in this Schedule.

If a Non-Participating Provider arranges or performs Health Care Services for you at a Participating Provider Facility, all related eligible non-facility charges from any Non-Participating Providers will be covered at the Non-Participating Provider level of benefits as described in this Schedule. You will be responsible for any charges that may exceed the Usual and Customary Amount.

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VI. Exclusions

The exclusions in this Section VI. apply to all Health Care Services.

Many exclusions are interrelated so please read this entire section.

The Plan will not cover charges Incurred for any of the following services:

- Non-Emergency ambulance service from Hospital to Hospital such as transfers and admission to Hospitals performed only for convenience.
- Health Care Services that the Plan Administrator determines are not Medically Necessary unless the specific terms of a Participating Provider's written agreement with the national network vendor applicable to the Plan precludes application of the exclusion.
- Routine maintenance chiropractic care.
- Blood, urine, or hair analysis related to chiropractic services.
- Performance of ultrasound, MRI, EMG, waveform and nuclear medicine diagnostic studies or other enhanced diagnostic imaging.
- Manipulation under anesthesia related to chiropractic services.
- Nutritional and food supplements, except as covered under this Schedule.
- Dental services covered under your dental plan.
- Preventive dental procedures.
- Health Care Services or dental services, orthodontia, and all associated expenses, except as stated in this section.
- Health Care Services or dental services for cracked or broken teeth that result from biting, chewing, disease, or decay.
- Dental implants.
- Health Care Services or dental services related to periodontal disease.
- Occlusal adjustment or occlusal equilibration.
- Treatment of bruxism.
- Any durable medical equipment or supplies not listed as eligible as determined by the Plan Administrator.
- Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage.
- Durable equipment necessary for the operation of equipment determined not to be eligible for coverage.
- Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use.
- Replacement or repair of items when damaged or destroyed by misuse, abuse, or carelessness, lost, or stolen.
- Duplicate or similar items.
- Hearing aids, devices to improve hearing and related fittings or Health Care Services.
- Communication aids or devices; equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication board, or computer or electronic assisted communication.
- Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges
  for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds.
- Vehicle/car or van modifications including, but not limited to, handbrakes, hydraulic lifts, and car carrier.
- Over-the-counter orthotics and appliances.
- Orthopedic shoes, except as covered under this Schedule.
- Other equipment and supplies, and oral nutritional and electrolyte substances that the Plan Administrator determines are not eligible for coverage.
- Charges for sales tax, mailing or delivery.
- Upgrades to or replacement of any items that are considered Eligible Charges and covered under this Schedule unless the item is no longer functional and is not repairable.
- Glucose meters, blood pressure monitors, and peak flow meters are not covered under this section of this Schedule. Please refer to the "Preventive Health Care Services" section of the Schedule for coverage of these items.
- Cochlear implants.
- Health Care Services or items for personal comfort or convenience.
- Non-Emergency Services received in an emergency room.

- Non-emergency Health Care Services performed directly in connection with the performance of a non-covered health care service.
- Non-Emergency Services received outside the United States.
- Health Care Services, Companion and home care services, unskilled nursing services, services provided by your family or a person who shares your legal residence.
- Health Care Services and other services provided as a substitute for a primary caregiver in the home.
- Health Care Services and other services that can be performed by a non-medical person or self-administered.
- Home health aides, unless determined to be Medically Necessary by the Plan Administrator.
- Health Care Services and other services provided in your home for convenience.
- Health Care Services and other services provided in your home due to lack of transportation.
- Custodial care.
- Health Care Services classified as home health services provided at any site other than your place of residence.
- Health Care Services and other services rendered by Providers unlicensed or not certified by the appropriate state regulatory agency.
- Services, seminars, or programs that are primarily educational in nature.
- Health education, except when:
  - Provided during an office visit for non-Preventive Health Care Services; or
  - It is counseling which is treated as a Preventive Health Care Service.
- Tobacco cessation intervention programs and services, except when covered as Preventive Health Care Services.
- Nutritional counseling, except when:
  - Provided during a confinement; or
  - Provided in a Physician's office, clinic system or Hospital setting:
    i. For the diagnosis and treatment of diabetes; or
    ii. To a Covered Person who has been diagnosed by a Physician with a chronic medical condition; or
    iii. As counseling that is treated as a Preventive Health Care Service.
- 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.
- 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 Preventive Health Care Services.
- Charges for duplicating and obtaining medical records from Non-Participating Providers, unless requested by the Plan Administrator.
- Genetic testing and associated Health Care Services, except as covered under this Schedule.
- Hypnosis and chelation therapy, except chelation therapy will be covered when Medically Necessary for the treatment of heavy metal poisoning.
- Non-prescribed over-the-counter contraceptives, including condoms, spermicides, and emergency contraceptives.
- Anesthesia and facility services related to sterilization procedures performed during other surgical procedures such as Cesarean section birth, gall bladder removal, and abdominal hernia repair are not covered under this section of this Schedule.
- Reversal of sterilization procedures.
- Private-duty nursing care, except:
  - Inpatient private-duty nursing care by a licensed nurse (R.N., L.P.N., or L.V.N.) when Medically Necessary and not Custodial in nature and the Hospital's Intensive Care Unit (ICU) is filled or the Hospital has no ICU, or
  - For a ventilator-dependent patient, up to 120 hours of services provided by a private-duty nurse or personal care assistant solely for the purpose of communication or interpretation for the patient.
- Travel, transportation, other than ambulance transportation, and/or living expenses.
- Orthoptics.
- Refractive surgery (e.g. Lasik) for ophthalmic conditions that are correctable by contacts or glasses.
- Health Care Services and associated expenses for gender reassignment, except when Medically Necessary.
- Autopsies.
- Treatment for compulsive gambling.
- Health Care Services to hold or confine a Covered Person under chemical influence when no Medically Necessary services are required, regardless of where the services are received (e.g. detoxification centers).
- Health Care Services including facility charges performed in a free-standing birth center unattached to a Hospital facility.
- Health Care Services for maternity labor and delivery in the home.
- Nutritional and food supplements, except as covered in this Schedule.

- Non-Preventive Health Care Services are not covered under this section of this Schedule.
- Routine foot care, unless required due to blindness, diabetes, or peripheral vascular disease.
- Treatment of cleft lip and cleft palate, except for such treatment of a Covered Dependent child if treatment is scheduled or started prior to the Covered Dependent child reaching age 19.
- Vision therapy/orthoptics.
- Health Care Services provided by an audiologist that are not provided in an office setting.
- Marital counseling, relationship counseling, family counseling except as otherwise covered in this Schedule, or other similar counseling or training services.
- Counseling, studies, Health Care Services, or confinements ordered by a court or law enforcement officer that are not determined to be Medically Necessary by the Plan Administrator.
- Biofeedback.
- Surgical treatments and procedures to treat one-sided deafness.
- Growth hormone therapy prescribed for children due to short stature only, or for adults with no documented significant deficiency of growth hormone.
- Contact lenses and their related fittings, except when prescribed as Medically Necessary for the treatment of keratoconus.
    - 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 licensed health care Providers; or e-mails, or facsimile transmissions between a licensed health care Provider and a patient.
    - Acupuncture.
    - Elective abortion, except in situations where the life of the mother would be endangered if the fetus is carried to full term.
    - Bariatric surgeries, including preoperative procedures, initial procedures, surgical revisions, and subsequent procedures.
    - Costs associated with Clinical Trials that are not Routine Patient Costs.
    - Health Care Services for Sickness or Injury sustained:
        - While engaging in or the attempt to engage in a felony act, whether or not the individual is formally charged or convicted of such an act. 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 alcoholism.
        - While voluntarily participating in a riot, insurrection, or civil disobedience.
        - While in a war or any act of war. "War" means declared or undeclared war and includes acts of terrorism.
- 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.
- The following Infertility services:
    - Treatment of male and female Infertility and associated Health Care Services, unless covered under your plan.
    - Artificially assisted technology such as, but not limited to, artificial insemination (AI) and intrauterine insemination (IUI).
    - In vitro fertilization, unless covered under your plan.
    - Gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures, unless covered under your plan.
    - Intracytoplasmic sperm injection (ICSI).
    - Sperm, ova or embryo acquisition, retrieval, or storage.
    - Reversal of voluntary sterilization.
    - Adoption costs.
- The following transplant services:
    - Health Care Services related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures that are Investigative for your condition.
    - Health Care Services related to non-human organ implants.
    - Health Care Services related to human organ transplants not specifically approved as Medically Necessary by the Plan Administrator.
    - 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 future covered services.
- Travel Services, except as covered under this Schedule.
- Health Care Services for or in connection with fetal tissue transplantation, except for non-investigative 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.

- In-person therapy visits provided in your home for convenience.
- Therapy for treatment of stuttering.
- Therapy for conditions that are self-correcting.
- Services which do not demonstrate measurable and sustainable improvement within two weeks to three months, depending on the physical and mental capacities of the individual.
- Voice training and voice therapy.
- Secretin infusion therapy.
- Sensory integration therapy when used for a reason other than the treatment of feeding disorders.
- Group therapy for PT, OT, and ST.
- Health Care Services for homeopathy and immunoaugmentative therapy.
- Recreational, Educational, or self-help therapy or items primarily Educational in nature or for vocation, comfort, convenience, or recreation. Recreational therapy is therapy provided solely for the purpose of recreation, including, but not limited to: a) physical therapy or occupational therapy to improve athletic ability, and b) braces or guards to prevent sports injuries.
- Vocational Rehabilitation.
- Massage therapy.
- Alternative therapies such as aromatherapy and reflexology.
- Health Care Services provided by massage therapists, doulas, and personal trainers.
- Health club memberships.
- Any Health Care Service performed during or in conjunction with an annual or periodic wellness exam that exceeds the services described in this section of the Schedule.
- Electronic cigarettes, e-cigarettes, personal vaporizers, and similar forms of nicotine delivery systems.
- Tobacco cessation intervention programs and Health Care Services, except as covered under the Schedule.
- Health Care Services related to surrogate pregnancy for a person who is not a Covered Person under this Schedule.
- Vision lenses, eyeglasses, frames, and their related fittings.
- Routine eye examinations, except as covered under this Schedule.
- Routine hearing examinations, except as covered under this Schedule.
- Any weight loss programs and related Health Care Services that are not otherwise covered as preventive health care services.
- Health Care Services and supplies not ordered by a Provider, such as but not limited to, cholesterol testing, glucose testing and mammograms unless specifically listed in the Plan's Schedule of Preventive Health Care Services or provided by a Participating Provider.
- Health Care Services to treat conditions that are cosmetic in nature.
- 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.
- Procedures that are generally Cosmetic, or for convenience or comfort reasons.
- 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.
- Private room, except when Medically Necessary or if it is the only option available at the admitted facility.
- Respite, rest or Custodial Care except as specifically described in this Schedule.
- Health Care Services received before coverage under this Plan begins or after your coverage under this Plan ends.
- Health Care Services that the Plan Administrator determines are Investigative and associated expenses unless the specific terms of a Participating Provider's written agreement with the national network vendor applicable to the Plan precludes application of the exclusion.
- Health Care Services not directly related to your care.
- Health Care Services ordered or rendered by Providers or para-professionals unlicensed by the appropriate state regulatory agency.

- Health Care Services not rendered in the most cost-efficient setting or manner appropriate for the condition based on medical standards and accepted practice parameters of the community or provided at a frequency other than that accepted by the medical community as medically appropriate.
- Charges for Health Care Services determined to be duplicate services by the Plan Administrator.
- Charges that exceed the Usual and Customary Amount for Health Care Services received from Non-Participating Providers, including Non-Participating Provider pharmacies.
- Health Care Services prohibited by law or regulation, or illegal under applicable laws.
- Charges for Health Care Services that are eligible for payment under any insurance policy, including auto insurance, or under a Workers' Compensation law, employer liability law or any similar law.
- Any Health Care 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.
- Health Care Services provided by providers who have not completed professional level education and licensure as determined by the Plan Administrator.
- Charges for medical services that are paid or payable under any auto insurance policy, which covers the Covered Person, or for which the Covered Person is required by law to enroll.
- 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.
- Health Care Services 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.
- Services provided to you if you also have other primary insurance coverage for those services and you do not provide the Plan with the necessary information to pursue coordination of benefits, as required under this Schedule.
- Costs, charges, fees, and other losses for non-Health Care Services.

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VII. Definitions of Capitalized Terms

Acute Care Facility	A facility that provides care to a covered person who is in the acute phase of a sickness or injury and who will have a stay of less than 30 calendar days.
Affordable Care Act	The federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance and regulations issued under these acts.
Ancillary Services	Subject to changes made by the U.S. Department of Health and Human Services, ancillary services are, with respect to a hospital or ambulatory surgical center, which is a participating provider: 1. health care services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and health care services provided by assistant surgeons, hospitalists, and intensivists; 2. diagnostic services (including radiology and laboratory services); and 3. health care services provided by a non-participating provider if there is no participating provider who can furnish such health care services at such hospital or ambulatory surgical center.
Benefits	The health care services covered under the Plan as approved by the Plan Administrator as covered services, as explained in this Schedule and any amendments.
Biofeedback	The technique of making unconscious or involuntary bodily processes (such as heartbeat or brain waves) perceptible to the senses in order to manipulate them by conscious mental control.
Claim	A request for benefits made by a covered person or the covered person's authorized representative in accordance with the procedures described in this Schedule. It includes pre-certification requests
Clinical Trial	A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The clinical trial must meet one of the following: 1. Federally funded clinical trial in which the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following: a. National Institutes of Health. b. Centers for Disease Control and Prevention. c. Agency for Health Care Research and Quality. d. Centers for Medicare & Medicaid Services. e. Cooperative group or center of any of the entities described in paragraphs a through d above or the Department of Defense or the Department of Veterans Affairs. f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants. g. If the clinical study or investigation is conducted by the Department of Veterans Affairs, Department of Defense, or the Department of Energy, has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and there has been an unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review. 2. A study or investigation conducted under an investigational new drug application reviewed by the FDA. 3. The study or investigation is a drug trial that is exempt from having an investigational new drug application.

Coinsurance	A portion of eligible charges from non-participating providers that is paid by you. Your coinsurance is a percentage of those eligible charges that are: 1) calculated at the time the claim is processed, 2) subject to the usual and customary amount or (3) the amount you must pay after satisfying your deductible for emergency services provided by a non-participating provider.
Compassionate Use	A method of providing experimental therapeutics prior to final FDA approval for use in humans. This procedure is used with very sick individuals who have no other treatment options. Often, case-by-case approval must be obtained from the FDA for compassionate use of a drug, device, or therapy.
Compounded Drugs	Customized medications prepared by a pharmacist from scratch using raw chemicals, powders, and devices according to a physician's specifications to meet your needs.
Confinement	An uninterrupted stay of 24 hours or more in a hospital, skilled nursing facility, rehabilitation facility, or residential treatment facility.
Copayment	The fixed amount of eligible charges you must pay to the provider for covered health care services received. The copayment may not exceed the charge billed for the covered health care service.
Cosmetic	Services, medications, and procedures that improve physical appearance but do not correct or improve a physiological function or are not medically necessary.
Covered Dependent	A covered employee's eligible dependent.
Covered Employee	The person: 1. On whose behalf contribution is paid; and 2. Whose employment is the basis for membership; and 3. Who is enrolled under the Plan.
Covered Person	A covered employee or covered dependent.
Covered Services	Health care services that are provided by your provider or clinic and are covered by the Plan, subject to all of the terms, conditions, limitations, and exclusions of the Plan.
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, such as assistance in walking, bathing, and eating.
Day Treatment Services	Any professional or health care services at a hospital or licensed treatment facility for the treatment of mental and substance use disorders.
Deductible	The amount of eligible charges that each covered person must incur in a Plan Year for health care services from providers before the Plan will pay benefits.
Designated Convenience Care Center	A health care clinic whose primary purpose is to provide immediate treatment for the diagnosis of minor conditions.
Educational	A health care service: 1. Whose primary purpose is to provide training in the activities of daily living, instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities; or 2. That is provided to promote development beyond any level of function previously demonstrated, except in the case of a child with congenital, developmental, or medical conditions that have significantly delayed speech or motor development as long as progress is being made towards functional goals set by the attending physician.
Eligible Charges	A charge for health care services, subject to all of the terms, conditions, limitations, and exclusions of the Plan for which the Plan or covered person will pay.
Emergency (Also Emergency Medical Condition)	See definition of emergency medical condition.

Emergency Department of a Hospital

A hospital outpatient department that provides emergency services.

Emergency Medical Condition (Also Emergency)

A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity, (including severe pain,) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Emergency Services

1. With respect to an emergency medical condition:
   a) A medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department, to evaluate such emergency medical condition; and
   b) Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

2. Inclusion of additional services:
   a) Unless each of the conditions described in subclause 2.b. are met, items and services:
      i. Which are covered services; and
      ii. That are furnished by a non-participating provider or non-participating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after you are stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in clause 1 are furnished.
   b) Conditions. If you are stabilized and furnished additional items and services described in subclause 2 after such stabilization by a provider or facility described in subclause 2, the conditions are the following:
      i. Such provider or facility determines you are able to travel using nonmedical transportation or nonemergency medical transportation.
      ii. Such provider furnishing such additional items and services satisfies the notice and consent criteria required by federal law with respect to such items and services.
      iii. You are in a condition to receive the information provided in the notice and to provide informed consent, in accordance with applicable federal and state law.
      iv. Any other conditions required by law, such as conditions relating to coordinating care transitions to participating providers and facilities.

Fee Schedule

The amount that the participating provider has contractually agreed to accept as reimbursement in full for covered services. This amount may be less than the provider's usual charge for the health care service.

If health care services are delivered to you via telehealth and/or virtual visit by a distant site participating provider who is **not** a designated participating provider for telemedicine, the Plan will reimburse such participating provider on the same basis and using the same fee schedule as would apply if the covered services had been delivered in person by the distant site participating provider.

Formulary

A list, which may change from time to time, of preferential prescription drugs that is used by the Plan.

Gravie	Gravie Administrative Services, which is a third-party administrator (TPA) providing administrative services to your Employer in connection with the operation of the Plan.
Habilitative Therapy	Therapy provided to develop initial functional levels of movement, strength, daily activity, or speech.
Health Care Service(s)	Medical or behavioral services including pharmaceuticals, devices, technologies, tests, treatments, therapies, supplies, procedures, hospitalizations, or provider visits.
Homebound	When you are unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute homebound status.
Hospital	A facility that provides diagnostic, medical, therapeutic, and surgical services by or under the direction of physicians and with 24-hour registered nursing services. The hospital is not mainly a place for rest or custodial care and is not a nursing home or similar facility.
Incurred	Health care services rendered to you shall be considered to have been incurred at the time or date the health care service was actually purchased or provided.
Infertility	Inability to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination: 1. One year, if you are a female under age 35 or a male of any age, or 2. Six months, if you are a female age 35 or older, provided that your infertility is not related to voluntary sterilization or failed reversal of voluntary sterilization.
Injury	Bodily damage other than sickness including all related conditions and recurrent symptoms.
Investigative	As determined by the Plan Administrator, a drug, device or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The Plan Administrator 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.
Medically Necessary	Any health care services, preventive health care services, and other preventive services that the Plan Administrator, in its discretion and on a case-by-case basis, determines are appropriate and necessary in terms of type, frequency, level, setting, and duration, for your diagnosis or condition; and the care must: 1. Be consistent with the medical standards and generally accepted practice parameters of providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; 2. Help restore or maintain your health; 3. Prevent deterioration of your condition; 4. Prevent the reasonably likely onset of a health problem or detect an incipient problem.

Non-Designated Transplant Network Provider	A transplant provider that is not contracted with or through the TPA to provide organ or bone marrow transplant or stem cell support and any related services and aftercare. A non-designated transplant network provider may be either a participating provider or a non-participating provider.
Non-Participating Provider	1. A physician or other health care provider who, when providing health care services, is acting within the scope of practice of that provider's license or certification under applicable State law; or 2. A facility, like a clinic or hospital; That is not a participating provider.
Out-of-Network Rate	The term 'out-of-network rate' means, with respect to emergency services provided by a non-participating provider: 1. Subject to clause (iii), the amount determined in accordance with any state law in effect in the state where such emergency services were provided; 2. Subject to clause (iii), if no such state law which would determine the amount under clause (i) is in effect: i. Subject to subclause 2(b), the amount agreed to by the TPA and the non-participating provider; or ii. If the TPA and the non-participating provider enter the independent dispute resolution (IDR) process under the No Surprises Act and do not agree on an amount before a certified IDR entity makes a determination on the amount to be paid to the non-participating provider, then the amount determined by the certified IDR entity; or 3. In the case the state has an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the state approves under such All-Payer Model Agreement for such emergency services provided by the non-participating provider.
Out-of-Pocket Limit	The maximum amount of money you must pay for health care services from participating providers before this Plan pays your eligible charges at 100%. If you reach benefit, day, or visit maximums, you are responsible for amounts that exceed the out-of-pocket limit. Expenses you pay for copayments will apply to the out-of-pocket limit.
Participating Provider	1. A physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law; or 2. A facility, like a hospital or clinic: That is directly contracted to participate in the specific TPA participating provider network designated by Plan Administrator to provide benefits to covered persons enrolled in this Plan. The participating status of providers may change from time to time. Participating providers may also be offered from other Preferred Provider Organizations that have contracted with TPA.
Physician	A licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), or Doctor of Chiropractic (D.C.).
Plan	The North Conejos School District RE1-J Group Health Plan, as amended from time to time.
Plan Administrator	North Conejos School District RE1-J. The Plan Administrator retains ultimate authority for this Plan including final appeal determinations. The Plan Administrator is also the Named Fiduciary for purposes of ERISA.
Plan Year	The period following the effective date of the Plan and each subsequent 12-month period this Plan remains in force.

Prescription Drug	A drug approved by the FDA for use only as prescribed by a provider properly authorized to prescribe that drug
Preventive Health Care Services	The covered services that are listed and covered in this Schedule as shown under the Preventive Health Care Services and/or Preventive Contraceptive Methods and Counseling for Women sections of the Benefit Schedule. To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following: 1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations (USPSTF). 2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention. 3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA). 4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).
Provider	A health care professional, physician, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide health care services to you.
Qualifying Payment Amount	The calculation for this amount is to be determined in accordance with the applicable federal regulation. Call Customer Service for further information.
Recognized Amount	With respect to an item or service furnished by a non-participating provider, except for non-participating air ambulance services: 1. Subject to clause (iii), in the case of such item or service furnished in a state that has in effect a law that determines the amount to be paid for such item or service; 2. Subject to clause (iii), in the case of such item or service furnished in a state that does not have in effect such a state law, the amount that is the qualifying payment amount; or 3. In the case of such item or service furnished in a state with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the state approves under such system for such item or service.
Reconstructive	Medically necessary surgery to restore or correct: 1. A defective body part when such defect is incidental to or resulting from injury, sickness, or prior surgery of the involved body part; or 2. A covered dependent child's congenital disease or anomaly which has resulted in a functional defect as determined by a physician.
Rehabilitative Care	Skilled restorative service that is rendered for the purpose of maintaining and improving functional abilities, within a predictable period of time, (generally within a period of six months) to meet your maximum potential ability to perform functional daily living activities. Not considered rehabilitative care are: skilled nursing facility care; home health services; chiropractic services, speech, physical and occupational therapy services for chronic medical conditions, or long-term disabilities, where progress toward such functional ability maintenance and improvement is not anticipated.
Residential Treatment Facility	A facility that is licensed by the appropriate state agency and provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, or treatment for sickness related to mental health and substance use related disorders.

Routine Patient Costs	The cost of any covered services that would typically be covered if you were not enrolled in an approved clinical trial. Routine patient costs do not include: 1. The cost of the investigational item, device, or health care service that is the subject of the approved clinical trial. 2. Items and health care services provided solely to satisfy data collection and analysis needs and not used in direct clinical management. 3. A health care service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
Sickness	Presence of a physical or mental illness or disease.
Skilled Care	Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to provide care or assess your changing condition. Long-term dependence on respiratory support equipment does not in and of itself define a need for skilled care.
Skilled Nursing Facility	A Medicare licensed bed or facility (including an extended care facility, a long-term acute care facility, a hospital swing-bed, and a transitional care unit) that provides skilled care.
Specialist	Providers other than those practicing in the areas of family practice, general practice, internal medicine, OB/GYN or pediatrics.
Specialty Drugs	Injectable and non-injectable prescription drugs, as determined by the Plan Administrator, which have one or more of the following key characteristics: 1. Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes; 2. Intensive patient training and compliance assistance are required to facilitate therapeutic goals; 3. There is limited or exclusive product availability and/or distribution; 4. There are specialized product handling and/or administration requirements; or 5. Are produced by living organisms or their products.
Stabilize, To	With respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency condition involving a pregnant woman who is having contractions, to deliver (including the placenta).
Third Party Administrator (TPA)	Gravie Administrative Services.
Telemedicine	Care provided by designated participating providers performed without physical face to face interaction, but through electronic (including telephonic) communication allowing evaluation, assessment and the management of health care services that leads to a treatment plan provided by a participating provider who is a licensed physician or a participating provider who is a qualified licensed health care professional. A list of telemedicine participating providers may be obtained by calling Customer Service or by checking the Gravie website at https://member.gravie.com. For purposes of this , a participating provider who contracts to be a designated telemedicine care participating provider shall not be treated or construed as performing telehealth and/or virtual visit at a distant site.
Transplant Services	Transplantation (including retransplants) of the human organs or tissue, including all related post-surgical treatment and drugs and multiple transplants for related care.
Urgent Care Center	A health care facility whose primary purpose is to offer and provide immediate, short-term medical care for minor immediate medical conditions not on a regular or routine basis.
Usual and Customary Amount	The average amount for each covered service or supply that by discretion of the Plan Administrator is customary in the geographic area in which the health care service is provided.

Vocational Rehabilitation	Health care services for a covered person designed to obtain or regain skills or abilities beyond those activities of daily living, including but not limited to, a device or an enhanced device or service requested or needed to enable the covered person to perform activities for an occupation.

Gravie HSA $6,350 Ded/$6,350 OOPM
Schedule of Benefits

July 01, 2024

QUICK REFERENCE GUIDE

Questions?	**Gravie Administrative Services Customer Service staff is available to answer questions about your coverage Monday through Friday from 8AM to 5PM Central Time.** **Customer Service:** **866.863.6232** **When contacting Customer Service, please have your identification card available. If your questions involve a bill, we will need to know the date of service, type of service, the name of the provider and the charges involved.**
Telephone Numbers for Utilization Management Vendor for Pre-certification and Pre-Service/Concurrent Care Claims	**Monday through Friday 7 AM to 7 PM Central Time** **Customer Service: 855.451.8365** **CVS Caremark: 833.847.8881** **Aetna: 855.451.8365**
Website	**Gravie member website:** https://member.gravie.com **Aetna provider directory:** www.aetna.com/asa
Mailing Address	**Claims, appeal requests, pre-certification, and written inquiries should be mailed to:** **Customer Service Department** **Gravie Administrative Services** **P.O. Box 211543** **Eagan, MN 55121**
Prescription Drugs **CVS Caremark**	**Telephone: 833.847.8881** **Website: www.gravie.com**
Identification Cards	The TPA issues an identification (ID) card containing important coverage information. Please verify the information on the ID card and notify Customer Service if there are errors. If any ID card information is incorrect, Claims for Benefits under the Plan or bills and/or invoices for your health care may be delayed or temporarily denied. You will be asked to present your ID card whenever you receive services. If any Covered Person permits the use of their Identification Card by any other person, such card may be retained by this Plan, and all rights of such Covered Person pursuant to this Plan may be terminated.

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I. About This Schedule of Benefits

This Schedule of Benefits ("Schedule") lists the Deductibles, Copayments, or payment percentage, if any apply to the covered services you receive under the Plan. You should review this Schedule to become aware of these and any limits that apply to these services. Benefits are not covered for excluded services and exclusions include, but are not limited to, health care

services that are not Medically Necessary as determined by the Plan Administrator. Be sure to review the list of exclusions as well. A provider recommendation or performance of a service, even if it is the only service available for your particular condition, does not mean it is a covered service. Benefits are not available for Medically Necessary services unless such services are also covered services. **Benefits are limited to the most cost effective and medically necessary alternative**.

How your cost share works

You are required to pay any Deductible, Coinsurance and/or Out-of-Pocket Limit. Benefits listed in this Schedule are according to what the Plan pays. Benefits are limited to the most cost effective and Medically Necessary alternative. Any amount of Coinsurance you must pay to the Provider is based on 100% of Eligible Charges less the percentage covered by the Plan. Plan payment begins after you have satisfied any applicable Deductible, Coinsurance and/or Out-of-Pocket Limit.

Discounts negotiated by or on behalf of the TPA with Providers may affect your Coinsurance cost-sharing amount. This Plan may pay higher Benefits if you choose a Participating Provider. If you use a Non-Participating Provider, in addition to any Deductible and Coinsurance, you pay all charges that exceed the Usual and Customary Amount, when applicable.

II. Benefits Summary

A. BENEFIT DEDUCTIBLE

	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Covered Employee Once you have Incurred Eligible Charges equal to the Deductible shown below, the Plan will pay Benefits for the rest of the Plan year. Expenses you pay for any amount in excess of the Usual and Customary amount will not apply to the Deductible. Except as described below, a separate Deductible applies for Health Care services from Non-Participating Providers. **Note:** Any manufacturer coupon or manufacturer copay assistance funds can be used towards member cost share for qualifying service, however, these coupon and assistance funds will not accumulate towards the member Deductible or Out of Pocket totals.	$6,350 per Covered Person	$10,000 per Covered Person per Plan Year for Eligible Charges received from Non-Participating Providers.
Family (Covered Employee and Covered Dependents) The family must satisfy the family Deductible per Plan Year for Health Care Services before the Plan will pay Benefits for the family in that Plan Year. There is an embedded Deductible shown in the table below that applies for each Covered Person within the family. If any Covered Person within the family satisfies such embedded Deductible, the Plan will pay Benefits for such Covered Person before the family Deductible is met. The Plan will not pay benefits for the Eligible Charges applied toward the family Deductible. **Note:** Any manufacturer coupon or manufacturer copay assistance funds can be	$12,700 per family $12,700 per family ($6,350 per Covered Person)	$20,000 per family ($10,000 per Covered Person) per Plan Year for Eligible Charges from Non-Participating Providers.

used towards member cost share for qualifying service, however, these coupon and assistance funds will not accumulate towards the member Deductible or Out of Pocket totals.		

B. BENEFIT OUT-OF-POCKET LIMIT

	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Covered Employee The Out-of-Pocket Limit applies to Health Care Services received from Participating Providers. Except as described below, if you receive services from a Non-Participating provider, the Out-of-Pocket Limit does not apply. After the Covered Employee has met the Out-of-Pocket Limit per Plan Year for Health Care services from Participating Providers, the Plan covers the remaining Eligible Charges Incurred from Participating Providers for the remainder of the Plan Year. It is the Covered Employee's responsibility to demonstrate to the Plan that the Out-of-Pocket Limit is satisfied, and to pay any amounts greater than the Out-of-Pocket Limits if any Benefit, day, or visit maximums are exceeded. **Note:** Any manufacturer coupon or manufacturer copay assistance funds can be used towards member cost share for qualifying service, however, these coupon and assistance funds will not accumulate towards the member Deductible or Out of Pocket totals.	$6,350 per Covered Person	None.
Family (Covered Employee and Covered Dependents) The family Out-of-Pocket Limit applies to Health Care Services received from Participating Providers. There is an embedded Out-of-Pocket Limit shown in the table below that applies for each Covered Person within the family. If any Covered Person within the family satisfies such embedded Out-of-Pocket Limit, the Plan will pay benefits for such Covered Person before the family Out-of-Pocket Limit is met. If you or your Covered Dependents receive services from a Non-Participating Provider, the Out-of-Pocket Limit does not apply. After the family has met the family Out-of-Pocket Limit per Plan Year for Health Care Services from Participating Providers, the Plan covers the remaining Eligible Charges incurred from Participating Providers for the remainder of the Plan Year. It is the family's responsibility to demonstrate to the Plan the family Out-of-Pocket Limit has been satisfied and to pay any amounts greater than the family Out-of-Pocket Limit if any benefit, day, or visit maximums are exceeded. **Note:** Any manufacturer coupon or manufacturer copay assistance funds can be	$12,700 per family $12,700 per family ($6,350 per Covered Person)	None.

used towards member cost share for qualifying service, however, these coupon and assistance funds will not accumulate towards the member Deductible or Out of Pocket totals.		

NOTE: Your coverage is either "Covered Employee only" or "family." Therefore, only one of the following sections ("Covered Employee only" or "Family") applies to you, unless the Plan expressly provides otherwise. If you have questions about which section applies to you, contact TPA or your employer.

Deductible and Out-of-Pocket Limits are for Eligible Charges from Participating Providers, charges calculated for Non-Participating Providers of Emergency Services, charges calculated for Non-Participating Providers of air ambulance services, and charges calculated for Non-Participating Providers of non-Emergency Services at a hospital or ambulatory surgical center which is a participating provider*.

Cost Sharing. The amount of the flat fee Copayments is calculated on Provider allowed charges. The amount of Copayments vary as described later in this Schedule. The calculation of the Coinsurance is based on the least of the Provider's allowed charge, the Fee Schedule negotiated by the TPA with the Participating Provider, or the Usual and Customary Amount, except for: (1) the calculation of the Coinsurance for Emergency Services provided by a Non-Participating Provider, in which case, the calculation of the Coinsurance will be based on the Recognized Amount; (2) the calculation of the Coinsurance for air ambulance services provided by a Non-Participating provider, in which case, the calculation of the Coinsurance will be based on the lesser of the Qualified Payment Amount and billed charges; and (3) the calculation of the Coinsurance for Non-Participating Providers of non-Emergency Services at a Hospital or ambulatory surgical center which is a Participating Provider, in which case, the calculation of the Coinsurance will be based on the Recognized Amount.* If you have a Deductible, it is first subtracted from the allowed charge, Fee Schedule, or the Usual and Customary Amount, the Recognized Amount, or the amount calculated for air ambulance services provided by a Non-Participating Provider whichever is applicable, then the Coinsurance percentage is applied to the remainder.

* If a Non-Participating Provider provides non-Emergency Health Care Services at a Hospital or ambulatory surgical center which is a Participating Provider and the Non-Participating Provider has satisfied the notice and consent requirements described in the Annual Compliance Notices document entitled Balance Billing Under the No Surprises Act, then the Plan will pay for charges for such non-Emergency Health Care Services according to the terms of the Non-Participating Provider Benefit in this Schedule and any amounts paid by you toward the Deductible for charges for such non-Emergency Health Care Services will count toward the Deductible for Non-Participating Providers.

Note: For Non-Participating Providers, in addition to any Deductible and Coinsurance, you pay all charges that exceed the Usual and Customary Amount.

C. MEDICAL BENEFIT COST-SHARING

Covered Service	Participating Provider Plan Payment	Non-Participating Provider Plan Payment
Ambulance Services • Ambulance services for emergency • Non-emergency transportation	• 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges after the Deductible.	• Same as the Participating Provider Benefit for emergency ambulance services. • 50% of Eligible Charges after the Deductible for Non-Participating Provider.
Chiropractic Services	100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider.
Dental Services	See "Office Visits" and "Hospital Services".	See "Office Visits" and "Hospital Services".
Durable medical equipment (DME)	100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider.
Emergency Services Note: Includes urgent care clinics within a hospital and ER urgent care.	100% of Eligible Charges for emergency services after the Deductible.	100% of the Out-of-Network rate after the Participating Provider Deductible.
Home Health Services	100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider.
Hospice Care	100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider.
Hospital Services • Outpatient Hospital Services, Ambulatory Surgical Center, or other Freestanding Outpatient Surgical Center • Outpatient Hospital, Partial Hospital, and Rehabilitation Services in a Day Hospital Program for Mental and Substance Use Related Disorders • Laboratory and Pathology X-Ray and Enhanced Radiology, except when part of a bundled claim for a Hospital inpatient or outpatient procedure. • Telehealth and/or Virtual Visits • Inpatient Hospital Services • Inpatient Hospital and Residential Treatment Facility Services for Mental and Substance Use Related Disorders • Non-Routine Prenatal and Postnatal care.	• 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider.
Infertility Services • Diagnostic Services • Surgical Correction of Physiological Abnormalities causing Infertility	• 100% of Eligible Charges after the Deductible. • 100% of Eligible Charges after the Deductible. • See Pharmacy Benefit Cost-Sharing Below.	• See "Office Visits" and "Hospital Services". • See "Office Visits" and "Hospital

• Prescription drugs for the treatment of Infertility		Services". • See Pharmacy Benefit Cost-Sharing Below.
Office Visits • **Primary Care Visit** • **Specialty Care Visit** • **Urgent Care Visit** • **Telemedicine Visits** Office visits include: Sickness or Injury; allergy visits; chemotherapy; radiation therapy; laboratory and pathology; x-ray and enhanced radiology; dialysis; surgical services; telehealth and/or virtual visits; convenience care; non-routine prenatal and postnatal care.	100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider, except for telemedicine services, which are not covered.
Organ and Bone Marrow Transplant Services	See "Office Visits" and "Hospital Services."	See "Office Visits" and "Hospital Services."
Physical Therapy, Occupational Therapy, And Speech Therapy	See "Office Visits" and "Hospital Services".	See "Office Visits" and "Hospital Services".
Preventive Health Care Services Includes certain routine services such as: • Counseling for certain conditions. • Routine immunizations. • Routine laboratory tests, pathology, and radiology. • Routine physical examinations. • Routine screenings for certain cancers and certain other conditions. • Prescribed preventive medications required under the Affordable Care Act. • Tobacco cessation intervention program Prescription Drugs and prescribed over the counter (OTC) medications	100% of Eligible Charges. Deductible does not apply.	50% of Eligible Charges after the Deductible for Non-Participating Provider. **Note:** Out-of-network pharmacy services are not covered.
Reconstructive Surgery	100% of Eligible Charges after the Deductible.	See "Office Visits" and "Hospital Services".
Skilled Nursing Facility Services	100% of Eligible Charges after the Deductible.	50% of Eligible Charges after the Deductible for Non-Participating Provider.

D. PHARMACY BENEFIT COST-SHARING

Covered Service	Participating Provider Plan Payment	Non-Participating Provider Plan Payment
Retail • Up to a 30-calendar day supply.	**Generic drugs designated as Tier 1**: 100% of Eligible Charges after the Deductible. **Preferred Brand drugs designated as Tier 2**: 100% of Eligible Charges after the Deductible. **Non-Preferred Brand drugs designated as Tier 3**:	Not covered.

	100% of Eligible Charges after the Deductible. **Non-Formulary drugs**: Not covered.	
Mail Order • Up to a 90-calendar day supply.	**Generic drugs designated as Tier 1**: 100% of Eligible Charges after the Deductible. **Preferred Brand drugs designated as Tier 2**: 100% of Eligible Charges after the Deductible. **Non-Preferred Brand drugs designated as Tier 3**: 100% of Eligible Charges after the Deductible. **Non-Formulary drugs**: Not covered.	Not covered.
90-Day Retail/Maintenance Drug • Up to a 90-calendar day supply.	**Generic drugs designated as Tier 1**: 100% of Eligible Charges after the Deductible. **Preferred Brand drugs designated as Tier 2**: 100% of Eligible Charges after the Deductible. **Non-Preferred Brand drugs designated as Tier 3**: 100% of Eligible Charges after the Deductible. **Non-Formulary drugs**: Not covered.	Not covered.
Specialty Drugs* • Up to a 30-calendar day supply for retail or mail order. • Specialty Drugs may be oral or injectable • Must be purchased through a CVS specialty pharmacy unless distribution is limited (see list at www.gravie.com) Note: Prescription Drugs which CVS Caremark determines are Specialty Drugs may not be covered at the generic, preferred brand, non-preferred brand, mail order, or non-formulary benefit level. *Excludes insulin	100% of Eligible Charges per prescription after the Deductible has been met if enrolled in the PrudentRx Solution for Specialty Drugs and filled at a CVS pharmacy. Note: if you are enrolled in the PrudentRx Solution and choose to disenroll, your cost for the Specialty Drug will be 30% of the Eligible Charges after the Deductible. For Specialty Drugs that are not eligible for the PrudentRx Solution, your cost will be a 0% Coinsurance of Eligible Charges after the Deductible.	Not covered.
Women's Preventive Contraceptive Methods received at a retail or mail order pharmacy • Generic oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law up to a 30-calendar day supply from a retail pharmacy, up to a	**Retail pharmacy:** 100% of Eligible Charges. Deductible does not apply. **Mail order pharmacy:** 100% of Eligible Charges. Deductible does not apply. **Retail/maintenance drug pharmacy:**	Not covered.

90-calendar day supply from a mail order pharmacy, and up to a 90-calendar day supply from a retail/maintenance drug pharmacy; and • Brand name oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists up to a 30-calendar day supply from a retail pharmacy, and up to a 90-calendar day supply from a mail order pharmacy, and up to a 90-calendar day supply from a retail/maintenance drug pharmacy.	100% of Eligible Charges. Deductible does not apply.	
Women's Preventive Contraceptive Methods received at a retail or mail order pharmacy Brand name oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists up to a 30-calendar day supply from a retail pharmacy, and up to a 90-calendar day supply from a mail order pharmacy, and up to a 90-calendar day supply from a retail/maintenance drug pharmacy.	**Retail pharmacy:** **Preferred Brand drugs designated as Tier 2**: 100% of Eligible Charges after the Deductible. **Non-Preferred Brand drugs designated as Tier 3**: 100% of Eligible Charges after the Deductible. **Non-Formulary drugs**: Not covered. **Mail order pharmacy:** **Preferred Brand drugs designated as Tier 2**: 100% of Eligible Charges after the Deductible. **Non-Preferred Brand drugs designated as Tier 3**: 100% of Eligible Charges after the Deductible. **Non-Formulary drugs**: Not covered. **Retail/maintenance drug pharmacy:** **Preferred Brand drugs designated as Tier 2**: 100% of Eligible Charges after the Deductible. **Non-Preferred Brand drugs designated as Tier 3**: 100% of Eligible Charges after the Deductible. **Non-Formulary drugs**: Not covered.	Not covered.
Women's preventive contraceptive methods, sterilization procedures, and education received at a provider's office:		

• Generic injectable, implantable, and insertable contraceptives that require a prescription under applicable law; and	• 100% of Eligible Charges. Deductible does not apply.	• 50% of Eligible Charges after the Deductible.
• Brand name injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists.	• 100% of Eligible Charges. Deductible does not apply.	• 50% of Eligible Charges after the Deductible.
• Brand name injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists.	• 100% of Eligible Charges after the Deductible.	• Not covered.
• Sterilization procedures, excluding the reversal of sterilization procedures.	• 100% of Eligible Charges. Deductible does not apply.	• 50% of Eligible Charges after the Deductible.
• Covered Person education and counseling about contraceptive methods.	• 100% of Eligible Charges. Deductible does not apply.	• 50% of Eligible Charges after the Deductible.

III. Covered Benefits

A. Ambulance Services

Air ambulance services. Covered air ambulance services provided by a Non-Participating Provider are subject to the same Deductible requirements that would apply if the services were provided by a Participating Provider of air ambulance services. The Deductible requirements must be calculated as the lesser of the qualifying payment amount and the billed amount for the services.

The Plan covers ambulance service to the nearest Hospital or medical center where initial care can be rendered for a medical emergency. Air ambulance transport to the nearest Hospital that is able to render medically necessary care, is covered only when the condition is an acute medical emergency and is authorized by a physician.

The Plan also covers emergency ambulance (air or ground) transfer from a Hospital not able to render the Medically Necessary care to the nearest Hospital or medical center able to render the Medically Necessary care only when the condition is a critical medical situation and is ordered by a Physician and coordinated with a receiving physician.

Pre-certification is recommended for:

- Non-emergency ambulance service, from Hospital to Hospital when care for your condition is not available at the Hospital where you were first admitted; and
- Non-emergency transfers by ambulance from a Hospital to other facilities for subsequent covered care or from home to Physician offices or other facilities for outpatient treatment procedures or tests when medical supervision is required en route.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

B. Chiropractic Services

Note: Some services that may be provided during an office visit may be subject to the Deductible (e.g. x-ray)

Coverage includes chiropractic services to treat acute musculoskeletal conditions, by manual manipulation therapy. Diagnostic services are limited to Medically Necessary radiology. Treatment is limited to conditions related to the spine or joints.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

C. Dental Services

The Plan Administrator considers dental procedures to be services rendered by a dentist or dental specialist to treat the supporting soft tissue and bone structure.

Accidental Dental Services. Treatment and repair for services required due to an accidental Injury must be started within six months and completed within twelve months of the date of the Injury. The Plan covers services to treat and restore damage done to a sound, natural tooth as a result of an accidental Injury. Coverage is for external trauma to the face and mouth only. A sound, natural tooth is a tooth, including supporting structures, that is healthy and would be able to continue functioning for at least one year. Primary (baby) teeth must have a life expectancy of one year before loss.

Medically Necessary Dental Services. The Plan covers dental services, limited to 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. The Plan covers surgical extraction of impacted wisdom teeth.

Medically Necessary Hospitalization for Dental Care. Eligible Charges are those Incurred by a Covered Person who: (1) is a child under age five; (2) is severely disabled; or (3) has a medical condition, unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a Physician, dentist, or dental Specialist.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

D. Durable Medical Equipment (DME), Services, and Prosthetics

Wigs for hair loss resulting from a medical condition are limited to a maximum of one wig per Covered Person per plan year.

Diabetic supplies: Coverage includes over-the-counter diabetic supplies, syringes, blood and urine test strips and other diabetic supplies as Medically Necessary.

Note: See "Preventive Health Services" section for coverage of glucose meters. If you require a blood glucose meter as part of your treatment for diabetes, you may obtain a PREFERRED meter free of charge from CVS Caremark by visiting Caremark.com/ManagingDiabetes or calling the number on the back of your ID card.

Note: Non-participating providers must have a Medicare provider number for their charges to be eligible for coverage.

The Plan covers certain equipment and Health Care Services, nutritional formulas, and enteral feedings, which may include; amino acid-based formulas, other oral nutritional, and electrolyte substances; and special dietary treatment for phenylketonuria (PKU); ordered or prescribed by a Physician and provided by DME/prosthetic vendors. For verification of eligible equipment and supplies, call Customer Service. 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 has determined that the item is appropriate for rental only. The Plan Administrator reserves the right to determine if an item will be approved for rental or purchase.

The Plan also covers the following:

- Custom molded foot orthotics.
- Medically Necessary durable medical equipment, orthotics, and prosthetics.
- When Medically Necessary, therapeutic shoes for diabetes, prosthetic shoes, rehabilitative foot orthotics following surgery or trauma.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

E. Emergency Services

The emergency room Copayment is waived if you are admitted within 24 hours for the same emergency condition treated in the emergency room.

Note: Services other than Emergency Services received in an emergency room are not covered. If you choose to receive non-Emergency Services in an emergency room, you are solely responsible for the cost of these services.

If you have an Emergency that requires immediate treatment, call 911 or go to the nearest emergency facility. If possible under the circumstances, you should telephone your Physician or the clinic where you normally receive care. A Physician will advise you how, when, and where to obtain the appropriate treatment.

Notwithstanding anything in this Schedule to the contrary, the Plan shall cover emergency services, whether provided by a Participating Provider or a Non-Participating Provider, without the need for any pre-certification.

In the case of Emergency Services provided by a Non-Participating Provider, your Copayment, Deductible and Coinsurance will be calculated as if the total amount charged for such Emergency Services were equal to the Recognized Amount.

Covered services, whether provided by a Participating Provider or a Non-Participating Provider, are subject to all of the Benefit limitations set forth in this Schedule. You should provide notice to the Utilization Management vendor of an admission to an inpatient facility within 48 hours or as soon as reasonably possible.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

F. Home Health Services

Home health care is available as an alternative to facility or clinic-based care.

Services are limited to 100 visits (4 hours of service = 1 visit) per Covered Person per plan year for home health services.

Services are also limited to 100 visits for palliative care (4 hours of service = 1 visit) per Covered Person per plan year if you are eligible to receive palliative care in the home but you are not homebound.

The Plan covers skilled home health services that are directed by a Physician and received from a licensed Home Health Care Agency. Services may include: Skilled Care; physical therapy; occupational therapy; speech therapy; respiratory therapy; home health care as an alternative to facility or clinic-based care and other Medically Necessary therapeutic services that are rendered in your home.

In order for services to be received in your home, you must be Homebound, or the Plan Administrator must determine the services are medically appropriate and the most cost effective to the Plan.

A Health Care Service shall not be considered Skilled Care merely because it is performed by, or under the direct supervision of, a licensed registered nurse. Where a Health Care Service (such as tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person, or self-

administered, without the direct supervision of a licensed registered nurse, the Health Care Service shall not be regarded as Skilled Care, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of "blended" services (i.e., services that include skilled and non-skilled components) is covered under the Plan.

The Plan covers palliative care benefits if you are not homebound up to the visit limit stated above. Palliative care includes symptom management, education, and establishing goals of care.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

G. Hospice Care

The Plan covers hospice services for terminally ill patients in a hospice program. The patient must meet the eligibility requirements of the program and elect to receive services through the hospice program. The services will be provided in the patient's home or hospice center, with inpatient care available when Medically Necessary. Hospice services are in lieu of curative or restorative treatment.

Eligibility. In order to be eligible to be enrolled in the hospice program, you must:

- Be terminally ill with Physician certification of six months or less to live; and
- Have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than restorative treatment or treatment attempting to cure the disease or condition).

You may withdraw from the hospice program at any time.

Hospice services include the following services provided in accordance with an approved hospice treatment plan:

- Care provided in your home by an interdisciplinary hospice team (which may include a Physician, nurse, social worker, and spiritual counselor) and home health aide services;
- One or more periods of continuous care provided in your home or in a setting that provides day care for pain or symptom management by a registered nurse, licensed practical nurse, or home health aide, when Medically Necessary as determined by the Plan Administrator;
- Medically Necessary inpatient services;
- Respite care for caregivers in your home or in an appropriate setting. Respite care must be authorized in advance to give your primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain you at home;
- Medically Necessary medications for pain and symptom management;
- Durable medical equipment when authorized in advance and determined by the Plan Administrator to be Medically Necessary.

Continuous care is defined as two to 12 hours of service per calendar day provided by a registered nurse, licensed practical nurse, or home health aide during a period of crisis in order to maintain you in your home when you are terminally ill.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

H. Hospital Services

Note: For inpatient Hospital services, each Covered Person's confinement, including that of a covered newborn child, is separate and distinct from the confinement of any other Covered Person.

If you have Covered Employee only coverage, on the date of birth of a newborn, you, and your new Covered Dependent(s), when enrolled, become subject to the terms and conditions of family coverage.

In the case of Health Care Services (other than Emergency Services) furnished by a Non-Participating Provider with respect to a visit at a Hospital or ambulatory surgical center which is a Participating Provider:

a) Unless the Non-Participating Provider has satisfied the notice and consent requirements:

   i. Your Deductible and Coinsurance will be calculated as if the total amount charged for such non-Emergency Health Care Services were equal to the Recognized Amount; and

   ii. The coinsurance percentage applied to such charges is 100% .

   iii. The Plan will pay 50% of the Out-of-Network rate after the Deductible.

b) If the Non-Participating Provider has satisfied the notice and consent requirements, then the Plan will pay according to the terms of the Non-Participating Provider Benefit in the table above.

Notify the Utilization Management vendor of an admission to an inpatient facility within 48 hours or as soon as reasonably possible.

Some outpatient Hospital services that are commonly performed in an office visit may be covered under the Plan as an office visit. Contact Customer Service if you have a question about your Plan.

Outpatient Hospital, Ambulatory Surgical Center, or other Freestanding Outpatient Surgical Center Services, Partial Hospital or Day Treatment Services. The Plan covers Health Care Services authorized by a Physician for the diagnosis or treatment of Sickness or Injury on an outpatient basis:

- Use of operating rooms or other outpatient departments, rooms, or facilities;
- General nursing care, anesthesia, radiation therapy or other medications administered during treatment, blood, and blood plasma and other diagnostic or treatment related outpatient services;
- Mental health and substance use related disorder services, such as:
  - An initial court-ordered exam for a covered dependent age 18 and under;
  - Outpatient professional services for evaluation and diagnostic services, crisis intervention, therapeutic services including psychiatric services and treatment of mental and nervous conditions;
  - Diagnosis and treatment of substance-related conditions including evaluations, diagnostic services, therapeutic services, and psychiatric services;
  - Outpatient individual and group therapy;
  - Outpatient family therapy that is recommended by a designated Provider treating a minor Covered Dependent child; and
  - Medication management.
  - Telehealth and/or Virtual Visit services may include interactive audio, messaging, and video communications, permitting real time or asynchronous communication between a distant site Provider of Health Care Services and the Covered Person.
- Laboratory tests, pathology, and radiology; and
- Physician and other professional medical and surgical services rendered while an outpatient.
- Medically necessary genetic testing determined by TPA to be covered services if it is determined that: 1) the Covered Person displays clinical features, or is at direct risk of inheriting the mutation in question (presymptomatic); and 2) the result of a Covered Person's screening test during prenatal care is abnormal, or the Covered Person has a high-risk pregnancy; and 3) the result of the test will directly impact the current treatment being delivered to the Covered Person; and 3) after history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.

The Plan also covers Preventive Health Care Services. These preventive services will be covered as shown in the Preventive Health Care Services, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this Schedule.

Inpatient Services. The Plan covers Health Care Services authorized by a Physician for the treatment of acute Sickness or Injury that requires the level of care only available in an Acute Care Facility, Hospital, or Residential Treatment Facility. Inpatient services include, but are not limited to:

- Room and board;

- The use of operating rooms, intensive care facilities, newborn nursery facilities;
- General nursing care, anesthesia, radiation therapy or other medications administered during treatment, blood, and blood plasma, and other diagnostic or treatment related inpatient services;
- Physician and other professional medical and surgical services;
- Mental health and substance use related disorder services;
- Laboratory tests, pathology, and radiology; and
- For a ventilator-dependent patient, up to 120 hours of services provided by a private-duty nurse or personal care assistant solely for the purpose of communication or interpretation for the patient.
- Inpatient private-duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.) when Medically Necessary and not custodial in nature and the Hospital's Intensive Care Unit (ICU) is filled or the Hospital has no ICU.

The Plan covers a semi-private room. Benefits for a private room are available only when the private room is Medically Necessary for a Sickness or Injury or if it is the only option available at the admitted facility. If you choose a private room when it is not Medically Necessary, Plan payment toward the cost of the room shall be based on the average semi-private room rate in that facility.

Emergency Services that Lead to an Inpatient Admission

If you were incapacitated in a manner that prevented you from providing the notice described under "Emergency Services," or if you are a minor and your parent (or guardian) was not aware of your admission, then the time period begins when the incapacity no longer exists or when your parent (or guardian) is made aware of the admission. You are considered incapacitated only when: (1) you are physically or mentally unable to provide the required notice; and (2) you are unable to provide the notice through another person.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

I. Infertility Services

This Plan covers the professional services necessary to diagnose Infertility and the related tests, facility charges, and laboratory work related to eligible services. Unless covered under your Plan, services for the treatment of Infertility are not eligible for coverage. Certain Prescription Drugs for the treatment of Infertility and charges for surgical correction of physiological abnormalities causing Infertility may be covered**.**

Contact your Employer to determine if Infertility treatment is covered under your plan. Please refer your Plan's Infertility Rider for coverage details.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

J. Office Visits

Note: Some services that may be provided during an office visit may be subject to the Deductible, such as, but not limited to, laboratory, enhanced diagnostic imaging, pathology, and radiology.

The Plan covers office visits and urgent care center, telemedicine, and designated convenience care center visits related to diagnosis, care, or treatment of medical, mental health, and substance use related conditions, Sickness, or Injury:

- Outpatient professional services for evaluation, diagnosis, crisis intervention, therapy, including Medically Necessary group therapy, psychiatric services, and treatment of mental and nervous disorders; and
- Diagnosis and treatment of substance use related disorders, including evaluation, diagnosis, therapy, and psychiatric services.
- Laboratory tests, pathology, and radiology.
- Allergy injections.

- Contact lenses prescribed as Medically Necessary for the treatment of keratoconus. The lenses and fitting are Eligible Charges under the Durable Medical Equipment (DME) Benefit. Covered Persons must pay for lens replacement.
- Surgical service performed during an office visit.
- Oral surgery is covered for: 1) treatment of oral neoplasm and non-dental cysts; 2) fracture of the jaws; and 3) trauma to the mouth and jaws.
- Treatment of confirmed, existing temporomandibular disorder (TMD) and craniomandibular disorder (CMD). Dental services required to directly treat TMD or CMD are eligible. TMD splints are Eligible Charges under the Durable Medical Equipment (DME) Benefit.
- Port wine stain elimination or maximum feasible treatment to lighten or remove the coloration.
- Diabetic outpatient self-management training and Educational services.
- An Emergency examination of a child ordered by judicial authorities.
- Telehealth and/or virtual visit services may include interactive audio and video communications, permitting real time communication between a distant site Provider of Health Care Services and the Covered Person.
- Medically Necessary genetic testing determined by TPA to be Covered Services if it is determined that: 1) the Covered Person displays clinical features, or is at direct risk of inheriting the mutation in question (presymptomatic); and 2) the result of the test will directly impact the current treatment being delivered to the Covered Person; and 3) after history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.

The Plan also covers Preventive Health Care Services. These preventive services will be covered as shown in the Preventive Health Care Services, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this Schedule.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

K. Organ and Bone Marrow Transplant Services

The Plan covers eligible Transplant Services that are pre-certified and determined by the Plan Administrator to be Medically Necessary and not Investigative. Transplant Services must be received at a designated transplant network provider. Certain drugs or Gene Therapies may require pre-certification prior to the procedure to see if those are covered under your plan.

Coverage for organ transplants, bone marrow transplants and bone marrow rescue services is subject to periodic review. The Plan Administrator evaluates Transplant Services for therapeutic treatment and safety. This evaluation continues at least annually or as new information becomes available and it results in specific guidelines about Benefits for Transplant Services. You may call the TPA at the telephone number listed inside the front cover for information about these guidelines.

Benefits may be available for the following transplants when the transplant meets the definition of a Covered Service and is not Investigative:

- Bone marrow transplants and peripheral stem cell transplants with or without high dose chemotherapy.
- Heart transplants.
- Heart/lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.
- Liver transplants.
- Pancreas transplants.
- Small bowel transplants.

Transplant coverage includes a private room and all related post-surgical treatment and drugs. The transplant related treatment provided shall be subject to and in accordance with the provisions, limitations, and other terms of this Schedule.

Medical and Hospital expenses of the donor are covered only when the recipient is a Covered Person and the transplant has been authorized in advance by the Plan Administrator. Treatment of medical complications that may occur to the donor are not covered.

Travel services are paid for by the Plan under the following circumstances:

- The Covered Person or the non-covered living donor must live more than 50 miles from the transplant center.
  - The Plan will pay for the travel and housing up to the maximum listed on the Transplant Services Rider.
  - Expenses will be paid for the following individuals:
    - The Covered Person who lives more than 50 miles from the transplant center.
    - One or two parents of the Covered Person if the Covered Person is a Covered Dependent child.
    - An adult to accompany the Covered Person if the Covered Person is not a Covered Dependent child.
    - The non-covered living donor who lives more than 50 miles from the transplant center.

Covered travel and housing expenses include the following:

- Airfare.
- Tolls and parking fees.
- Gas/mileage.
- Lodging at or near the transplant center including:
  - Apartment rental.
  - Hotel rental.
  - Applicable taxes.
  - Meals

Lodging for purposes of this Plan does not include private residences. Lodging reimbursement that is greater than $50 per person per day, may be subject to IRS codes for taxable income.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

L. Physical Therapy, Occupational Therapy and Speech Therapy

The Plan covers office visits and outpatient physical therapy (PT), occupational therapy (OT) and speech therapy (ST) for Rehabilitative Care rendered to treat a medical condition, Sickness, or Injury. The Plan also covers outpatient PT, OT, and ST Habilitative Therapy for medically diagnosed conditions that have significantly limited the successful initiation of normal motor or speech development. PT, OT, and ST must be provided by or under the direct supervision of a licensed physical therapist, occupational therapist, or speech therapist for appropriate services within their scope of practice. OT and ST must be ordered by a Physician, physician assistant or a certified nurse practitioner. Coverage is limited to Rehabilitative Care or Habilitative Therapy that demonstrates measurable functional improvement within a reasonable period of time.

Digital Physical Therapy. You may be eligible to participate in the programs and services of Gravie's digital physical therapy partner at no additional cost. More information is available by contacting Customer Service.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

M. Prescription Drug Services

Coverage includes Prescription Drugs dispensed at a pharmacy.

Note: This section does not cover or provide benefits for oral, injectable, or Prescription Drugs and insertable devices that are Preventive Health Care Services described in the "Preventive Contraceptive Methods and Counseling for Women" section of this Schedule.

With the exception of contraceptive drugs for women, benefits for Specialty Drugs and/or injectable drugs, are as described in this section, regardless of the place of service where the Specialty Drug and/or injectable drug is dispensed or administered.

The Usual and Customary Amount for Prescription Drugs obtained from a Non-Participating Provider pharmacy is the cost of the generic equivalent of the Prescription Drug and the dispensing fee, or if a generic equivalent does not exist, the charge that the Plan Administrator determines is customary for such Prescription Drugs.

If you or your provider require that you need to take a brand name drug when there is an FDA-approved generic drug available then you are required to pay the brand name drug copayment PLUS the difference in priced between the brand name drug and the generic alternative. Many of our generic drugs are available at no cost; please consult the Formulary at www.gravie.com.

The difference in cost between the brand name drug and the generic will not apply to the Out-of-Pocket Limit, Deductible or to any Copayments or Coinsurance that you are responsible for. When you have reached the Out-of-Pocket Limit, you must still pay for the difference in the cost between the brand name and the generic drug.

Please see the Preventive Health Care Services section for coverage of Prescription Drugs, including certain insulin, on the Gravie Basic Formulary Preventive Drug list.

The Plan Administrator uses a drug Formulary to determine which Prescription Drugs, including their generic equivalents, are covered. The Formulary is the Gravie Basic Formulary. The Formulary is subject to periodic review and modification. For information, you may call Gravie at the phone number listed on the inside front cover of this Schedule or on the back of your ID card to locate retail pharmacies participating in the Retail/Maintenance Drug Pharmacy Network.

You may be required to take a 90-day supply of a maintenance medication. For a comprehensive list, please call Customer Service or look at the Maintenance List posted on www.gravie.com. You may contact Gravie at the phone number listed on the inside front cover of this Schedule or on the back of your ID card to locate retail pharmacies participating in the Retail/Maintenance Drug Pharmacy Network.

For certain medical conditions, there is a need to manage the use of specific drugs before alternative (second line) drugs are prescribed for the same medical condition. This is known as step therapy. Covered Persons in a step therapy program will need to meet the requirements of that program prior to receiving the second line drug. For information, you may call Gravie at the phone number listed on the inside front cover of this Schedule or on the back of your ID card. Step therapy can apply to Formulary or non-Formulary drugs and brand or generic drugs. The step therapy list is subject to periodic review and modification by the Plan.

Compounded Drugs will be covered only if obtained from a pharmacy that is Participating Provider provided that at least one active ingredient is a Prescription Drugs. Payment for a Compounded Drugs that has a commercially prepared product available that is identical to or similar to the Compounded Drugs will be considered for coverage after documented failure of the commercially prepared product(s). A commercially prepared product is one that is available at the pharmacy in its final, usable form and does not need to be compounded at the pharmacy. The applicable Benefit level will be applied. Compounded Drugs containing any product that is excluded by the Plan will not be covered including dosages and route of administration that have not been approved by the FDA. Compounded Drugs will be covered according to the Covered Person's pharmacy network Benefits.

Prescription Drugs covered as Preventive Health Care Services. The Plan covers certain prescription drugs which are required to be covered without cost-sharing as Preventive Health Care Services under the Affordable Care Act. The Plan's Formulary identifies these Prescription Drugs as being included in the "$0 Cost Share" tier and may be obtained by accessing the Gravie website or by calling Gravie. More information regarding Benefits for Prescription

Drugs that are Preventive Health Care Services can be found under the "Preventive Contraceptive Methods and Counseling for Women" and "Preventive Health Care Services" sections of this Schedule.

Biosimilar Drugs. If all of the following apply:

1. You or your Provider request a Specialty Drug that is a biological product licensed by the FDA under section 351(a) of the Public Health Service Act (PHS Act), and
2. The FDA has determined another biological product to be biosimilar to the Specialty Drug that has been requested by your Provider, and
3. The Plan Administrator has included such biosimilar product on its list of approved biosimilar drugs in relation to the Specialty Drug that has been requested by your Provider,

Then you must pay any applicable Out-of-Pocket Limit, Copayment, Deductible and Coinsurance for the Specialty Drug requested by your Provider plus the difference in cost between the Specialty Drug requested by your Provider and the biosimilar product that is on the Plan Administrator's list of approved biosimilar drugs.

Off-label use of drugs. Off-label use of drugs, provided that they are not Investigative, may be covered in either of the following circumstances:

1. A 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 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 health care services, off-label use of a drug must be Medically Necessary.

Prior authorization. Certain Prescription Drugs require pre-certification before you can have your prescription filled at the pharmacy. For information, you may call Gravie at the phone number listed on inside cover of this Schedule, on the back of your ID card, or by visiting www.gravie.com.

PrudentRx Solution for Specialty Medications. You may be eligible to participate in the CVS Caremark PrudentRx specialty medication copay assistance program if you are currently taking, or if you begin taking certain Specialty Drugs. This program will help you enroll in financial assistance programs offered by the manufacturer for your eligible Specialty Drug with the goal of helping you avoid most out-of-pocket expenses for your therapy.

Prescription Drug Exclusions:

- Compounded Drugs that are being used for bio-identical hormone replacement therapy, unless otherwise covered.
- Compounded drugs received from a Non-Participating Provider.
- Replacement of a Prescription Drug due to loss, damage, or theft.
- Prescription Drugs or OTC drugs in the same classification of drugs as the following:
  1. Non-Sedating Antihistamines (NSAs).

2. Non-steroidal Anti-Inflammatory drugs (NSAIDs).
3. H2 antagonists (H2As).
4. Proton Pump Inhibitors (PPIs).

- Over-the-counter drugs with or without a Physician's prescription, except as covered under this Schedule.
- Over-the-counter home testing products, except as covered under this Schedule.
- Drugs not approved by the FDA, drugs not approved by the FDA for a particular use (i.e. "off-label" use of drugs), except off-label use of drugs in accordance with the section entitled "Off-label use of drugs" or when the Plan Administrator, at its sole discretion, determines to include the drug on its Formulary or approves coverage of the drug for the particular use.
- Take home drugs when dispensed by a Physician.
- Weight loss drugs, including off-label use of drugs for weight loss unless in accordance with the section entitled "Off-label use of drugs."
- Prescription Drugs and over-the-counter drugs for tobacco cessation, except as covered as a Preventive Health Care Service.
- Drugs used for Cosmetic purposes.
- Unit dose packaging per request of the covered person.
- Prescription Drugs if purchased by mail order through a program not administered by the Plan's pharmacy vendor.
- Non-FDA approved mechanism of delivery (e.g., medication that is FDA approved for oral use, but is being applied topically).
- Drugs that are given or administered as part of a drug manufacturer's study.
- Off-label use of drugs, determined to be Investigative.
- Growth hormone therapy prescribed for children due to short stature only, or for adults with no documented significant deficiency of growth hormone.
- Oral, injectable and insertable contraceptives and contraceptive devices, except as covered as a Preventive Health Care Service in the Preventive Contraceptive Methods and Counseling for Women section of this Schedule.
- Specialty Drugs received from a Non-Participating Provider pharmacy.
- Prescribed or non-prescribed vitamins or minerals including over the counter, unless covered as Preventive Health Care Services.
- 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 section entitled "Off-label use of drugs."
- Cannabis/Marijuana, except medical cannabis/marijuana when provided by Providers licensed by applicable state law to sell medical cannabis/marijuana.
- Prescription Drugs and prescribed OTC drugs for tobacco cessation, except as covered under the Schedule.

N. Preventive Contraceptive Methods and Counseling for Women

The Plan covers preventive contraceptive methods and counseling services by female Covered Persons as described in the Preventive Health Care Services Schedule. The Schedule, which includes preventive contraceptive methods and counseling services for women provided by the Affordable Care Act, is available on the TPA's member website or by calling Customer Service.

This coverage includes the full range of Food and Drug Administration approved contraceptive methods for women with reproductive capacity, including women's contraceptive drugs, devices, and delivery methods obtained from a retail pharmacy, mail order pharmacy, or received at a Provider's office.

If you or your Provider request a brand name women's contraceptive that requires a prescription under applicable law when a generic alternative is available, you are required to pay the difference in cost between the brand name and the generic contraceptive, in addition to any applicable Copayments or Coinsurance.

The difference in cost between the brand name contraceptive and the generic will not apply to the Out-of-Pocket Limit, Deductible or to any Copayments or Coinsurance that you are responsible for. When you have reached the Out-of-Pocket Limit, you must still pay for the difference in the cost between the brand name and the generic contraceptive.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

O. Preventive Health Care Services

The Plan covers preventive services required by the Affordable Care Act. The Schedule may be amended, from time to time, on a prospective basis, and is available by contacting Customer Service.

Female Covered Persons may obtain annual preventive health examinations and prenatal screenings from obstetricians and gynecologists in the Participating Provider Network, without a referral from another Physician or prior approval from the Plan.

Child health supervision services includes pediatric preventive services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations, up to age 18. Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months.

Two designated tobacco cessation intervention program attempts are available per Covered Person per plan year, limited to four counseling sessions per attempt. Tobacco cessation Prescription Drugs and prescribed over the counter (OTC) medications when used in connection with or separate from designated tobacco cessation counseling program attempts, are limited to a maximum of 31-calendar days per prescription or refill per Covered Person and a total 93-calendar day supply per Covered Person per attempt for up to two attempts per Covered Person per plan year. For a complete list of covered medications, please visit www.gravie.com.

Routine Covered Services Required by the Affordable Care Act:

- Counseling for certain conditions. This includes, but is not limited to:
  - Breastfeeding support and counseling, with access to breastfeeding supplies.
  - Breast cancer genetic counseling (BRCA) for women at higher risk.
  - Sexually transmitted infection counseling.
  - Alcohol or drug misuse counseling.
- Routine immunizations. This includes, but is not limited to:
  - Flu (influenza).
  - Hepatitis A and B.
  - Human Papillomavirus (HPV).
  - Shingles.
- Routine screenings for certain cancers and certain other conditions. This includes, but is not limited to:
  - Colorectal cancer screening in adults ages 45 to 75 years.
  - Cholesterol screening for adults of certain ages or at a high risk.
  - Breast cancer screening (mammogram) for average-risk women.
  - Cervical cancer screening average-risk women aged 21 to 65 years.

Preventive Health Care Services that are in Addition to Those Required by the Affordable Care Act:

- Routine eye examination, limited to one exam per Covered Person per plan year.
- Routine hearing examination limited to one exam per Covered Person per plan year.
- Routine prenatal care services.
- One routine postnatal care exam that includes a health exam, assessment, education, and counseling provided during the period immediately after childbirth.

- 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.
- Prostate-specific antigen (PSA) blood tests and digital rectal examinations to screen for prostate cancer for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older.
- Blood pressure monitor for Covered Person diagnosed with hypertension.
- Peak flow meter for Covered Person diagnosed with asthma.
- Glucose meter for Covered Person diagnosed with diabetes. If you require a blood glucose meter as part of your treatment for diabetes, you may obtain a PREFERRED meter free of charge from CVS Caremark by visiting Caremark.com/ManagingDiabetes or calling the number on the back of your ID card.
- Retinopathy screening for Covered Person with diabetes.
- Hemoglobin A1c testing for Covered Person diagnosed with diabetes.
- International Normalized Ratio (INR) testing for Covered Person diagnosed with liver disease or bleeding disorders.
- Low-density Lipoprotein (LDL) testing for Covered Person diagnosed with heart disease.

Notes:

- For a list of prescribed preventive medications that are required under the Affordable Care Act, please refer to the Gravie Basic Formulary at the website located on the inside cover of this Schedule or by calling Customer Service. If you are taking a specialty medication that is also preventive, you must follow the terms of the PrudentRx Solution for specialty medications.
- Non-Preventive Health Care Services are not covered under this section of the Schedule.
- Non-routine Health Care Services, including but not limited to non-routine prenatal services, are not covered under this section of the Schedule.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

P. Reconstructive Surgery

The Plan covers Medically Necessary Reconstructive surgery due to Sickness, accident, or congenital anomaly that is incidental to or follows surgery resulting from injury, Sickness, or other diseases of the involved part, or when such surgery is performed on a Covered Dependent child because of a congenital disease or anomaly which has resulted in a functional defect as determined by the attending Physician. Eligible Charges include eligible Hospital, Physician, laboratory, pathology, radiology, and facility charges. Contact Customer Service to determine if a specific procedure is covered.

Reconstructive surgery following a mastectomy includes the following:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of mastectomy, including lymphedemas.

Health Care Services will be determined in consultation with you and the attending Physician. Such coverage will be subject to Copayments, Out of Pocket Limit, Deductible, Coinsurance, and other Plan provisions.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

Q. Skilled Nursing Facility Services

Coverage is limited to a maximum of 120 days per Covered Person per plan year.

The Plan covers the eligible Skilled Nursing Facility services for post-acute treatment and Rehabilitative Care of a Sickness or Injury. These services must be directed by a Physician and authorized in advance by the Plan

Administrator. Please follow the pre-certification procedure described in Section II., Benefits Summary, for the procedure you must follow.

Skilled Nursing Facility services include room and board, daily skilled nursing, and related services. The Plan Administrator determines when care no longer meets criteria for coverage.

The Plan covers a semi-private room. Benefits for a private room are available only when the private room is Medically Necessary for a Sickness or Injury or if it is the only option available at the admitted facility. If you choose a private room when it is not Medically Necessary, Plan payment toward the cost of the room shall be based on the average semi-private room rate in that facility. Only services that qualify as reimbursable under Medicare are eligible charges.

Note: Please see Section VI. Exclusions for a list of services that are not covered.

IV. Pre-certification Requirements

Pre-certification of Health Care Services does not guarantee either payment or the amount of payment. Eligibility for, and payment of, Benefits are subject to all of the terms of this Schedule. Please read the entire Schedule to determine which other provisions may also affect Benefits. The Utilization Management vendor only certifies that the Health Care Services are Medically Necessary.

Pre-certification Requirement: Pre-certification requires that you or your Provider request that certain Health Care Services be authorized as Medically Necessary in advance by your plan's Utilization Management vendor.

Pre-certification by the Utilization Management vendor is required for the following Health Care Services:

- All inpatient admissions including but not limited to Hospital, Skilled Nursing Facility, rehabilitation, and residential treatment facilities;
- Transplant Services, excluding cornea;
- Procedures that could be construed to be Cosmetic;
- The following high dollar outpatient diagnostic services:
  - PET
  - Capsule endoscopy
  - Genetic Testing (including BRCA)
  - Sleep Study
  - CT for non-orthopedic
  - MRI for non-orthopedic
- The following outpatient continuing care services:
  - Chemotherapy (including oral)
  - Radiation Therapy
  - Oncology and transplant related injections, infusions, and treatments (e.g. CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g. antiemetic and antihistamine)
  - Hyperbaric Oxygen
- Dialysis; and
- Durable Medical Equipment (DME), limited to electric/motorized scooters or wheelchairs and pneumatic compression devices exceeding $5,000;
- Home health care;
- Select outpatient surgeries that could be considered experimental or Investigational;
- Sexual dysfunction healthcare services; and
- Certain injections or infusions administered in an outpatient hospital, home infusion, or in a Provider's office.

The Plan reserves the right to deny a claim for services if pre-certification was not obtained.

If you have questions about pre-certification and when you are required to obtain it, please contact Gravie for assistance.

Certain Prescription Drugs may require prior authorization before you can have your prescription filled at the pharmacy. For information, you may call Gravie at the phone number listed on the inside front cover of this Schedule, on the back of your ID card, or search the Formulary linked at www.gravie.com.

Pre-Certification Procedure for Non-Acute Care Pre-Service Claims

Non-acute care pre-service Claims are Claims for non-acute care services that require pre-certification and are submitted in accordance with the pre-service Claim filing procedures for the Plan.

Filing Procedure for Non-Acute Care Pre-Service Claims. To request pre-certification and file a non-acute care pre-service Claim, a phone call must be made to the Utilization Management vendor at the telephone number shown on your id card and on the inside cover of this Schedule at least seven business days before the date services requiring pre-certification are provided and all essential data elements must be supplied. An expedited review is available if your attending Provider believes your medical condition warrants it. Please refer to the subsection below entitled "Essential Data Elements for Pre-Service Claims" for the list of essential data elements that are required to file a pre-service Claim. If you or your attending Provider have not submitted the request in accordance with these filing procedures, including a failure to submit all essential data elements, your request will be treated as incorrectly filed, and you will be notified within five calendar days. Please note that the time periods for making an initial Benefit determination begin when the Utilization Management vendor receives a pre-certification request submitted in accordance with the Plan's filing procedures.

If your attending Provider requests pre-certification on your behalf, the Provider will be treated as your authorized representative under the Plan for purposes of such request and the submission of your claim and associated appeals unless you provide the TPA with specific direction otherwise within three business days from the Plan Administrator's notification that an attending Provider was acting as your authorized representative. Your direction will apply to any remaining appeals.

A request or inquiry relating to the availability of Benefits or payment for future services that do not require pre-certification will not be treated as a Claim under the Plan.

Initial Benefit Determination of Non-Acute Care Pre-Service Claims. You and your attending Provider will be notified of the TPA's initial Benefit determination within 15 calendar days (or a shorter time period as required by applicable law) after receipt of a pre-certification request submitted in accordance with the Plan's filing procedures, provided the TPA has all necessary information needed to make an initial Benefit determination.

If the TPA does not have all information it needs to make an initial Benefit determination, or in other circumstances permitted by law, then it may extend the time period for making the initial Benefit determination by 15 calendar days (or a shorter time period as required by applicable law). The TPA will notify you of the extension and the time period to provide the requested information. If you do not provide the requested information within the time period specified, your Claim will be denied.

The initial Benefit determination may be made to your attending Provider by telephone.

If your pre-certification request is denied, written notification will be provided to you and your attending Provider. This notice will explain:

- Information sufficient to identify the Claim involved and any information required by law;
- The reason for the denial;
- The part of the Plan on which it is based;
- Any additional material or information needed to make the Claim acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

Expedited Pre-Certification Procedure for Acute Care Pre-Service Claims

Acute care services are services needed when a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of your attending Provider, could cause severe pain. An expedited initial Benefit determination will be made for Claims for services that require pre-certification and are submitted in accordance with the pre-service Claim filing procedures for the Plan, if your attending Provider believes your medical condition warrants acute care services.

Filing Procedure for Acute Care Pre-Service Claims. To request expedited pre-certification and file an acute care pre-service Claim, a phone call must be made to the Utilization Management vendor before the date services requiring pre-certification are provided and all essential data elements must be supplied. Please refer to the subsection below entitled "Essential Data Elements for Pre-Service Claims" for the list of essential data elements that are required to file a pre-service Claim. If you or your attending Provider have not submitted the request in accordance with these filing procedures, including a failure to submit all essential data elements, your request will be treated as incorrectly filed, and you will be notified within 24 hours. Please note that the time periods for making an expedited initial Benefit determination begin when the Utilization Management vendor receives a pre-certification request submitted in accordance with the Plan's filing procedures.

If your attending Provider requests pre-certification on your behalf, the Provider will be treated as your authorized representative under the Plan for purposes of such request and the submission of your Claim and associated appeals unless you provide the TPA with specific direction otherwise within three business days from the Plan Administrator's notification that an attending Provider was acting as your authorized representative. Your direction will apply to any remaining appeals.

A request or inquiry relating to the availability of Benefits or payment for future services that do not require pre-certification will not be treated as a Claim under the Plan.

Expedited Initial Benefit Determination of Acute Care Pre-Service Claims. An expedited initial Benefit determination will be provided by the TPA to you and your attending Provider as quickly as your medical condition requires, but no later than 72 hours (or such shorter time as required by applicable law) following receipt of a pre-certification request submitted in accordance with the Plan's filing procedures.

If the TPA does not have all information it needs to make an initial Benefit determination, you will be notified within 24 hours. You will then have 48 hours, or longer time as granted to you in the notification, to provide the requested information. If you do not provide the requested information within the time period specified, your request will be denied. You will be notified of the initial Benefit determination within 48 hours after the earlier of the TPA's receipt of the requested information or the end of the time period specified for you to provide the requested information.

The initial Benefit determination may be made to your attending Provider by telephone.

If your pre-certification request is denied, written notification will be provided to you and your attending Provider. This notice will explain:

- Information sufficient to identify the Claim involved and any information required by law;
- The reason for the denial;
- The part of the Plan on which it is based;
- Any additional material or information needed to make the Claim acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

Essential Data Elements for Pre-Service Claims (including Concurrent Care Claims)

You or your attending Provider must submit at least the following essential data elements when calling the Utilization Management vendor to request pre-certification and file a pre-service Claim (or requesting to extend a previously pre-certified treatment and file a concurrent care Claim):

- The identity of the Covered Person and Provider of services;
- The date(s) of services;

- A specific medical diagnosis; and
- A specific treatment, Health Care Service, or procedure code for which pre-certification approval (or extended treatment) is requested.

An explanation of these essential data elements will be provided to you, upon request and free of charge, by calling the Utilization Management vendor. If you or your attending Provider have not submitted the pre-certification (or extended treatment) request in accordance with the Plan's filing procedures for pre-service Claims, including a failure to submit all essential data elements, your request will be treated as incorrectly filed and you will be notified within applicable timeframes.

Procedure for Concurrent Care Claims

Filing Procedure for Concurrent Care Claims. If an ongoing course of treatment was pre-certified by the Plan Administrator for a specified period of time or number of treatments and you or your attending Provider request to extend acute care services, your extension request and concurrent care Claim must be submitted in accordance with the filing procedure for acute care pre-service Claims, as described above. If an ongoing course of treatment was pre-certified by the Plan Administrator for a specified period of time or number of treatments and you or your attending Provider request to extend non-acute care services, your extension request and concurrent care Claim must be submitted in accordance with the filing procedure for non-acute care pre-service Claims, as described above. If you or your attending Provider have not submitted the extension request in accordance with the Plan's filing procedures, including a failure to submit all essential data elements, your request will be treated as incorrectly filed and you will be notified within 24 hours in the case of a request to extend acute care services, and within five calendar days in the case of a request to extend non-acute care services. Please note that the time periods for making an initial Benefit determination begin when the Utilization Management vendor receives an extended treatment request submitted in accordance with the Plan's filing procedures.

If your attending Provider requests extended treatment on your behalf, the Provider will be treated as your authorized representative under the Plan for purposes of such request and the submission of your Claim and associated appeals unless you provide the TPA with specific direction otherwise within three business days from the Plan Administrator's notification that an attending Provider was acting as your authorized representative. Your direction will apply to any remaining appeals.

A request or inquiry relating to the availability of Benefits or payment for future services or extended treatments that do not require pre-certification will not be treated as a Claim under the Plan.

Initial Benefit Determination of Concurrent Claims. If an ongoing course of treatment was previously pre-certified for a specified period of time or number of treatments and you request to extend acute care services, the TPA will make the initial Benefit determination on your extended treatment request within 24 hours following receipt of a properly filed extended treatment request, provided your request is made at least 24 hours before the end of the approved treatment. If a properly filed request for extended treatment is not made at least 24 hours before the end of the approved treatment, your request will be treated as a pre-certification request for acute care services and handled in accordance with the expedited pre-certification procedures outlined above for such services.

If an ongoing course of treatment was previously pre-certified for a specified period of time or number of treatments and you request to extend non-acute care services, your request will be treated as a pre-certification request for non-acute care services and handled in accordance with the pre-certification procedures outlined above for such services.

The initial Benefit determination may be made to your attending Provider by telephone.

If your concurrent care Claim and extended treatment request is denied, written notification will be provided to you and your attending Provider. This notice will explain:
- Information sufficient to identify the Claim involved and any information required by law;
- The reason for the denial;
- The part of the Plan on which it is based;

- Any additional material or information needed to make the Claim acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

V. Additional Benefit Information

A. Provider Directory

You may find Participating Providers on the designated website listed on the inside cover of this Schedule. Coverage may vary according to your provider selection.

The list of Participating Providers frequently changes and the TPA does not guarantee that a listed Provider is a Participating Provider. You should verify that the Provider you choose is a Participating Provider by calling Customer Service at the telephone number listed on the inside cover of this Schedule. If you call Customer Service, the TPA will respond to you as soon as practicable but in no case later than 1 business day after your call is received, through a written electronic communication or, at your request, a hard copy communication.

If You called Customer Service, or used an Internet-based provider directory made available by the TPA to confirm that a Provider was a Participating Provider before you received certain Health Care Services from the Provider, but the Provider which furnished the Health Care Services after you received such information was a Non-Participating Provider:

Then the Plan:

(A) Shall not impose on you a cost-sharing amount (e.g. a Deductible or Copayment) for such Health Care Services furnished by the Non-Participating Provider that is greater than the cost-sharing amount that would apply had such Health Care Services been furnished by a Participating Provider; and

(B) Shall apply the Out-of-Pocket Maximum that would apply if such Health Care Services were furnished by a Participating Provider.

B. Case Management/Alternative Care

In cases where your condition is expected to be or is of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional who understands both medical procedures and health care coverage under the Plan.

Under certain conditions, the Plan Administrator will consider other care, services, supplies, reimbursement of expenses, or payments of your serious Sickness or Injury that would not normally be covered or would only be partially covered. The Plan Administrator and your Physician will determine whether any medical care, treatments, services, supplies, reimbursement of expenses or payments will be covered. Such care, treatment, services, supplies, reimbursable expenses, or payments provided will not be considered as setting any precedent or creating any future liability, with respect to you, or any other Covered Person.

Other care, treatments, services, or supplies must meet both of the following tests:

1. Be determined in advance by the Plan Administrator to be Medically Necessary and cost effective in meeting your long term or intensive care needs in connection with a catastrophic Sickness or Injury; and
2. The charges Incurred would not otherwise be payable or would be payable at a lesser percentage.

Alternative Care

If your attending health care professional advises you to consider alternative care for a Sickness or Injury that includes Health Care Services not covered under the contract, your attending health care professional should contact the Utilization Management Vendor who will contact the Plan Administrator. The Plan Administrator has

full discretionary authority to consider paying for such non-covered Health Care Services and may consider an alternative care plan if the Plan Administrator finds that:

1. The recommended alternative care offers a medical therapeutic value equal to or greater than the current treatment or confinement;
2. The current treatment or confinement is covered under this Schedule;
3. The current treatment or confinement may be changed without jeopardizing your health; and
4. The Health Care Services provided under the alternative care plan will be as cost effective as the Health Care Services provided under the current treatment or confinement plan.

The Plan Administrator will make each alternative care coverage determination on a case-by-case basis and no decision will set any precedent for future claims. Payment of benefits, if any, will be determined by the Plan Administrator.

Any alternative care decision must be approved by you, the attending health care professional, and the Plan Administrator before such alternative care begins.

C. Routine Patient Costs Associated with Clinical Trials

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 Health Care 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.

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.

D. Limited Access to Participating Providers

In the event that the Plan Administrator determines you are receiving Health Care Services, including Prescription Drugs, in a quantity or manner that might be harmful to your health, the Plan Administrator will notify you that your access to Participating Providers is limited. You will have 30 calendar days in which to select one participating Physician, Hospital, and pharmacy to coordinate your health care. If you do not select those Participating Providers within 30 calendar days, the Plan Administrator will choose for you.

Failure to receive Health Care Services through your selected Participating Providers will result in denial of coverage. If your condition requires care or treatment from other providers, you must obtain a written referral from your selected participating Physician.

E. Continuity of Care

1) If you are a continuing care patient and:
   a) The Plan Administrator's contract with the Participating Provider that is providing your continuing care terminates for any reason other than the Participating Provider's failure to meet applicable quality standards or fraud;

b) Your benefits under this Schedule for the Health Care Services (except Prescription Drugs) provided by the Participating Provider that is providing your continuing care terminate because of a change in the terms of the Plan Administrator contract with such Participating Provider.

2) Then:

a) The Plan Administrator will notify you of the applicable event described in (1) and your right to elect continued transitional care from such Non-Participating Provider (in the event of notice under (1)(A)) or such Participating Provider (in the event of notice under (1)(B));

b) The Plan Administrator will provide you with an opportunity to notify the Plan of your need for transitional care; and

c) The Plan Administrator will allow you to elect to continue to have benefits for transitional care provided under this Schedule, under the same terms and conditions as would have applied under this Schedule had the applicable termination not occurred, as long as such benefits are for the course of treatment provided by such Non-Participating Provider (in the event of notice under (1)(A)) or such Participating Provider (in the event of notice under (1)(B)) relating to your status as a continuing care patient during the period beginning on the date on which the notice in (2)(A) is provided and ending on the earlier of:

i. The 90-day period beginning on such date; or

ii. The date on which you are no longer a Continuing Care Patient of such Non-Participating Provider (in the event of notice under (1)(A)) or such Participating Provider (in the event of notice under (1)(B)).

3) Continuing care patients are defined as individuals who, with respect to a provider or facility, are at least one of the following:

1. Undergoing treatment from the provider or facility for a serious and complex condition, defined as:

a. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.

b. In the case of a chronic illness or condition, a condition that is:

i. Life-threatening, degenerative, potentially disabling, or congenital; and

ii. Requires specialized medical care over a prolonged period of time.

2. Undergoing a course of institutional or inpatient care from the provider or facility.

3. Scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery.

4. Pregnant and undergoing treatment for pregnancy from the provider or facility.

5. Terminally ill and receiving treatment for such illness from the provider or facility.

F. Transition of Care

If a covered person is under the care of a non-participating provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a Non-Participating Provider may be covered at the Participating Provider level of benefits for a limited period of time. The TPA will review and approve or deny such requests.

G. For Non-Emergency Services Received in a Participating Provider Facility from a Non-Participating Provider

If a Participating Provider arranges and/or performs Health Care Services for you at a Participating Provider facility, all related eligible non-facility charges from both Participating Providers and Non-Participating Providers, will be covered at the participating provider level of benefits as shown in this Schedule.

If a Non-Participating Provider arranges or performs Health Care Services for you at a Participating Provider Facility, all related eligible non-facility charges from any Non-Participating Providers will be covered at the Non-Participating Provider level of benefits as described in this Schedule. You will be responsible for any charges that may exceed the Usual and Customary Amount.

VI. Exclusions

The exclusions in this Section VI. apply to all Health Care Services.

Many exclusions are interrelated so please read this entire section.

The Plan will not cover charges Incurred for any of the following services:

- Non-Emergency ambulance service from Hospital to Hospital such as transfers and admission to Hospitals performed only for convenience.
- Health Care Services that the Plan Administrator determines are not Medically Necessary unless the specific terms of a Participating Provider's written agreement with the national network vendor applicable to the Plan precludes application of the exclusion.
- Routine maintenance chiropractic care.
- Blood, urine, or hair analysis related to chiropractic services.
- Performance of ultrasound, MRI, EMG, waveform and nuclear medicine diagnostic studies or other enhanced diagnostic imaging.
- Manipulation under anesthesia related to chiropractic services.
- Nutritional and food supplements, except as covered under this Schedule.
- Dental services covered under your dental plan.
- Preventive dental procedures.
- Health Care Services or dental services, orthodontia, and all associated expenses, except as stated in this section.
- Health Care Services or dental services for cracked or broken teeth that result from biting, chewing, disease, or decay.
- Dental implants.
- Health Care Services or dental services related to periodontal disease.
- Occlusal adjustment or occlusal equilibration.
- Treatment of bruxism.
- Any durable medical equipment or supplies not listed as eligible as determined by the Plan Administrator.
- Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage.
- Durable equipment necessary for the operation of equipment determined not to be eligible for coverage.
- Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use.
- Replacement or repair of items when damaged or destroyed by misuse, abuse, or carelessness, lost, or stolen.
- Duplicate or similar items.
- Hearing aids, devices to improve hearing and related fittings or Health Care Services.
- Communication aids or devices; equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication board, or computer or electronic assisted communication.
- Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges
  for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds.
- Vehicle/car or van modifications including, but not limited to, handbrakes, hydraulic lifts, and car carrier.
- Over-the-counter orthotics and appliances.
- Orthopedic shoes, except as covered under this Schedule.
- Other equipment and supplies, and oral nutritional and electrolyte substances that the Plan Administrator determines are not eligible for coverage.
- Charges for sales tax, mailing or delivery.
- Upgrades to or replacement of any items that are considered Eligible Charges and covered under this Schedule unless the item is no longer functional and is not repairable.
- Glucose meters, blood pressure monitors, and peak flow meters are not covered under this section of this Schedule. Please refer to the "Preventive Health Care Services" section of the Schedule for coverage of these items.
- Cochlear implants.
- Health Care Services or items for personal comfort or convenience.
- Non-Emergency Services received in an emergency room.

- Non-emergency Health Care Services performed directly in connection with the performance of a non-covered health care service.
- Non-Emergency Services received outside the United States.
- Health Care Services, Companion and home care services, unskilled nursing services, services provided by your family or a person who shares your legal residence.
- Health Care Services and other services provided as a substitute for a primary caregiver in the home.
- Health Care Services and other services that can be performed by a non-medical person or self-administered.
- Home health aides, unless determined to be Medically Necessary by the Plan Administrator.
- Health Care Services and other services provided in your home for convenience.
- Health Care Services and other services provided in your home due to lack of transportation.
- Custodial care.
- Health Care Services classified as home health services provided at any site other than your place of residence.
- Health Care Services and other services rendered by Providers unlicensed or not certified by the appropriate state regulatory agency.
- Services, seminars, or programs that are primarily educational in nature.
- Health education, except when:
  - Provided during an office visit for non-Preventive Health Care Services; or
  - It is counseling which is treated as a Preventive Health Care Service.
- Tobacco cessation intervention programs and services, except when covered as Preventive Health Care Services.
- Nutritional counseling, except when:
  - Provided during a confinement; or
  - Provided in a Physician's office, clinic system or Hospital setting:
    i. For the diagnosis and treatment of diabetes; or
    ii. To a Covered Person who has been diagnosed by a Physician with a chronic medical condition; or
    iii. As counseling that is treated as a Preventive Health Care Service.
- 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.
- 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 Preventive Health Care Services.
- Charges for duplicating and obtaining medical records from Non-Participating Providers, unless requested by the Plan Administrator.
- Genetic testing and associated Health Care Services, except as covered under this Schedule.
- Hypnosis and chelation therapy, except chelation therapy will be covered when Medically Necessary for the treatment of heavy metal poisoning.
- Non-prescribed over-the-counter contraceptives, including condoms, spermicides, and emergency contraceptives.
- Anesthesia and facility services related to sterilization procedures performed during other surgical procedures such as Cesarean section birth, gall bladder removal, and abdominal hernia repair are not covered under this section of this Schedule.
- Reversal of sterilization procedures.
- Private-duty nursing care, except:
  - Inpatient private-duty nursing care by a licensed nurse (R.N., L.P.N., or L.V.N.) when Medically Necessary and not Custodial in nature and the Hospital's Intensive Care Unit (ICU) is filled or the Hospital has no ICU, or
  - For a ventilator-dependent patient, up to 120 hours of services provided by a private-duty nurse or personal care assistant solely for the purpose of communication or interpretation for the patient.
- Travel, transportation, other than ambulance transportation, and/or living expenses.
- Orthoptics.
- Refractive surgery (e.g. Lasik) for ophthalmic conditions that are correctable by contacts or glasses.
- Health Care Services and associated expenses for gender reassignment, except when Medically Necessary.
- Autopsies.
- Treatment for compulsive gambling.
- Health Care Services to hold or confine a Covered Person under chemical influence when no Medically Necessary services are required, regardless of where the services are received (e.g. detoxification centers).
- Health Care Services including facility charges performed in a free-standing birth center unattached to a Hospital facility.
- Health Care Services for maternity labor and delivery in the home.
- Nutritional and food supplements, except as covered in this Schedule.

- Non-Preventive Health Care Services are not covered under this section of this Schedule.
- Routine foot care, unless required due to blindness, diabetes, or peripheral vascular disease.
- Treatment of cleft lip and cleft palate, except for such treatment of a Covered Dependent child if treatment is scheduled or started prior to the Covered Dependent child reaching age 19.
- Vision therapy/orthoptics.
- Health Care Services provided by an audiologist that are not provided in an office setting.
- Marital counseling, relationship counseling, family counseling except as otherwise covered in this Schedule, or other similar counseling or training services.
- Counseling, studies, Health Care Services, or confinements ordered by a court or law enforcement officer that are not determined to be Medically Necessary by the Plan Administrator.
- Biofeedback.
- Surgical treatments and procedures to treat one-sided deafness.
- Growth hormone therapy prescribed for children due to short stature only, or for adults with no documented significant deficiency of growth hormone.
- Contact lenses and their related fittings, except when prescribed as Medically Necessary for the treatment of keratoconus.
    - 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 licensed health care Providers; or e-mails, or facsimile transmissions between a licensed health care Provider and a patient.
    - Acupuncture.
    - Elective abortion, except in situations where the life of the mother would be endangered if the fetus is carried to full term.
    - Bariatric surgeries, including preoperative procedures, initial procedures, surgical revisions, and subsequent procedures.
    - Costs associated with Clinical Trials that are not Routine Patient Costs.
    - Health Care Services for Sickness or Injury sustained:
        - While engaging in or the attempt to engage in a felony act, whether or not the individual is formally charged or convicted of such an act. 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 alcoholism.
        - While voluntarily participating in a riot, insurrection, or civil disobedience.
        - While in a war or any act of war. "War" means declared or undeclared war and includes acts of terrorism.
- 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.
- The following Infertility services:
    - Treatment of male and female Infertility and associated Health Care Services, unless covered under your plan.
    - Artificially assisted technology such as, but not limited to, artificial insemination (AI) and intrauterine insemination (IUI).
    - In vitro fertilization, unless covered under your plan.
    - Gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures, unless covered under your plan.
    - Intracytoplasmic sperm injection (ICSI).
    - Sperm, ova or embryo acquisition, retrieval, or storage.
    - Reversal of voluntary sterilization.
    - Adoption costs.
- The following transplant services:
    - Health Care Services related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures that are Investigative for your condition.
    - Health Care Services related to non-human organ implants.
    - Health Care Services related to human organ transplants not specifically approved as Medically Necessary by the Plan Administrator.
    - 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 future covered services.
- Travel Services, except as covered under this Schedule.
- Health Care Services for or in connection with fetal tissue transplantation, except for non-investigative 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.

- In-person therapy visits provided in your home for convenience.
- Therapy for treatment of stuttering.
- Therapy for conditions that are self-correcting.
- Services which do not demonstrate measurable and sustainable improvement within two weeks to three months, depending on the physical and mental capacities of the individual.
- Voice training and voice therapy.
- Secretin infusion therapy.
- Sensory integration therapy when used for a reason other than the treatment of feeding disorders.
- Group therapy for PT, OT, and ST.
- Health Care Services for homeopathy and immunoaugmentative therapy.
- Recreational, Educational, or self-help therapy or items primarily Educational in nature or for vocation, comfort, convenience, or recreation. Recreational therapy is therapy provided solely for the purpose of recreation, including, but not limited to: a) physical therapy or occupational therapy to improve athletic ability, and b) braces or guards to prevent sports injuries.
- Vocational Rehabilitation.
- Massage therapy.
- Alternative therapies such as aromatherapy and reflexology.
- Health Care Services provided by massage therapists, doulas, and personal trainers.
- Health club memberships.
- Any Health Care Service performed during or in conjunction with an annual or periodic wellness exam that exceeds the services described in this section of the Schedule.
- Electronic cigarettes, e-cigarettes, personal vaporizers, and similar forms of nicotine delivery systems.
- Tobacco cessation intervention programs and Health Care Services, except as covered under the Schedule.
- Health Care Services related to surrogate pregnancy for a person who is not a Covered Person under this Schedule.
- Vision lenses, eyeglasses, frames, and their related fittings.
- Routine eye examinations, except as covered under this Schedule.
- Routine hearing examinations, except as covered under this Schedule.
- Any weight loss programs and related Health Care Services that are not otherwise covered as preventive health care services.
- Health Care Services and supplies not ordered by a Provider, such as but not limited to, cholesterol testing, glucose testing and mammograms unless specifically listed in the Plan's Schedule of Preventive Health Care Services or provided by a Participating Provider.
- Health Care Services to treat conditions that are cosmetic in nature.
- 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.
- Procedures that are generally Cosmetic, or for convenience or comfort reasons.
- 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.
- Private room, except when Medically Necessary or if it is the only option available at the admitted facility.
- Respite, rest or Custodial Care except as specifically described in this Schedule.
- Health Care Services received before coverage under this Plan begins or after your coverage under this Plan ends.
- Health Care Services that the Plan Administrator determines are Investigative and associated expenses unless the specific terms of a Participating Provider's written agreement with the national network vendor applicable to the Plan precludes application of the exclusion.
- Health Care Services not directly related to your care.
- Health Care Services ordered or rendered by Providers or para-professionals unlicensed by the appropriate state regulatory agency.

- Health Care Services not rendered in the most cost-efficient setting or manner appropriate for the condition based on medical standards and accepted practice parameters of the community or provided at a frequency other than that accepted by the medical community as medically appropriate.
- Charges for Health Care Services determined to be duplicate services by the Plan Administrator.
- Charges that exceed the Usual and Customary Amount for Health Care Services received from Non-Participating Providers, including Non-Participating Provider pharmacies.
- Health Care Services prohibited by law or regulation, or illegal under applicable laws.
- Charges for Health Care Services that are eligible for payment under any insurance policy, including auto insurance, or under a Workers' Compensation law, employer liability law or any similar law.
- Any Health Care 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.
- Health Care Services provided by providers who have not completed professional level education and licensure as determined by the Plan Administrator.
- Charges for medical services that are paid or payable under any auto insurance policy, which covers the Covered Person, or for which the Covered Person is required by law to enroll.
- 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.
- Health Care Services 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.
- Services provided to you if you also have other primary insurance coverage for those services and you do not provide the Plan with the necessary information to pursue coordination of benefits, as required under this Schedule.
- Costs, charges, fees, and other losses for non-Health Care Services.

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VII. Definitions of Capitalized Terms

Acute Care Facility	A facility that provides care to a covered person who is in the acute phase of a sickness or injury and who will have a stay of less than 30 calendar days.
Affordable Care Act	The federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance and regulations issued under these acts.
Ancillary Services	Subject to changes made by the U.S. Department of Health and Human Services, ancillary services are, with respect to a hospital or ambulatory surgical center, which is a participating provider: 1. health care services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and health care services provided by assistant surgeons, hospitalists, and intensivists; 2. diagnostic services (including radiology and laboratory services); and 3. health care services provided by a non-participating provider if there is no participating provider who can furnish such health care services at such hospital or ambulatory surgical center.
Benefits	The health care services covered under the Plan as approved by the Plan Administrator as covered services, as explained in this Schedule and any amendments.
Biofeedback	The technique of making unconscious or involuntary bodily processes (such as heartbeat or brain waves) perceptible to the senses in order to manipulate them by conscious mental control.
Claim	A request for benefits made by a covered person or the covered person's authorized representative in accordance with the procedures described in this Schedule. It includes pre-certification requests
Clinical Trial	A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The clinical trial must meet one of the following: 1. Federally funded clinical trial in which the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following: a. National Institutes of Health. b. Centers for Disease Control and Prevention. c. Agency for Health Care Research and Quality. d. Centers for Medicare & Medicaid Services. e. Cooperative group or center of any of the entities described in paragraphs a through d above or the Department of Defense or the Department of Veterans Affairs. f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants. g. If the clinical study or investigation is conducted by the Department of Veterans Affairs, Department of Defense, or the Department of Energy, has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and there has been an unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review. 2. A study or investigation conducted under an investigational new drug application reviewed by the FDA. 3. The study or investigation is a drug trial that is exempt from having an investigational new drug application.

Coinsurance	A portion of eligible charges from non-participating providers that is paid by you. Your coinsurance is a percentage of those eligible charges that are: 1) calculated at the time the claim is processed, 2) subject to the usual and customary amount or (3) the amount you must pay after satisfying your deductible for emergency services provided by a non-participating provider.
Compassionate Use	A method of providing experimental therapeutics prior to final FDA approval for use in humans. This procedure is used with very sick individuals who have no other treatment options. Often, case-by-case approval must be obtained from the FDA for compassionate use of a drug, device, or therapy.
Compounded Drugs	Customized medications prepared by a pharmacist from scratch using raw chemicals, powders, and devices according to a physician's specifications to meet your needs.
Confinement	An uninterrupted stay of 24 hours or more in a hospital, skilled nursing facility, rehabilitation facility, or residential treatment facility.
Copayment	The fixed amount of eligible charges you must pay to the provider for covered health care services received. The copayment may not exceed the charge billed for the covered health care service.
Cosmetic	Services, medications, and procedures that improve physical appearance but do not correct or improve a physiological function or are not medically necessary.
Covered Dependent	A covered employee's eligible dependent.
Covered Employee	The person: 1. On whose behalf contribution is paid; and 2. Whose employment is the basis for membership; and 3. Who is enrolled under the Plan.
Covered Person	A covered employee or covered dependent.
Covered Services	Health care services that are provided by your provider or clinic and are covered by the Plan, subject to all of the terms, conditions, limitations, and exclusions of the Plan.
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, such as assistance in walking, bathing, and eating.
Day Treatment Services	Any professional or health care services at a hospital or licensed treatment facility for the treatment of mental and substance use disorders.
Deductible	The amount of eligible charges that each covered person must incur in a Plan Year for health care services from providers before the Plan will pay benefits.
Designated Convenience Care Center	A health care clinic whose primary purpose is to provide immediate treatment for the diagnosis of minor conditions.
Educational	A health care service: 1. Whose primary purpose is to provide training in the activities of daily living, instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities; or 2. That is provided to promote development beyond any level of function previously demonstrated, except in the case of a child with congenital, developmental, or medical conditions that have significantly delayed speech or motor development as long as progress is being made towards functional goals set by the attending physician.
Eligible Charges	A charge for health care services, subject to all of the terms, conditions, limitations, and exclusions of the Plan for which the Plan or covered person will pay.
Emergency (Also Emergency Medical Condition)	See definition of emergency medical condition.

Emergency Department of a Hospital

A hospital outpatient department that provides emergency services.

Emergency Medical Condition (Also Emergency)

A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity, (including severe pain,) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Emergency Services

1. With respect to an emergency medical condition:
   a) A medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department, to evaluate such emergency medical condition; and
   b) Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

2. Inclusion of additional services:
   a) Unless each of the conditions described in subclause 2.b. are met, items and services:
      i. Which are covered services; and
      ii. That are furnished by a non-participating provider or non-participating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after you are stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in clause 1 are furnished.
   b) Conditions. If you are stabilized and furnished additional items and services described in subclause 2 after such stabilization by a provider or facility described in subclause 2, the conditions are the following:
      i. Such provider or facility determines you are able to travel using nonmedical transportation or nonemergency medical transportation.
      ii. Such provider furnishing such additional items and services satisfies the notice and consent criteria required by federal law with respect to such items and services.
      iii. You are in a condition to receive the information provided in the notice and to provide informed consent, in accordance with applicable federal and state law.
      iv. Any other conditions required by law, such as conditions relating to coordinating care transitions to participating providers and facilities.

Fee Schedule

The amount that the participating provider has contractually agreed to accept as reimbursement in full for covered services. This amount may be less than the provider's usual charge for the health care service.

If health care services are delivered to you via telehealth and/or virtual visit by a distant site participating provider who is **not** a designated participating provider for telemedicine, the Plan will reimburse such participating provider on the same basis and using the same fee schedule as would apply if the covered services had been delivered in person by the distant site participating provider.

Formulary

A list, which may change from time to time, of preferential prescription drugs that is used by the Plan.

Gravie	Gravie Administrative Services, which is a third-party administrator (TPA) providing administrative services to your Employer in connection with the operation of the Plan.
Habilitative Therapy	Therapy provided to develop initial functional levels of movement, strength, daily activity, or speech.
Health Care Service(s)	Medical or behavioral services including pharmaceuticals, devices, technologies, tests, treatments, therapies, supplies, procedures, hospitalizations, or provider visits.
Homebound	When you are unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute homebound status.
Hospital	A facility that provides diagnostic, medical, therapeutic, and surgical services by or under the direction of physicians and with 24-hour registered nursing services. The hospital is not mainly a place for rest or custodial care and is not a nursing home or similar facility.
Incurred	Health care services rendered to you shall be considered to have been incurred at the time or date the health care service was actually purchased or provided.
Infertility	Inability to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination: 1. One year, if you are a female under age 35 or a male of any age, or 2. Six months, if you are a female age 35 or older, provided that your infertility is not related to voluntary sterilization or failed reversal of voluntary sterilization.
Injury	Bodily damage other than sickness including all related conditions and recurrent symptoms.
Investigative	As determined by the Plan Administrator, a drug, device or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The Plan Administrator 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.
Medically Necessary	Any health care services, preventive health care services, and other preventive services that the Plan Administrator, in its discretion and on a case-by-case basis, determines are appropriate and necessary in terms of type, frequency, level, setting, and duration, for your diagnosis or condition; and the care must: 1. Be consistent with the medical standards and generally accepted practice parameters of providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; 2. Help restore or maintain your health; 3. Prevent deterioration of your condition; 4. Prevent the reasonably likely onset of a health problem or detect an incipient problem.

Non-Designated Transplant Network Provider	A transplant provider that is not contracted with or through the TPA to provide organ or bone marrow transplant or stem cell support and any related services and aftercare. A non-designated transplant network provider may be either a participating provider or a non-participating provider.
Non-Participating Provider	1. A physician or other health care provider who, when providing health care services, is acting within the scope of practice of that provider's license or certification under applicable State law; or 2. A facility, like a clinic or hospital; That is not a participating provider.
Out-of-Network Rate	The term 'out-of-network rate' means, with respect to emergency services provided by a non-participating provider: 1. Subject to clause (iii), the amount determined in accordance with any state law in effect in the state where such emergency services were provided; 2. Subject to clause (iii), if no such state law which would determine the amount under clause (i) is in effect: i. Subject to subclause 2(b), the amount agreed to by the TPA and the non-participating provider; or ii. If the TPA and the non-participating provider enter the independent dispute resolution (IDR) process under the No Surprises Act and do not agree on an amount before a certified IDR entity makes a determination on the amount to be paid to the non-participating provider, then the amount determined by the certified IDR entity; or 3. In the case the state has an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the state approves under such All-Payer Model Agreement for such emergency services provided by the non-participating provider.
Out-of-Pocket Limit	The maximum amount of money you must pay for health care services from participating providers before this Plan pays your eligible charges at 100%. If you reach benefit, day, or visit maximums, you are responsible for amounts that exceed the out-of-pocket limit. Expenses you pay for copayments will apply to the out-of-pocket limit.
Participating Provider	1. A physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law; or 2. A facility, like a hospital or clinic: That is directly contracted to participate in the specific TPA participating provider network designated by Plan Administrator to provide benefits to covered persons enrolled in this Plan. The participating status of providers may change from time to time. Participating providers may also be offered from other Preferred Provider Organizations that have contracted with TPA.
Physician	A licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), or Doctor of Chiropractic (D.C.).
Plan	The North Conejos School District RE1-J Group Health Plan, as amended from time to time.
Plan Administrator	North Conejos School District RE1-J. The Plan Administrator retains ultimate authority for this Plan including final appeal determinations. The Plan Administrator is also the Named Fiduciary for purposes of ERISA.
Plan Year	The period following the effective date of the Plan and each subsequent 12-month period this Plan remains in force.

Prescription Drug	A drug approved by the FDA for use only as prescribed by a provider properly authorized to prescribe that drug
Preventive Health Care Services	The covered services that are listed and covered in this Schedule as shown under the Preventive Health Care Services and/or Preventive Contraceptive Methods and Counseling for Women sections of the Benefit Schedule. To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following: 1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations (USPSTF). 2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention. 3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA). 4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).
Provider	A health care professional, physician, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide health care services to you.
Qualifying Payment Amount	The calculation for this amount is to be determined in accordance with the applicable federal regulation. Call Customer Service for further information.
Recognized Amount	With respect to an item or service furnished by a non-participating provider, except for non-participating air ambulance services: 1. Subject to clause (iii), in the case of such item or service furnished in a state that has in effect a law that determines the amount to be paid for such item or service; 2. Subject to clause (iii), in the case of such item or service furnished in a state that does not have in effect such a state law, the amount that is the qualifying payment amount; or 3. In the case of such item or service furnished in a state with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the state approves under such system for such item or service.
Reconstructive	Medically necessary surgery to restore or correct: 1. A defective body part when such defect is incidental to or resulting from injury, sickness, or prior surgery of the involved body part; or 2. A covered dependent child's congenital disease or anomaly which has resulted in a functional defect as determined by a physician.
Rehabilitative Care	Skilled restorative service that is rendered for the purpose of maintaining and improving functional abilities, within a predictable period of time, (generally within a period of six months) to meet your maximum potential ability to perform functional daily living activities. Not considered rehabilitative care are: skilled nursing facility care; home health services; chiropractic services, speech, physical and occupational therapy services for chronic medical conditions, or long-term disabilities, where progress toward such functional ability maintenance and improvement is not anticipated.
Residential Treatment Facility	A facility that is licensed by the appropriate state agency and provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, or treatment for sickness related to mental health and substance use related disorders.

Routine Patient Costs	The cost of any covered services that would typically be covered if you were not enrolled in an approved clinical trial. Routine patient costs do not include: 1. The cost of the investigational item, device, or health care service that is the subject of the approved clinical trial. 2. Items and health care services provided solely to satisfy data collection and analysis needs and not used in direct clinical management. 3. A health care service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
Sickness	Presence of a physical or mental illness or disease.
Skilled Care	Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to provide care or assess your changing condition. Long-term dependence on respiratory support equipment does not in and of itself define a need for skilled care.
Skilled Nursing Facility	A Medicare licensed bed or facility (including an extended care facility, a long-term acute care facility, a hospital swing-bed, and a transitional care unit) that provides skilled care.
Specialist	Providers other than those practicing in the areas of family practice, general practice, internal medicine, OB/GYN or pediatrics.
Specialty Drugs	Injectable and non-injectable prescription drugs, as determined by the Plan Administrator, which have one or more of the following key characteristics: 1. Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes; 2. Intensive patient training and compliance assistance are required to facilitate therapeutic goals; 3. There is limited or exclusive product availability and/or distribution; 4. There are specialized product handling and/or administration requirements; or 5. Are produced by living organisms or their products.
Stabilize, To	With respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency condition involving a pregnant woman who is having contractions, to deliver (including the placenta).
Third Party Administrator (TPA)	Gravie Administrative Services.
Telemedicine	Care provided by designated participating providers performed without physical face to face interaction, but through electronic (including telephonic) communication allowing evaluation, assessment and the management of health care services that leads to a treatment plan provided by a participating provider who is a licensed physician or a participating provider who is a qualified licensed health care professional. A list of telemedicine participating providers may be obtained by calling Customer Service or by checking the Gravie website at https://member.gravie.com. For purposes of this , a participating provider who contracts to be a designated telemedicine care participating provider shall not be treated or construed as performing telehealth and/or virtual visit at a distant site.
Transplant Services	Transplantation (including retransplants) of the human organs or tissue, including all related post-surgical treatment and drugs and multiple transplants for related care.
Urgent Care Center	A health care facility whose primary purpose is to offer and provide immediate, short-term medical care for minor immediate medical conditions not on a regular or routine basis.
Usual and Customary Amount	The average amount for each covered service or supply that by discretion of the Plan Administrator is customary in the geographic area in which the health care service is provided.

Vocational Rehabilitation	Health care services for a covered person designed to obtain or regain skills or abilities beyond those activities of daily living, including but not limited to, a device or an enhanced device or service requested or needed to enable the covered person to perform activities for an occupation.

COLORADO STATE-SPECIFIC BENEFIT ADDENDUM

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A. INTRODUCTION

This Addendum supplements your Summary Plan Description (SPD) and Schedule of Benefits (SOB). Please keep this Addendum with your SPD and SOB for future reference as it contains additional benefits and other important information available under your Plan.

B. BENEFIT MANDATE CHART

In addition to the information in the Summary Plan Description, the following information applies:

Benefit Section	Covered Service and Description
Dental Services	**Treatment of Cleft Lip and Cleft Palate for a Covered Dependent Child.** There shall be no age limit on benefits for newborn children born with cleft lip or cleft palate or both. Medically Necessary treatment includes oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; Medically Necessary orthodontic treatment; Medically Necessary prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment.
Dental Services	**Medically Necessary Hospitalization for Dental Care**. Eligible Charges are those Incurred by a Covered Person who, in the opinion of the treating dentist, at least one of the following criteria is met for a dependent child under age nineteen: (1) has a physical, mental, or medically compromising condition; (2) has a medical condition, such as extensive orofacial and dental trauma unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment; (3) has dental needs for which local anesthesia is ineffective due to an acute infection, anatomic variation, or allergy; or (4) is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a Physician, dentist, or dental Specialist.
Durable Medical Equipment (DME), Services, and Prosthetics; Hospital Services; Office Visits	**Hearing Aids.** Hearing aids for a minor child Covered Person for hearing loss that has been verified by a Physician and an audiologist. Coverage includes: a. Initial hearing aids and replacement hearing aids not more frequently than every five years; b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.
Durable Medical Equipment (DME), Services, and Prosthetics; Hospital Services; Office Visits	**Phenylketonuria (PKU).** Testing for Phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency. Medical foods, for the purpose of this benefit, refer exclusively to prescription metabolic

	formulas and their modular counterparts, obtained through a pharmacy. Medical foods are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects. Coverage for inherited enzymic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not be limited to the following diagnosed conditions: • Phenylketonuria; • Maternal Phenylketonuria; • Maple Syrup Urine Disease; • Tyrosinemia; • Homocystinuria; • Histidinemia; • Urea Cycle Disorders; • Hyperlysinemia; • Glutaric Acidemias; • Methylmalonic Academia; and • Propionic Academia. Covered care and treatment of such conditions shall include, to the extent medically appropriate, medical foods for home use for which a participating Physician has issued a written, oral, or electronic prescription. The maximum age to receive this benefit is 21, except that the maximum age for women who are of child-bearing age is 35.
Physical Therapy, Occupational Therapy and Speech Therapy	**Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder (ASD).** Treatment for applied behavior analysis for the treatment of autism spectrum disorder (ASD) is covered. Coverage includes: • Evaluation and assessment services; • Behavior training and management; • Habilitative or rehabilitative care, which includes speech, occupational, and physical therapies. Speech, occupation, and physical therapies may exceed 20 visits if deemed medically necessary; • Pharmacy and medication if covered by the individual's health plan; • Psychiatric care; • Psychological care, including family counseling; and • Therapeutic care, which includes speech, occupational, and applied behavioral analytic physical therapies. Any treatment for ASD must be deemed Medically Necessary.
Physical Therapy, Occupational Therapy and Speech Therapy	**Congenital Defects and Birth Abnormalities.** The Plan provides coverage for Medically Necessary treatment and care of medically diagnosed congenital defects and birth abnormalities for the first 31 days of the newborn's life. After the first 31 days of life, the Plan will provide Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a Covered Dependent child from the child's third birthday to the child's sixth birthday.
Prescription Drug Services	**Eye Drop Refills.** Additional bottles of prescription eye drops, if requested at the time the original prescription is filled, and the prescription states that an additional bottle is needed for use in a day care center, school, or adult day program, is limited to one every three months. Coverage for a renewal of the original prescription if the prescription states that additional quantities are needed and the renewal does not exceed the number of additional quantities needed, and is requested a number of days after receipt of the original prescription or latest renewal, as follows:

	• 21 days for a 30-day supply; • 42 days for a 60-day supply; or • 63 days for a 90-day supply.
Prescription Drug Services	**Oral Cancer Chemotherapy.** The Plan will not require a higher Copayment or Coinsurance amount for an anticancer Prescription Drug determined to be Medically Necessary to kill or slow the growth of cancerous cells that is orally administered than for an anticancer Prescription Drug that is injected or intravenously administered as long as it is not prescribed for the convenience of the Covered Person or Physician.

C. APPEALS PROCESS

Internal Appeals Process

The internal review process for an appeal of a Claim that is wholly or partially denied and for a rescission (retroactive termination) of your coverage, as defined by the Affordable Care Act, is:

1. **Acute Care Services Appeals**

   If your request for pre-certification of acute care services is wholly or partially denied and you have not received such services or if you are currently receiving acute care services and the continuation of these services is wholly or partially denied, you or your authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that your request was denied. Your appeal can be submitted to the TPA in writing, by telephone, or electronically, along with any issues, comments, and additional information, as appropriate. The TPA will forward your appeal to the Plan Administrator for its decision.

   As quickly as your medical condition requires, but no later than 72 hours of receipt of your appeal by the Plan Administrator, you will receive notice of the Plan Administrator's decision, including the specific reasons for it and references to the part of the Plan on which it is based, and the procedure for requesting an external review. This time period may be extended if you agree.

2. **Non-Acute Care Services Appeals**

   a. **First Appeal**. If your request for pre-certification of non-acute care services is wholly or partially denied and you have not received such non-acute care services or if you are currently receiving non-acute care services and a request for the continuation of these services is wholly or partially denied, you or your authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that your request is denied. Your appeal can be submitted to the TPA in writing, along with any issues, comments, and additional information, as appropriate.

      Within 15 calendar days after your written first appeal is received by the TPA, you will receive notice of the TPA's decision, including the specific reasons for it, references to the part of the Plan on which it is based, and the procedure for requesting a second appeal from the Plan Administrator. This time period may be extended if you agree subject to applicable law.

      Second Appeal. Within 60 calendar days after receiving a notice that your first appeal was denied, you or your authorized representative may submit a second appeal. Your second appeal can be submitted to the TPA in writing, along with any issues, comments, and additional information, as appropriate.

      Within 15 calendar days after your written second appeal is received by the Plan Administrator, you will receive notice of the Plan Administrator's decision, including the specific reasons for it and references to

the part of the Plan on which it is based, and the procedure for requesting an external review. This time period may be extended if you agree subject to applicable law.

3. **Concurrent Care Claims**

If your concurrent care Claim for Benefits is wholly or partially denied, you or your authorized representative may submit an appeal to the TPA on the same basis as described above. Acute concurrent care Claim appeal requests should be submitted to the TPA, and will be processed, the same as acute care services appeals above. Non-acute concurrent care Claim appeal requests should be submitted to the TPA, and will be processed, the same as non-acute care services appeals above.

4. **Post-Service Appeals**

a. **First Appeal**. If your post-service Claim for Benefits is wholly or partially denied, you or your authorized representative may submit an appeal within 180 calendar days after receiving notice that your Claim is denied. Your appeal can be submitted to the TPA in writing, along with any issues, comments, and additional information as appropriate.

Within 30 calendar days after your written first appeal is received by the TPA, you will receive notice of the TPA's decision, including the specific reasons for it and references to the part of the Plan on which it is based, and the procedure for requesting a second appeal from the Plan Administrator. This time period may be extended if you agree.

Second Appeal. Within 60 calendar days after receiving a notice that your first appeal was denied, you or your authorized representative may submit a second appeal. Your second appeal can be submitted to the TPA in writing along with any issues, comments, and additional information, as appropriate.

Within 30 calendar days after your written second appeal is received by the Plan Administrator, you will receive notice of the Plan Administrator's decision, including the specific reasons for it and references to the part of the Plan on which it is based. This time period may be extended if you agree.

5. **Access to Relevant Documents**

Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your appeal. If the Plan Administrator or the TPA generates, relies upon, or considers any new or additional evidence in connection with an appeal, or identifies any new or additional rationale for a denial in connection with an appeal, it will be provided to you so that you have a reasonable opportunity to respond. You have the right to present written evidence and testimony as part of the appeals process.

External Review Process

External Review Process

If you or someone acting on your behalf has exhausted at least one the Plan Administrator's internal appeals levels, you or your authorized representative may file a request for external review with the TPA. The TPA will contact the Colorado Division of Insurance, who will inform the TPA of the name of the independent external review entity to which the request should be sent. There is no cost to file an external review. You are deemed to have exhausted the internal appeals process if the Plan Administrator waives the exhaustion requirement, the Plan Administrator fails to substantially comply with the requirements of this section, or you request and expedited external review at the same time you qualify for and request an acute care service appeal.

If you want an external review, you must request it within four months after the date of the Plan Administrator's denial determination. Cases involving Medical Necessity, appropriateness, health care setting, level of care, or effectiveness are eligible for external review. When filing a request for external review, you may be required to authorize the release of your medical records to may be required to be reviewed for the purpose of reaching a decision on your request for external review.

The independent external review entity shall submit the expert determination to the carrier, the individual requesting independent external review, and the physician or other health care professional of the individual requesting an independent external review within 45 calendar days after the independent external review entity has received a request for external review. In the case of an expedited review, the independent external review entity shall submit the determinations as expeditiously as possible and no more than 72 hours after the independent external review entity received a request for an expedited external review. If the notice of the determination in an expedited review is not made in writing, the independent external review entity shall provide written confirmation of the decision within 48 hours after the date the notice of decision is transmitted to the individual, the physician, or other health care professional.

You or someone acting on your behalf may file a complaint with the Division of Insurance at any time. You may reach the Colorado Division of Insurance at:

1560 Broadway, Suite 850
Denver, CO 80202
303-894-7499 or 800-930-3745
Email: dora_insurance@state.co.us

D. SUBROGATION

Subrogation

For the purposes of this section in accordance with CO Code §§ 10-1-135, subrogation is permitted if you have first been fully compensated for all damages arising out of the claim.

1. If you make a recovery of an amount that is less than the total amount of coverage available under any third-party liability insurance policy or uninsured or underinsured motorist coverage, there is a rebuttable presumption you have been fully compensated.

2. If you make a recovery of an amount equal to the total amount of coverage available under all third-party liability insurance policies and uninsured or underinsured motorist coverages, there is a rebuttable presumption that you have not been fully compensated.

3. If you obtain a judgement, the amount of the judgement is presumed to be the amount necessary to fully compensate you.

4. The Plan's right to recover its subrogation interest shall be reduced by an amount equal to the proportionate share of the attorney fees and expenses you pay in obtaining your recovery unless the Plan is separately represented by an attorney.

5. If the Plan is separately represented by an attorney, the attorney representing the Plan and the attorney representing the Covered Person may enter into an agreement regarding allocation of costs and reasonable attorney fees. If the Plan and the Covered Person cannot reach agreement on allocation, Plan and the Covered Person shall submit the matter to binding arbitration.

Notice Requirement

You must provide notice to the Plan Sponsor within 60 days if your recovery is less than the sum of all damages incurred by you and you feel you have not been fully compensated. The notice shall include:

- The total amount and source of the recovery.
- The coverage limits applicable to any available insurance policy, contract, or benefit plan.
- The amount of any costs charged to you.

If the recovery was obtained through a settlement agreement that contains a confidentiality provision that affect the requirements above, the confidentiality provision is unenforceable as to the disclosure of the required information. Any disputes regarding the recovery being less than the sum of all damages incurred by you will be resolved by arbitration.

If you have not pursued a claim against a third party allegedly at faults for your injuries by the date that is 60 days prior to the date on which the statute of limitations applicable to your claim expires, the Plan may bring a direct action for subrogation against the at-fault party.

Reimbursement Rights

You agree to hold in constructive trust the proceeds of any settlement or judgment for the Plan's and the Plan Administrator's benefit under this Section. If you fail to reimburse the Plan out of any recovery or reimbursement received for all benefits paid or to be paid as a result of your sickness or injury, you will be liable for any and all expenses, whether fees or costs, associated with the Plan's, the Plan Administrator's, the TPA's and their designees' attempts to recover such money from you.

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ANNUAL COMPLIANCE NOTICES
2024

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A. Summary of Benefits and Coverage (SBC)

As required by the Patient Protection and Affordable Care Act (ACA), the SBC is an informational summary of your benefits and coverage under the SPD, including coverage examples, that is prepared in a uniform style. If there is a conflict between the SPD and the SBC, the SPD governs and the TPA will administer your coverage in accordance with the SPD.

B. Privacy

This Plan is subject to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule. In accordance with the HIPAA Privacy Rules, the Plan and the TPA acting on the Plan's behalf, maintains, uses, or discloses your Protected Health Information for purposes such as claims processing, utilization review, quality assessment, case management and otherwise as necessary to administer the Plan or as may be required or permitted by law. You can obtain a copy of the Plan's Notice of Privacy Practices (which summarizes the Plan's HIPAA Privacy Rule obligations, your HIPAA Privacy Rule rights and how the Plan may use or disclose health information protected by the HIPAA Privacy Rule) from the Plan Administrator.

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Rule, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals participating in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified within the meaning of the Privacy Rule, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use Protected Health Information (PHI), including electronic Protected Health Information (ePHI) for Plan Administration functions, as defined below, the Plan Sponsor agrees to the following provisions, which are more fully described in the Plan's Notice of Privacy Practices, distributed to Covered Persons upon enrollment and available upon request from the Plan Administrator:

a) Not use or further disclose PHI other than as permitted or required by this document or as required by law (as defined by the Privacy Rule);

b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan or the Plan Administrator on behalf of the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

c) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization that meets the requirements of the Privacy Rule;

d) Report to the Plan any PHI use or disclosure that is inconsistent with the permitted uses or disclosures of which the Plan Sponsor becomes aware;

e) Make available PHI for access to PHI requests in accordance with Section 164.524 of the Privacy Rule (45 CFR § 164.524);

f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Rule (45 CFR § 164.526);

g) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Rule (45 CFR § 164.528);

h) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan, or the Plan Administrator on behalf of the Plan, available to the Secretary of the US Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Rule (45 CFR § 164.500 et seq.);

i) If feasible, return or destroy all PHI received from the Plan, or the Plan Administrator on behalf of the Plan, that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the 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

j) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Rule (45 CFR § 164.504(f)(2)(iii)), is established as follows:

i. The following employees, or classes of employees, or other persons under control of the Plan Sponsor shall be given access to the PHI to be disclosed:

- Those individuals identified in the Plan Sponsor's HIPAA Policies and Procedures and in Exhibit A of Gravie's Plan Sponsor Certification form.

ii. The access to and use of PHI by the individuals described previously shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

iii. If any of the individuals described previously do not comply with the provisions of the Plan Document (as amended) relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Plan Sponsor further agrees that it will undertake the following requirements with respect to ePHI (terms used that are not otherwise defined herein will have the meaning attributed to them under the Standards for Security Standards for the Protection of Electronic Protected Health Information, Title 45, Parts 160 and 164, Subpart C, of the Code of Federal Regulations, promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91):

a. Implement adequate administrative, physical, and technical safeguards that will reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.

b. Ensure that the adequate separation described above between the Plan and the Plan Sponsor in its capacity as other than the Plan Administrator is supported by reasonable and appropriate security measures.

c. Ensure that any agent, including a subcontractor, to whom it provides e-PHI received from the Plan agrees to implement reasonable and appropriate security measures to protect the e-PHI.

d. Report to the Plan any material Security Incident of which it becomes aware not already known by the Plan.

"Plan Administration" functions are defined as activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. "Plan Administration" functions do not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan, or the Plan Administrator on behalf of the Plan, shall disclose PHI to the Plan Sponsor only upon receipt of a written certification by the Plan Sponsor that (a) the Plan Document contains the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Rule (45 CFR § 164.504(f)(1)(iii)), the Plan, the Plan Administrator on behalf of the Plan may disclose to the Plan Sponsor information about whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator, or Gravie to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to claims for benefits under the Plan. Such disclosures shall be made in accordance with the Privacy Rule.

5. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Rule.

C. Statement of Rights Under the 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 Plan because of the Women's Health and Cancer Rights Act of 1998 (WHCRA) and state law. 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.

Such coverage may be provided subject to the same annual deductibles and coinsurance and other Plan provisions as may be deemed appropriate and as are consistent with those established for other medical and surgical benefits under the Plan. Please refer to your Summary of Benefits for a full description of coverage under the Plan.

D. Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal and state law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the group health plan or health issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans or health issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or health issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification as described in the pre-certification provisions of the Benefit Schedule.

E. Family and Medical Leave Act (FMLA)

If you are absent from work due to an approved family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), coverage may be continued for the duration of the approved leave of absence as if there was no

interruption in employment. Such coverage will continue until the earlier of the expiration of such leave or the date you notify the Employer that you do not intend to return to work. You are responsible for all required contributions.

If you do not return after an approved leave of absence, coverage may be continued under the "COBRA Continuation Coverage" section, provided that you elect to continue under that provision. If you return to work immediately following your approved FMLA leave, no new waiting periods will apply.

FMLA applies to employees of a covered employer that work at a worksite within 75 miles of where that employer employs at least 50 employees.

F. 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. 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. This includes the covered employee's share and any portion previously paid by the Employer.

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 their 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.

G. 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:

1. A dependent child, under the plan's or coverage's terms, of a participant or beneficiary in the plan or coverage.
2. Was enrolled in the plan or coverage, on the basis of being a student at a postsecondary educational institution, immediately before the first day of the Medically Necessary Leave of Absence involved.

H. Qualified Medical Child Support Order (QMCSO) / National Medical Support Notice (NMSN)

With respect to the component benefit programs, 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), 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 has procedures for determining whether an order qualifies as a QMSCO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

I. COBRA Continuation Coverage

NOTE: The Consolidated Omnibus Budget Reconciliation Act (COBRA) generally requires employers with 20 or more employees who sponsor group health plans to offer employees, their spouses, and their dependents a

temporary period of continued health care coverage if they lose coverage through the employer's plan. State COBRA laws may apply to businesses with less than 20 full-time employees.

The covered employee, the covered spouse and covered dependent children may continue coverage under the Plan when a qualifying event occurs. You may elect COBRA for yourself regardless of whether the covered employee or other eligible dependents in your family elect COBRA. A covered employee and a covered spouse may elect COBRA on behalf of each other and/or their covered dependent children. If a loss of coverage qualifying event occurs:

1. In certain cases, the covered employee may continue his or her coverage and may also continue coverage for his or her covered spouse, covered dependent children, domestic partners and covered dependent children of the domestic partner when coverage would normally end

2. In certain cases, the covered spouse and covered dependent children may continue coverage when coverage would normally end. A domestic partner and the covered dependent children of the domestic partner may not continue coverage except as a dependent of a covered employee at the option of the covered employee;

3. Coverage will be the same as that for other similar covered persons; and

4. Continuation coverage under this Plan ends when this Plan terminates or as explained in detail on the following Continuation Chart. The covered employee, the covered spouse and covered dependent children may, however, be entitled to continuation coverage under another group health plan offered by the Employer. You should contact the Employer for details about other continuation coverage.

For additional information about your rights and obligations under the Plan and/or federal COBRA law, you should contact the Employer.

The Plan's designated COBRA Administrator may change from time to time. When that happens, you will be notified of the new COBRA Administrator.

Qualifying Events

1. Loss of coverage under this Plan by the covered employee due to one of these events:
   a. Voluntary or involuntary termination of employment of the covered employee for reasons other than "gross misconduct."
   b. Reduction in the hours of employment of the covered employee.
   c. Layoff of the covered employee.
   d. Leave of absence of the covered employee.
   e. Early retirement of the covered employee.

2. Loss of coverage under this Plan by the covered spouse and/or covered dependent children due to one of these events:
   a. Voluntary or involuntary termination of employment of the covered employee for reasons other than "gross misconduct."
   b. Reduction in the hours of employment of the covered employee.
   c. Layoff of the covered employee.
   d. Leave of absence of the covered employee.
   e. Early retirement of the covered employee.
   f. Covered employee becoming entitled to Medicare.
   g. Divorce or legal separation of the covered employee.
   h. Death of the covered employee.

3. Loss of coverage under this Plan by the covered dependent child due to loss of "dependent child" status under this Plan.

4. Loss of coverage under this Plan due to the bankruptcy of the Employer under Title XI of the United States Code. For purposes of this qualifying event (bankruptcy), a loss of coverage includes a substantial elimination of coverage that occurs within one year before or after commencement of the bankruptcy proceeding. Applies to the covered retiree, the covered spouse and covered dependent children.

Required Procedures

When the initial qualifying event is death, termination of employment or reduction in hours (including leave of absence, layoff, or retirement), or Medicare entitlement of the covered employee, or the bankruptcy of the Employer, the Plan Administrator will offer continuation coverage to qualified covered persons. You do not need to notify the Plan Administrator of these qualifying events. However, for other qualifying events including divorce or legal separation of the covered employee and loss of dependent child status, COBRA continuation is not available to you if you do not provide timely, written notice to the Plan Administrator as required below by the Plan. You must also provide timely, written notice to the designated COBRA Administrator of other events, such as a Social Security disability determination or second qualifying events, in order to be eligible for an extension of COBRA continuation as required by the Plan as stated in this section. To elect COBRA, you must make a timely, written election as required by the Plan as stated in this section.

What the Plan Administrator must do:

1. Provide initial general COBRA notices as required by law;

2. Determine if the covered person is eligible to continue coverage according to applicable laws;

3. Notify persons of the unavailability of COBRA continuation;

4. Notify the covered person of the covered person's rights to continue coverage provided that all required notice and notification procedures have been followed by the covered employee, covered spouse and/or covered dependent children;

5. Inform the covered person of the premium contribution required to continue coverage and how to pay the premium contribution; and

6. Notify the covered person when the covered person is no longer entitled to COBRA or when the covered person's COBRA continuation is ending before expiration of the maximum (18, 29, 36 month) continuation period.

What You must do:

1. You must notify the Plan Administrator in writing of a divorce or legal separation within 60 calendar days after either the date of the qualifying event, or the earliest date coverage would end due to the qualifying event, whichever is later;

2. You must notify the Plan Administrator in writing of a covered dependent child ceasing to be eligible within 60 calendar days after either the date of the qualifying event, or the earliest date coverage would end due to the qualifying event, whichever is later;

3. You must submit your written notice of a qualifying event within the 60-day timeframe, as explained previously in paragraphs 1 and 2, using the Plan's approved notice form. (You may obtain a copy of the approved form from the Plan Administrator.) This notice must be submitted to the Plan Administrator in writing and must include the following:
   - The name of the Plan;

- The name and address of the covered employee or former covered employee;
- The names and addresses of all applicable dependents;
- The description and date of the qualifying event;
- Requested documentation pertaining to the qualifying event such as: decree of divorce or legal separation; and
- The name, address and telephone number of the individual submitting the notice. This individual can be a covered employee, former covered employee, dependent, or a representative acting on behalf of the employee or dependent.

All written notices as described previously in paragraphs 1, 2, and 3, under "What You must do" must be timely sent to the Plan Administrator at the address indicated in the section of this SPD entitled "Specific Information About Your Plan."

You must follow the Plan's procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this SPD, unless a different procedure is expressly required by the Employer or its COBRA administrator.

4. To elect continuation, you must notify the designated COBRA Administrator of your election in writing within 60 calendar days after the date the covered person's coverage ends, or the date the covered person is notified of continuation rights, whichever is later. To elect continuation, you must complete and submit your written election within the 60-day timeframe using the Plan's approved election form. (You may obtain a copy of the approved form from the designated COBRA Administrator.) This election must be submitted to the designated COBRA Administrator in writing at the address as described in this section; and

5. You must pay continuation premium contributions:
   a. The premium contribution to continue coverage is the combined Employer plus covered employee rate charged under the Plan, plus the Employer may charge an additional two percent of that rate. For a covered person receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium contribution for those additional months may be increased to 150% of the Plan's total cost of coverage. The continuation election form will set forth your continuation premium contribution rate(s).
   b. The first premium contribution must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the covered person's monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
   c. The covered person must pay subsequent premium contributions by check on or before the required due date, plus the 30-calendar day grace period required by law or such longer period allowed by the Plan.

What You must do to apply for COBRA extension:

A. Social Security Disability:

1. If you are currently enrolled in COBRA continuation under this Plan, and it is determined that you are totally disabled by the Social Security Administration within the first 60 calendar days of your current COBRA coverage, then you may request an extension of coverage provided that your current COBRA coverage resulted from the covered employee's leave of absence, retirement, reduction in hours, layoff, or the covered employee's termination of employment for reasons other than gross misconduct. To request an extension of COBRA, you must notify the designated COBRA Administrator in writing of the Social Security Administration's determination within 60 calendar days after the latest of:
   - The date of the Social Security Administration's disability determination;
   - The date of the covered employee's termination of employment, reduction of hours, leave of absence, retirement, or layoff; or
   - The date on which you would lose coverage under the Plan as a result of the covered employee's termination, reduction of hours, leave of absence, retirement, or layoff.

2. You must submit your written notice of total disability within the 60-day timeframe, as described previously in paragraph 1, and before the end of the 18th month of your initial COBRA coverage using the Plan's approved disability notice form. (You may obtain a copy of the approved form from the designated COBRA Administrator.) This notice must be submitted, in writing, to the Plan designated COBRA Administrator and must include the following:
   - The name of the Plan;
   - The name and address of the covered employee or former covered employee;
   - The names and addresses of all applicable dependents currently on COBRA;
   - The description and date of the initial qualifying event that started your COBRA coverage;
   - The name of the disabled covered person;
   - The date the covered person became disabled;
   - The date the Social Security Administration made its determination of disability;
   - Requested copy of the Social Security Administration's determination of disability; and
   - The name, address and telephone number of the individual submitting the notice. This individual can be a covered employee, former covered employee, dependent, or a representative acting on behalf of the employee or dependent.

   You must follow the Plan's procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this SPD, unless a different procedure is expressly required by the Employer or its COBRA administrator.

   All written notices required for COBRA for a Social Security disability extension must be timely sent to the Plan Administrator at the address indicated in the section of this SPD entitled "Specific Information About Your Plan."

3. To elect an extension of COBRA, you must notify the designated COBRA Administrator of the Social Security Administration's determination, in writing, within the 60-calendar day and the initial 18-month continuation period timeframes, by following the notification procedure as previously explained in paragraphs 1 and 2, and submitting the Plan's approved form; and

4. You must pay continuation premium contributions:
   a. The premium contribution to continue coverage is the combined Employer plus covered employee rate charged under the Plan, plus the Employer may charge an additional two percent of that rate. For a covered person receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium contribution for those additional months may be increased to 150% of the Plan's total cost of coverage. The disability notice form will set forth your continuation premium contribution rate(s).
   b. The first premium contribution must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the covered person's monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
   c. The covered person must pay subsequent premium contributions by check on or before the required due date, plus the 30-calendar day grace period required by law or such longer period allowed by the Plan.

B. Second Qualifying Events for Covered Dependents Only:

1. If you are currently enrolled in COBRA continuation under this Plan and the covered employee dies, or in the case of divorce or a legal separation of the covered employee, or a covered dependent child loses eligibility, then you may request an extension of coverage provided that your current COBRA coverage resulted from the covered employee's leave of absence, retirement, reduction in hours, layoff, or the covered employee's termination of employment for reasons other than gross misconduct or resulted from

a Social Security Administration disability determination. To request an extension of COBRA, you must notify the designated COBRA Administrator in writing within 60 calendar days after the later of:

- The date of the second qualifying event (death, divorce, legal separation, loss of dependent child status); or
- The date on which the covered dependent(s) would lose coverage as a result of the second qualifying event.

Note: This extension is only available to a covered spouse and covered dependent children. This extension is not available when a covered employee becomes entitled to Medicare.

2. You must submit your written notice of a second qualifying event within the 60-day timeframe, as previously described in paragraph 1, using the Plan's approved second event notice form. (You may obtain a copy of the approved form from the designated COBRA Administrator.) This notice must be submitted to the designated COBRA Administrator in writing and must include the following:
   - The name of the Plan;
   - The name and address of the covered employee or former covered employee;
   - The names and addresses of all applicable dependents currently on COBRA;
   - The description and date of the initial qualifying event that started your COBRA coverage;
   - The description and date of the second qualifying event;
   - Requested documentation pertaining to the second qualifying event such as: a decree of divorce or legal separation or death certificate; and
   - The name, address and telephone number of the individual submitting the notice. This individual can be a covered employee, former covered employee, dependent, or a representative acting on behalf of the employee or dependent.

   You must follow the Plan's procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this SPD, unless a different procedure is expressly required by the Employer or its COBRA administrator.

   All written notices required for COBRA for a second qualifying event extension must be timely sent to the Plan Administrator at the address indicated in the section of this SPD entitled "Specific Information About Your Plan."

3. To elect an extension of COBRA, you must notify the designated COBRA Administrator of the second qualifying event in writing within the 60-calendar day timeframe, by following the notification procedure as previously explained in paragraphs 1 and 2, and submitting the Plan's approved form; and

4. You must pay continuation premium contributions:
   a. The premium contribution to continue coverage is the combined Employer plus covered employee rate charged under the Plan, plus the Employer may charge an additional two percent of that rate. For a covered person receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium contribution for those additional months may be increased to 150% of the Plan's total cost of coverage. The election form will set forth your continuation premium contribution rates.
   b. The first premium contribution must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the covered person's monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
   c. The *covered person* must pay subsequent premium contributions by check on or before the required due date, plus the 30-calendar day grace period required by law or such longer period allowed by the Plan.

Additional Notices You Must Provide: Other Coverages, Medicare Entitlement and Cessation of Disability

You must also provide written notice of (1) your other group coverage that begins after COBRA is elected under the Plan; (2) your Medicare entitlement (Part A, Part B or both parts) that begins after COBRA is elected under the Plan; and (3) the covered person, whose disability resulted in a COBRA extension due to disability, being determined to be no longer disabled by the Social Security Administration.

Your written notice for the events previously described in this section must be submitted using the Plan's approved notification form within 30 calendar days of the events requiring additional notices as previously described**. The notification form can be obtained from the designated COBRA Administrator and must be completed by you and timely submitted to the designated COBRA Administrator at the address as described in the SPD.** In addition to providing all required information requested on the Plan's approved notification form, your written notice must also include the following:

- If providing notification of other coverage that began after COBRA was elected, the name of the covered person who obtained other coverage, and the date that other coverage became effective.
- If providing notification of Medicare entitlement, the name and address of the covered person that became entitled to Medicare and the date of the Medicare entitlement.
- If providing notification of cessation of disability, the name and address of the formerly disabled covered person, the date that the Social Security Administration determined that the covered person was no longer disabled and a copy of the Social Security Administration's determination.

If you do not provide this required additional notice, you must reimburse any claims mistakenly paid for expenses incurred after the following applicable date:

1. Your other group coverage begins;
2. Your Medicare Part A or Part B enrollment begins; or
3. Your disability ends.

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CONTINUATION CHART

If coverage under this Plan is lost because this happens…	**Who is eligible to continue…**	**Coverage may be continued until the earliest of**: a) the date coverage would otherwise end under the Plan; or b) the end of the month in which the earliest of the following applicable events occurs:
The covered employee's leave of absence, early retirement, hours were reduced, layoff, or the covered employee's employment with the Employer ended for reasons other than gross misconduct.	Covered employee, covered spouse, and covered dependent children	• 18 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the Plan. • Entitlement, after COBRA is elected under the Plan, of the applicable covered person to either Part A or Part B or both Parts of Medicare.
Death of the covered employee. Divorce or legal separation from the covered employee. Entitlement of the covered employee to Medicare within 18 months before the covered employee's hours were reduced or termination of employment for reasons other than gross misconduct. Covered person must provide timely notice of such event in accordance with the Plan's notice procedures previously described for such events.	Covered spouse and covered dependent children	• 36 months after continuation coverage began. • 36 months after entitlement of covered employee to Medicare but only for an event which is the covered employee's Medicare entitlement within 18 months before the covered employee's hours were reduced or termination of employment. • Coverage begins under another group health plan after COBRA is elected under the Plan. • Entitlement, after COBRA is elected under the Plan, of the applicable covered person to either Part A or Part B or both Parts of Medicare.
Loss of eligibility by a covered dependent child. Covered person must provide timely notice of such event in accordance with the Plan's notice procedures previously described for such events.	Covered dependent child	• 36 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the Plan. • Entitlement, after COBRA is elected under the Plan, of the applicable covered person to either Part A or Part B or both Parts of Medicare.
The Employer files a voluntary or involuntary petition for protection under the bankruptcy laws found in Title XI of the United States Code.	Covered retiree, covered spouse, and covered dependent children	• Lifetime continuation coverage for covered retiree. • 36 months after death of covered retiree for covered spouse and covered dependent children. • Coverage begins under another group health plan after COBRA is elected under the Plan.
The covered employee, covered spouse or covered dependent child is determined by the Social Security Administration to be totally disabled within the first 60 calendar days of COBRA continuation coverage that resulted from the covered employee's leave of absence, early retirement, reduction in hours, layoff, or the covered employee's termination of employment with the Employer for reasons other than gross misconduct. Timely notice of such disability must be provided by the covered person in accordance with the Plan's notice procedures previously described for COBRA extensions due to Social Security disability.	Covered employee, covered spouse, and covered dependent children	• 29 months after continuation coverage began or until the first month that begins more than 30 calendar days after the date of any final determination that covered employee, covered spouse, or covered dependent child is no longer disabled. • Coverage begins under another group health plan after COBRA is elected under the Plan. • Entitlement, after COBRA is elected under the Plan, of the applicable covered person to either Part A or Part B or both Parts of Medicare.

Special Enrollment Periods

If you are a covered employee, covered spouse, or covered dependent who is enrolled in continuation coverage under this Plan due to a qualifying event (and not due to another enrollment event such as a special or annual enrollment), the Special Enrollment Period provisions of this SPD as referenced in the section which describes eligibility and enrollment will apply to you during the continuation period required by federal law as such provisions would apply to an active eligible covered employee. Eligible dependents that are newborn children or newly adopted children (as described in the eligibility and enrollment section) that are acquired by a covered employee during such covered employee's continuation period required by federal law and are enrolled through special enrollment, are entitled to continue coverage for the maximum continuation period required by law.

If the continuation period required by federal law has been exhausted, and you are enrolled for additional continuation coverage pursuant to state law, if applicable, or the eligibility provisions of this plan, you may be entitled to the special enrollment rights upon acquisition of a new dependent through marriage, birth, adoption, placement for adoption, or legal guardianship, as referenced in the section entitled Special Enrollment Period for Covered Persons due to the Acquisition of New Dependents.

Special Rule for Persons Qualifying for Federal Trade Act Adjustments

Federal trade act laws give special COBRA rights to covered employees who terminate employment or experience a reduction of hours, and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under federal laws, including the Trade Adjustment Assistance Reauthorization Act of 2015.

If you qualify or may qualify for trade adjustment assistance, contact the Plan Administrator for additional information. You must contact the Plan Administrator promptly after qualifying for trade adjustment assistance or you will lose your special COBRA rights.

Written Notices Required for COBRA Continuation

All notices, elections and information required to be furnished or submitted by a covered person, covered spouse, or covered dependent children for purposes of COBRA continuation must be submitted in writing by U.S. mail or hand-delivery, or as previously described in this section. Oral communications, including phone calls, voice mails or in-person statements and electronic e-mail do not constitute written notice and are not acceptable for COBRA purposes under the Plan.

J. Fraud, Misrepresentation, Rescission and Right to Audit

It is your responsibility to confirm the accuracy of statements made by the Plan Administrator or the TPA, in accordance with the terms of this SPD and other plan documents. Your coverage may not be retroactively terminated unless you request it or you (or someone acting on your behalf) falsifies information, submits fraudulent, altered, or duplicate billings, allows another person not covered under the Plan to use your coverage, or performs an act or practice that constitutes fraud or intentional misrepresentation (including an omission) of material fact under the terms of the Plan. Notwithstanding, you may be terminated, including being retroactively terminated, due to your failure to timely pay your required contributions.

Determination of your coverage will be made at the time a claim is reviewed. In addition, the Plan Administrator may require you to furnish proof of your eligibility status and may, at reasonable times and upon reasonable notice, audit or have audited your records regarding eligibility, enrollment, termination, contributions, and the coverage provided under the Plan. If the Plan Administrator determines that, after reasonable requests, you have failed to provide adequate records or sufficient proof of your eligibility status, the Plan Administrator may, in its sole discretion, rescind or terminate your coverage to the extent permitted by law.

K. Balance Billing Under the No Surprises Act

(1) If you receive emergency services (for which benefits are provided under this SPD) because of an emergency medical condition with respect to a visit at an emergency department of a hospital or an independent freestanding emergency department, which is a non-participating provider, then such non-participating provider may not bill you, and may not hold you liable, for any amount for such emergency services which is more than the copayment requirement for such services by participating providers under this SPD.

(2) If a non-participating provider furnishes health care services other than emergency services (for which benefits are provided under this SPD) to you at a hospital or ambulatory surgical center, which is a participating provider, then:

a) The non-participating provider may not bill you, and may not hold you liable, for any amount for such health care services furnished by such non-participating provider with respect to a visit at the hospital or ambulatory surgical center which is more than the deductible requirements for such services under this SPD; unless;

b) The health care services are not ancillary services and the non-participating provider satisfies the notice and consent criteria in paragraph (c).

c) The non-participating provider provides to the covered person:

i. A written notice in paper or electronic form, as selected by you, that contains the following information:

- A statement that the provider is a non-participating provider;
- The good faith estimated amount that such non-participating provider may charge you for the health care services involved (and any other related health care services reasonably expected to be furnished by the non-participating provider), including notification that the provision of the estimate or consent does not constitute a contract with respect to the estimated charges or a contract that binds the covered person to be treated by the hospital, ambulatory surgical center, or non-participating provider;
- A statement that prior notification or other care management limitations may be required in advance of receiving such health care services at the hospital or ambulatory surgical center;
- A statement that consent to receive such health care services from such non-participating provider is optional and that the covered person may instead seek care from an available participating provider and in that event the cost-sharing responsibility of the covered person

would not exceed the responsibility that would apply with respect to such health care services furnished by a participating provider.

ii. A consent form that must be signed by the covered persons before such health care services are furnished and that:

- Acknowledges that the covered person has been:
  - Provided with the written notice described in paragraph (i) of this subsection, in the form selected by the covered person; and
  - Informed that the payment of such charge by the covered person might not accrue toward meeting any limitation that your coverage places on cost sharing, including an explanation that such payment might not apply to an in-network deductible or out-of-pocket maximum applied under your coverage;
- States that by signing the consent form, the covered person agrees to be treated by the non-participating provider and understands the covered person may be balance billed and subject to cost sharing requirements that apply to health care services furnished by the non-participating provider; and
- Documents the time and date on which the covered person received the written notice described in paragraph (i) of this subsection and the time and date on which the covered person signed the consent form to be furnished such health care services by such non-participating provider.

The No Surprises Act prohibits balance billing in most circumstances. If you have questions regarding what constitutes a "Balance" bill, please contact Customer Service at the number listed on the inside cover of the SPD.

L. Genetic Information Nondiscrimination Act (GINA)

Notwithstanding any provision of this Plan to 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.

M. Mental Health Parity Act of 1996 (MHPA) and the 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. For further details, please contact the Plan Administrator.

N. No Surprises Act Notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Some states have their own surprise billing laws that protect consumers against surprise medical bills. Visit https://www.cms.gov/files/document/nsa-state-laws.pdf for more information about your rights under state law.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Some states have their own surprise billing laws that protect consumers against surprise medical bills. Visit https://www.cms.gov/files/document/nsa-state-laws.pdf for more information about your rights under state law.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may submit a complaint at https://www.cms.gov/medical-bill-rights/help/submit-a-complaint

Visit https://www.cms.gov/nosurprises and https://www.cms.gov/medical-bill-rights/know-your-rights/using-insurance for more information about your rights under federal law.