PayPal Holdings, Inc. Welfare Benefit Plan
CDHP with HSA Plan

Group No.: 18848

Plan Document
and
Summary Plan Description

Originally Effective: January 1, 2023

Amended and Restated Effective: January 1, 2024

P.O. Box 853921
Richardson, TX 75085-3921
(800) 925-2272
www.meritain.com

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ESTABLISHMENT OF THE PLAN

PayPal Holdings, Inc. (the "Employer" or the "Plan Sponsor") has adopted this amended and restated Plan Document and Summary Plan Description effective as of January 1, 2024, for the PayPal Holdings, Inc. CDHP with HSA Plan (hereinafter referred to as the "Plan" or "Summary Plan Description"), as set forth herein for the exclusive benefit of its Employees and their eligible Dependents and beneficiaries. The Plan was originally adopted by the Employer effective as of January 1, 2023.

Purpose of the Plan
The Plan Sponsor has established the Plan for your benefit and for the benefit of your eligible Dependents and beneficiaries, on the terms and conditions described herein. The Plan Sponsor's purpose in establishing the Plan is to help to protect you and your family by offsetting some of the financial problems that may arise from an Injury or Illness. To accomplish this purpose, the Plan Sponsor must attempt to control health care costs through effective plan design and the Plan Administrator must abide by the terms of the Plan Document and Summary Plan Description, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to manage their healthcare costs.

The Plan is not a contract of employment between you and your Employer and does not give you the right to be retained in the service of your Employer.

The purpose of this Plan is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses. This Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents or beneficiaries.

Adoption of this Plan Document and Summary Plan Description
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document and Summary Plan Description (SPD) as the written description of the Plan. This Plan represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, as amended from time to time. This Plan Document and SPD amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document and Summary Plan Description to be executed as of the date set forth below.

PayPal Holdings, Inc.

Dated:_____ By:_____

Name:_____

Title:_____

GENERAL OVERVIEW OF THE PLAN

The Plan Sponsor has entered into an agreement that provides the Plan access to one or more networks of Participating Providers called “Networks”. When used to describe a provider of health care services, a “Network” means the provider has a participation agreement (either directly or indirectly) in effect with respect to the Plan. Available Networks are identified on the Employee identification card. These Networks offer your health care services at discounted rates. Using a Network provider will normally result in a lower cost to the Plan as well as a lower cost to you. There is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you. You are also not required to designate a Primary Care Physician (PCP), but the Plan encourages you to select a PCP to help manage your care.

You have the right to select any Primary Care Physician (PCP) who participates in the Plan’s network and who is available to accept you or your family members. For Dependent Children, you may designate a pediatrician as the Primary Care Physician (PCP) .

You do not need prior authorization from the Third Party Administrator or from any other person (including a primary care provider) or a referral in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan’s network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization (precertification) for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Accolade at the phone number listed on your identification card or as shown on the General Plan Information page of this Plan Document.

Confirm the Network Status of Providers
Before obtaining services, you should always verify the Network status of a provider or facility. A provider's or facility’s status may change. You can verify the provider's or facility’s status by calling Accolade. A directory of providers is available online at Accolade or by calling the number on your identification card to request a copy.

If you receive a Covered Expense from a Non-Participating Provider or a non-Network facility and were informed incorrectly prior to receipt of the Covered Expense that the provider or facility was a Participating Provider or a Network facility, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network benefits. Additionally, in such circumstances, the Plan cannot impose a cost-sharing amount that is greater than the cost-sharing amount that would be imposed for Covered Expenses furnished by a Participating Provider or a Network facility, and the Plan must count any cost-sharing amounts toward any Participating Provider Deductible or Participating Provider Out-of-Pocket Maximum, as applicable. Refer to “Your Rights and Protections Against Surprise Medical Bills” for a notice regarding protections against balance billing and surprise medical bills.

Do not assume that a Participating Provider’s agreement includes all Covered Expenses. Some Participating Provider’s contract with the Network to provide only certain Covered Expenses, but not all Covered Expenses. Some Network providers choose to be a Participating Providers for only some services. Refer to your provider directory or contact Accolade for assistance.

Non-Participating Provider Exceptions
Unless otherwise described in this Plan, Covered Expenses rendered by a Non-Participating Provider will be paid at the Participating Provider level subject to the Usual and Customary provision of the Plan when a:

(1) Covered Person has an Emergency Medical Condition requiring immediate care.

(2) Covered Person receives services by a Non-Participating Provider who is under agreement with a Network facility.

(3) Participating Provider submits a specimen to a Non-Participating Provider laboratory.

(4) Covered Person receives services from a Network surgeon who uses a non-Network Assistant Surgeon.

(5) Participating Provider is not available within a 30-mile radius of the Covered Person’s residence.

(6) Covered Person receives services from a non-Network Midwife.

Not all providers based in Hospitals that are part of the Plan's Network or medical facilities that are part of the Plan's Network are Participating Providers. It is important when you enter a Hospital or medical facility that you request that ALL Physician services be performed by Participating Providers. By doing this, you will always receive the greater Participating Provider level of benefits.

A current list of Participating Providers is available, without charge, through Accolade at member.accolade.com. If you do not have access to a computer at your home, you may contact Accolade at the phone number on your identification card.

You have a free choice of any provider and you, together with your provider, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. Participating Providers are independent contractors; the Plan, Plan Sponsor, and the Plan Administrator do not make any representations, guarantees, or warranties as to the quality of care that may be rendered by any Participating Provider or other health care provider or facility.

If you choose to seek care outside Plan's network, the Plan generally pays benefits at a lower level. Except as otherwise provided by applicable law or as set forth in this Plan Document, you are required to pay the amount that exceeds the Covered Expense. The amount in excess of the Covered Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum except as required by applicable law or as otherwise described in this Plan Document. You may want to ask the Non-Participating Provider about its billed charges before you receive care.

Covered Expenses for Non-Emergency Medical Conditions

(1) For Covered Expenses that are non-Ancillary Services received from a Participating Provider or Network facility for Non-Emergency Medical Conditions from Non-Participating Providers or other non-Network providers who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided (regardless of whether the notice and consent criteria have been satisfied), you are not responsible, and the Non-Participating Provider may not bill you, for amounts in excess of your Copayment, Coinsurance, or Deductible which are based on the Recognized Amount. Your cost-sharing requirements cannot be greater than the requirements that would apply if such Covered Expenses were provided by a Participating Provider. Your cost-sharing payments with respect to such Covered Expenses will be counted toward the Participating Provider Deductible and Participating Provider Out-of-Pocket Maximums in the same manner as if such cost-sharing payments were made with respect to Covered Expenses furnished by Participating Providers.

(2) For Covered Expenses that are Ancillary Services received at certain Network facilities for Non-Emergency Medical Conditions from Non-Participating Providers or other non-Network providers, you are not responsible, and the Non-Participating Provider and non-Network Physicians may not bill you, for amounts in excess of your Copayment, Coinsurance, or Deductible which are based on the Recognized Amount.

Covered Expenses on an Emergency Basis for Emergency Medical Conditions

(1) For Covered Expenses that are Emergency Services/treatment for an Emergency Medical Condition provided by a Non-Participating Provider or non-Network emergency facility, you are not responsible, and the Non-Participating Provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance, or Deductible, which are based on the Recognized Amount. Your cost-sharing requirements cannot be greater than the requirements that would apply if such services were provided by a Participating Provider or Network emergency facility. Your cost-sharing payments with respect to such Emergency Services/Emergency Medical Condition treatment will be counted toward the Participating Provider Deductible and Participating Provider Out-of-Pocket Maximums in the same manner as if such cost-sharing payments were made with respect to Emergency Services/treatment of an Emergency Medical Condition when furnished by Participating Providers or Network emergency facilities.

Covered Expenses for Air Ambulance Services

(1) For Covered Expenses that are Air Ambulance services provided by a Non-Participating Provider, you are not responsible, and the Non-Participating Provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance, or Deductible, which are based on the rates that would apply if the service was provided by a Participating Provider. Your cost-sharing requirements with respect to such services shall be the same that would apply if the services were provided by a Participating Provider/Network provider of Air Ambulance services. Your cost-sharing requirement is calculated as if the total amount that would have been charged for the services by a Participating Provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services. Your cost-sharing amounts for the Air

Ambulance services will be counted toward the Participating Provider Deductible and Participating Provider Out-of-Pocket Maximum amount in the same manner as if such cost-sharing payments were made for items and services furnished by a Participating Provider.

Continuity of Care (Keeping a provider you go to now)
You may have to find a new provider when:

(1) The Plan's Network changes and the provider you have now is not in the new Network; or

(2) You are already enrolled in the Plan and your provider stops participating in the Plan's Network.

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery. Routine procedures, minor Illnesses and elective Surgical Procedures generally are not covered under this provision.

Contact the phone number on the back of your identification card to obtain further information on how to submit a request for continuity of care. If your request is approved to keep going to your current provider, you will be informed how long you can continue to see the provider. Reimbursement for approved continuity of care will be at the applicable Participating Provider benefit level subject to the Usual and Customary provision of the Plan.

Continuity of Care Under the No Surprises Act
This section applies if you are a "Continuing Care Patient." A "Continuing Care Patient" means an individual who, with respect to a provider or facility:

(1) Is undergoing a course of treatment for a serious and complex condition (as defined below) from the provider or facility;

(2) Is undergoing a course of institutional or Inpatient care from the provider or facility;

(3) Is 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) Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

(5) Is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such Illness from such provider or facility.

For purposes of this section, a "serious and complex condition" means:

(1) 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; or

(2) In the case of a chronic Illness or condition, a condition that:

   (a) Is life-threatening, degenerative, potentially disabling, or congenital; and

   (b) Requires specialized medical care over a prolonged period of time.

If, while you are a Continuing Care Patient with respect to a health care provider or facility that has a contractual relationship with the Plan:

(1) Such contractual relationship is terminated (including the expiration or nonrenewal of the contract, but not a termination of the contract for failure to meet applicable quality standards or for fraud); or

(2) Benefits provided under the Plan with respect to such provider or facility are terminated because of a change in the terms of the participation of the provider or facility, then the Plan shall meet the following requirements. The Plan will:

   (a) Notify you at the time of a termination of such termination and your right to elect continued transitional care from such provider or facility;

(b) Provide you with an opportunity to notify the Plan of your need for transitional care; and

(c) Permit you to elect to continue to have benefits provided under the Plan, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under the Plan had such termination not occurred, with respect to the course of treatment furnished by the provider or facility relating to your status as a Continuing Care Patient during the period beginning on the date on which the notice in the first bullet point 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 with respect to such provider or facility.

Costs
You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan.

Coinsurance
Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Medical Schedule of Benefits. Your Coinsurance payments count toward the Out-of-Pocket Maximum set by the Plan.

There may be differences in the Coinsurance percentage payable by the Plan depending upon whether you are using a Participating Provider or a Non-Participating Provider. These payment levels are also shown in the Medical Schedule of Benefits.

Copay
A Copay is the portion of the medical expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible. Your Copay payments count toward the Out-of-Pocket Maximum set by the Plan.

Deductible
A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan, except as otherwise shown in the Medical Schedule of Benefits. The family Deductible maximum, as shown in the Schedule of Benefits, is the maximum amount which must be Incurred by covered family members during a Calendar Year. When selecting family coverage, the entire family Deductible must be satisfied by one individual or collectively before benefits will be paid at the Coinsurance rate. Your Deductible payments count toward the Out-of-Pocket Maximum set by the Plan.

Out-of-Pocket Maximum
An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied, by one individual or collectively, before the Plan will pay 100% of Covered Expenses for any Covered Person in the family during the remainder of that Calendar Year.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

(1) Charges over Usual and Customary Charges for Non-Participating Providers.

(2) Charges this Plan does not cover, including precertification penalties.

Reimbursement for any eligible non-accumulating expenses will continue at the percentage payable shown in the Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, except as otherwise provided in this SPD or required by applicable law, you must pay any expenses that are in excess of the Usual and Customary Charges for Non-Participating Providers. This could result in you having to pay a significant portion of your claim. None of those amounts will accumulate toward your Out-of-Pocket Maximum.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact Accolade for assistance.

Integration of Deductibles and Out-of-Pocket Maximums
If you use a combination of Participating Providers and Non-Participating Providers, your total Deductible amount and Out-of-Pocket Maximum amount required to be paid will not exceed the amount shown for Non-Participating Providers. In other words, the amount of the Deductible expense and Out-of-Pocket Maximum you pay for both Participating Providers and Non-Participating Providers will be combined, and the total will not exceed the amount shown for Non-Participating Providers during a single Calendar Year.

All other maximum amounts (e.g., Calendar Year or Lifetime) are combined.

Determination of Non-Participating Provider/Non-Network Covered Expense Amounts
The Third Party Administrator has the discretion and authority to decide whether a treatment or supply is a Covered Expense and the amount that the Plan will pay for the Covered Expense. When Covered Expenses are received from a Non-Participating Provider or non-Network facility as described below, the following provisions apply to that determination.

Covered Health Services for Non-Emergency Medical Conditions
For Covered Expenses for non-Emergency Medical Conditions received at certain Network facilities from Non-Participating Providers or non-Network providers when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to an item or service as defined by the Secretary, the amount the Plan pays is based on one of the following in the order listed below as applicable:

(1) The reimbursement rate as determined by an applicable state All Payer Model Agreement.

(2) The initial payment made by the Third Party Administrator, or the amount subsequently agreed to by the non-Network provider and the Third Party Administrator.

(3) The amount determined by the Independent Dispute Resolution (IDR) process if the parties enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without satisfying the notice and consent criteria, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time an item or service is furnished, you are not responsible, and a Non-Participating Provider or a non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance, or Deductible, which are based on the Recognized Amount.

Covered Health Services for Emergency Medical Conditions

For Emergency Services/treatment for an Emergency Medical Condition provided by a Non-Participating Provider or non-Network emergency facility, the amount the Plan pays is based on one of the following in the order listed below as applicable:

(1) The reimbursement rate as determined by an applicable state All Payer Model Agreement.

(2) The initial payment made by the Third Party Administrator, or the amount subsequently agreed to by the non-Network provider or non-Network emergency facility and the Third Party Administrator.

(3) The amount determined by the Independent Dispute Resolution (IDR) process if the parties enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination.

IMPORTANT NOTICE: You are not responsible, and a Non-Participating Provider or non-Network emergency facility may not bill you, for amounts in excess of your applicable Copayment, Coinsurance, or Deductible, which are based on the Recognized Amount.

Covered Health Services for Air Ambulance Services
For Air Ambulance services provided by a Non-Participating Provider, the amount the Plan pays is based on one of the following in the order listed below as applicable

(1) The reimbursement rate as determined by an applicable state All Payer Model Agreement.

(2) The initial payment made by the Third Party Administrator, or the amount subsequently agreed to by the non-Network provider and the Third Party Administrator.

(3) The amount determined by the Independent Dispute Resolution (IDR) process if the parties enter the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination.

IMPORTANT NOTICE: You are not responsible, and a Non-Participating Provider may not bill you, for amounts in excess of your Copayment, Coinsurance, or Deductible, which are based on the rates that would apply if the service was provided by a Network provider.

When Covered Expenses are received from a non-Network provider, except as described above, the amount the Plan pays is based on the Usual and Customary provision of the Plan. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment, or any Deductible. Please contact the Third Party Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any Deductible.

Protections Against Surprise Billing and Balance Billing for Emergencies
If you receive Emergency Services with respect to an Emergency Medical Condition during a visit at an Emergency Department of a Hospital or an Independent Freestanding Emergency Department, a Nonparticipating Emergency Facility may not bill you or hold you liable for a payment amount for such Emergency Services that exceeds the cost-sharing requirement for such services. Similarly, a Non-Participating Provider may not bill you or hold you liable for a payment amount for such Emergency Services that exceeds the cost-sharing requirement for such services. However, those protections do not apply to certain items and services if you are able to travel using nonmedical transportation or nonemergency medical transportation to an available Participating Provider or Network facility located within reasonable travel distance and the Non-Participating Provider or Nonparticipating Emergency Facility follows detailed notice and consent requirements. You must be in a condition to receive the notice and consent information from the Non-Participating Provider or Nonparticipating Emergency Facility and provide your voluntary and informed consent. **You are not required to consent to receive items or services from a Non-Participating Provider or non-Network facility.** Even if you provide consent, a Non-Participating Provider or Nonparticipating Emergency Facility will still be subject to the requirement to not bill you or hold you liable for a payment amount for Emergency Services that exceeds the cost-sharing requirement for such services with respect to items and services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished. For more information, contact Accolade. .

Protections Against Surprise Billing and Balance Billing for Non-Emergencies
A Non-Participating Provider that provides certain items or services (other than Emergency Services) for which benefits are provided under the Plan at a Network facility may not bill you, and may not hold you liable for, a payment amount for such item or service with respect to a visit to the facility that exceeds the cost-sharing requirements for such item or service. However, that prohibition does not apply if the Non-Participating Provider (or the Network facility

on behalf of the provider) follows certain notice and consent requirements to obtain your voluntary and informed consent. **You are not required to consent to receive items or services from a Non-Participating Provider.** Even if you provide consent, a Non-Participating Provider will still be subject to the requirement to not bill you or hold you liable for a payment amount that exceeds the cost-sharing requirements for (i) Ancillary Services, and (ii) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished. For more information, contact Accolade.

Protections Against Surprise Billing and Balance Billing for Air Ambulances

If you are furnished Air Ambulance service for which benefits are available under the Plan from a Non-Participating Provider of Air Ambulance services, such provider may not bill you, and may not hold you liable for, a payment amount for the Air Ambulance services that is more than the cost-sharing amount for such services. For more information, contact Accolade.

MEDICAL MANAGEMENT PROGRAM

Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare while avoiding unnecessary expenses. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare provider. The Medical Management Program Administrator contact information for this Plan is identified on the Employee identification card and also on the General Plan Information page of this Plan.

Precertification
This plan uses the term "precertification" to refer to the process of requiring prior authorization for certain items or services before you receive them. Before you or your eligible Dependents are admitted to a medical facility or receive items or services from the list below, the Medical Management Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management Program Administrator's policies, procedures and guidelines. Once an Inpatient setting has been precertified (received prior authorization), working directly with your Physician or other health care provider, the Medical Management Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

The Plan provides coverage for pre-admission counseling. The primary objective of the pre-admission counseling program is to provide assistance to Covered Persons in preparation for their scheduled Hospital admission or elective Surgery. This program includes but is not limited to education for Covered Persons who will be admitted for Inpatient procedures and the review of sign and symptoms of infections.

The Medical Management Program Administrator will also assist and coordinate the initial implementation of any services you will need post hospitalization (called discharge planning) with the attending Physician and the facility. This could include registering you for specialized programs or case management when appropriate.

The Plan provides coverage for post-discharge counseling. This program is provided to Covered Persons who are discharged from the Hospital to a home setting. Case managers will contact Covered Persons who have been discharged from Hospitals to assess their health status, pain or discomfort level. The specially trained case managers will identify any complications or additional needs the Covered Person may have and discuss with the Covered Persons when it's necessary to contact their Physicians or seek medical attention.

Important Timeframes to Know
You, your Physician, the facility or someone acting on your behalf, must call the Medical Management Program Administrator (at the number listed on your Employee identification card or the General Plan Information page of this Plan) within the following time frames for a:

Non-emergency admission	48 hours before the scheduled admission
Non-emergency services	48 hours before you are scheduled to receive the services
Emergency admission	Within 48 hours or if later, the next business day after you are admitted

If the attending Physician feels that it is Medically Necessary for a patient to receive services for a greater length of time than initially precertified, the attending Physician or the medical facility must request the additional service or days as soon as reasonably possible, but no later than the final authorized day.

Penalty for Failure to Obtain Precertification
Your provider may precertify your treatment for you; however, you should verify prior to incurring Covered Expenses that your provider has obtained precertification. If your treatment is not precertified by you or your provider within the time periods described above, Medical Necessary Covered Expenses will be reduced as follows:

(1) Covered Expenses will be reduced by 50% up to $250 maximum per occurrence. The amount of the precertification penalty is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

If the Plan's required review procedures are not followed, a retrospective review will be conducted by the Medical Management Program Administrator to determine if the services provided met all other Plan provisions and requirements. If the review concludes the services were Medically Necessary and would have been approved had the required phone call been made, benefits will be considered subject to the penalty outlined above. However, any charges not deemed Medically Necessary will be denied.

List of Items and/or Services that Require Precertification (Prior Authorization)
The below items and/or services, if Covered Expenses under the Plan, must be precertified before any medical services are provided. To determine whether a benefit is covered or excluded, please review the Eligible Medical Expenses and/or General Exclusions and Limitations sections of your Plan. You can also contact Accolade for assistance in determining Covered Expenses. Additionally, if this Plan is secondary to Medicare, the following requirements do not apply.

All Inpatient Admissions:
- Acute
- Long-Term Acute Care
- Rehabilitation
- Mental Health / Substance Use Disorder
- Transplant
- Skilled Nursing Facility
- Residential Treatment Facility
- Obstetric – Prenotification only (precertification only required if days exceed Federal mandate)

Diagnostic Services (Outpatient and Physician):
- MRI
- MRA
- PET
- Capsule endoscopy
- Genetic testing (including BRCA)
- Sleep Study (facility based)

Outpatient and Physician – Surgery:
- All joint replacement surgeries
- Thyroidectomy, Partial or Complete
- Prostate or Ovary Removal – include Open Prostatectomy / Oopherectomy
- Back Surgeries and hardware related to surgery
- Osteochondral Allograft, knee
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Sleep apnea related surgeries, limited to:
  - Radiofrequency ablation (Coblation, Somnoplasty)
  - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)

Outpatient and Physician – Surgery (cont.):
- Mastectomy (including gynecomastia and prophylactic)
- Morbid obesity procedures
- Orthognathic procedures (e.g. Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Otoplasty
- Panniculectomy
- Rhinoplasty
- Rhytidectomy
- Scar revisions
- Septoplasty
- Varicose vein surgery/sclerotherapy

Continuing Care Services (Outpatient and Physician):
- **UM Carve Out to Progyny (833-838-5850)**
  - Infertility Treatment Services (with diagnosis of infertility)
- **UM by Accolade**
  - Chemotherapy (including oral)
  - Radiation Therapy
  - Oncology care including 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
  - Home Health Care (includes all services done in the home)
  - Durable Medical Equipment, limited to electric/motorized scooters or wheelchairs and pneumatic compression devices
  - Durable Medical Equipment over $1,000

Medical Evacuation
- Air Ambulance for non-emergency transportation

- Potentially Cosmetic Procedures, including but not limited to:
  - Abdominoplasty
  - Blepharoplasty
  - Cervicoplasty (neck lift)
  - Facial skin lesions (Photo therapy, laser therapy - excluding MOHS)
  - Hernia repair, abdominal and incisional (only when associated with a cosmetic procedure)
  - IDET (thermal intradiscal procedures)
  - Liposuction/lipectomy
  - Mammoplasty, augmentation and reduction (including removal of implant)

Important Notes:

- Precertification is recommended if a procedure could be considered Experimental and/or Investigational.
- Prenotification is recommended for maternity delivery admissions. Precertification is NOT REQUIRED for a maternity delivery admission, unless the stay extends past 48 hours for vaginal delivery or 96 hours for a cesarean section. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified, the confinement must be precertified with the Medical Management Program Administrator or a penalty will be applied. Please refer to the penalty section above.

Precertification Does Not Guarantee Payment

Precertification of the above benefits ensures the service being rendered is Medically Necessary and appropriate. All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment, services rendered must be considered a Covered Expense and are subject to all other provisions of the Plan.

Precertification does not guarantee coverage for, or the payment of, the service or procedure reviewed. The sole effect and meaning of receiving precertification is that, if precertification is given, coverage for the specific item or service will not be denied for lack of Medical Necessity, including length of stay in a facility. All other Plan provisions apply and must be satisfied to receive coverage.

If you or your provider receives precertification, that precertification determines that the particular admission, item, or service that is precertified is Medical Necessary, however, there may be other Plan coverage standards that still must be reviewed, and if any of those standards are not also met, coverage for the precertified admission, item, or service still could be denied upon further review of the claim for benefits.

Precertification does not control or attempt to control whether or not you receive any particular medical service, drug, supply, equipment, device, or treatment – the decision on whether to undergo any particular course of treatment is entirely up to you and your health care providers. The only effect of a denial of precertification is that you may not receive Plan benefits for the service, drug, supply, equipment, device, or treatment in question. Accordingly, if you and your health care provider believe that a particular service, drug, supply, equipment, device, or treatment is essential or in your best interests, even though precertification has been denied, you should make your own decision regarding such matters, without regard to the precertification decision. Refer to the next paragraph for information on how to appeal a denied precertification.

To File a Complaint or Request an Appeal to a Non-Certification

If it is determined that the item and/or services are not Medically Necessary (the precertification is denied), the notification you receive will explain why. Verbal appeal requests and information regarding the appeal process should be directed to the Medical Management Program Administrator as identified on the General Plan Information page of this Plan.

Case Management

Accolade provides case management support to Covered Persons who are at risk for frequent and high levels of medical care to empower them to reach their optimal level of wellness and quality of life. Accolade Clinical Nurse Assistants, who are registered nurses, work closely with Covered Persons to gather information about their health care needs and support the Covered Person in receiving timely and appropriate medical care from their healthcare providers. Accolade Clinical Nurse Assistants support the Covered Person with coordinating and accessing the care they need, monitoring their progress, maximizing the use of their benefits, and optimizing their self-management skills. Accolade helps the Covered Person to overcome barriers that prevent Covered Persons from being compliant with their prescribed treatment plans. The case manager helps identify appropriate providers and facilities throughout a continuum of services the Covered Person may require.

Components of Accolade case management include:

(1) Assessment of all needs

(2) Assistance in the development of a comprehensive care plan to address Covered Persons' problems and concerns

(3) Support in establishing care coordination as may be necessary to meet Covered Persons' needs and interests

(4) Targeted education to help the Covered Person close any knowledge gaps surrounding their care and/or condition

(5) Developing collaborative working relationship with the Covered Persons' families and their caregivers

(6) Supporting Covered Persons in accessing care according to their own preferences.

Accolade does not practice medicine or provide patient care. Accolade is an independent resource to support and assist you as you use the healthcare system and receive medical care from your own doctors, nurses and healthcare professionals. If you have a medical emergency, please contact 911 immediately.

Nurseline
Accolade Clinical Nurse Assistants, who are registered nurses, are available to support Covered Persons with their health questions and help Covered Persons determine the care needed to address their concerns. Clinical Nurse Assistants ask questions to assess a Covered Person's needs and then provide options to the Covered Person to assist them in obtaining the appropriate care. Given healthcare needs can occur at any time, Accolade Nurseline services are available 24 hours a day, including weekends and holidays. Covered Persons calling after business hours will be supported by Citra Health, a subcontractor of Accolade.

Disease Management/Chronic Care Condition Management
Accolade assists Covered Persons in managing their chronic medical or behavioral health condition with an extensive focus on identifying all needs related to or impacting a Covered Person's ability to successfully manage their condition. Accolade's holistic approach to supporting Covered Persons includes identifying medical, behavioral, financial or personal challenges associated with their condition. Accolade Clinical Nurse Assistants, who are registered nurses, actively engage and support Covered Persons by:

(1) Asking questions using evidenced based guidelines, assisting the Covered Person in: developing their own care plans, coordinating their care, and obtaining services they may need;

(2) Uncovering barriers or other factors impacting care, and assisting the Covered Person to overcome such barriers;

(3) Leveraging the use of technology to help Covered Persons better understand how to self-manage their condition;

(4) Conducting extensive education to enhance understanding and compliance with their treatment plans;

(5) Providing a dedicated Clinical Nurse Assistant who works closely and collaboratively with Covered Persons, their family, and their provider to ensure Covered Persons' needs are met.

Maternity Program
Accolade Clinical Nurse Assistants, who are registered nurses, start early by providing preconception support to Covered Persons to help them become physically and emotionally ready for pregnancy and parenthood.

Once a Covered Person is pregnant, Accolade provides an integrated maternity program that supports identifying and managing any pre-existing health conditions that can cause complications with a pregnancy. This specialized program assigns a Clinical Nurse Assistant, who is an obstetrical nurse, to provide support for all pregnant Covered Persons. Program components include:

(1) Comprehensive maternity assessment and identification to support Covered Persons' understanding of potential concerns;

(2) Assistance in the development of a personalized care plan that addresses identified needs;

(3) Dedicated Clinical Nurse Assistant that provides support and education throughout the pregnancy;

(4) Post-delivery support:

(a) Screening for post-partum depression;

(b) Breastfeeding support provided by certified lactation consultants;

(c) Education on newborn care and what to do in the first months of the newborn’s life.

MEDICAL SCHEDULE OF BENEFITS – CDHP WITH HSA PLAN

NOTE: The Medical Schedule of Benefits is subject to the limitations on surprise billing (sometimes referred to as balance billing) as described in the General Overview of the Plan section.

CDHP WITH HSA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE (combined with Prescription Drug Card)		
Single	$1,700	$2,700
Family	$3,400	$5,400
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)		
Single	$3,500	$6,000
Family	$7,000	$12,000
MEDICAL BENEFITS		
AccoladeCare Providers		
General Medical Consultations	90% after Deductible	Not Applicable
Behavioral Health Consultations	90% after Deductible	Not Applicable
NOTE: Your consult fee to use an AccoladeCare provider applies to your Deductible and Out-of-Pocket Maximum.		
Acupuncture	90% after Deductible	70% after Deductible
Calendar Year Maximum Benefit	24 visits	
Ambulance Services	90% after Deductible	Paid at the Participating Provider level of benefits
Ambulatory Surgical Center	90% after Deductible	70% after Deductible
Bone-Anchored Hearing Aids	90% after Deductible	70% after Deductible
Lifetime Maximum Benefit	1 device*	
*Lifetime maximum benefit does not apply if repair or replacement is necessary due to device malfunction.		
Cardiac Rehab (Outpatient)	90% after Deductible	70% after Deductible
Cellular and Gene Therapy	90% after Deductible	Not Covered
Chemotherapy (Outpatient – includes all related charges)	90% after Deductible	70% after Deductible
Chiropractic Care/Spinal Manipulation	90% after Deductible	70% after Deductible
Calendar Year Maximum Benefit	24 visits	
Cochlear Implants (refer to post-cochlear implant aural therapy for benefits for therapy after cochlear implant placement)	90% after Deductible	70% after Deductible

CDHP WITH HSA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Cognitive Therapy (Outpatient)	90% after Deductible	70% after Deductible
Cosmetic/Reconstructive Procedures (see Eligible Medical Expenses)	90% after Deductible	70% after Deductible
Dental Care (Accidental Dental – see Eligible Medical Expenses)		
Primary Care Physician (PCP)	90% after Deductible	70% after Deductible
Specialist	90% after Deductible	70% after Deductible
Anesthesia	90% after Deductible	70% after Deductible
Diabetic Education	100% after Deductible	70% after Deductible
Diabetic Eye Exams & Foot Care	100% after Deductible	70% after Deductible
Diabetic Supplies & Equipment	100% after Deductible	70% after Deductible
Diagnostic Testing, X-Ray, and Lab Services (Outpatient)	90% after Deductible	70% after Deductible
Drug Testing Calendar Year Maximum Benefit	18 presumptive drug tests 18 definitive drug tests	
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	90% after Deductible	70% after Deductible
Dialysis (Outpatient)	90% after Deductible	70% after Deductible
Durable Medical Equipment (DME)	90% after Deductible	70% after Deductible
Maximum Benefit	A single purchase per type of DME every 3 years (includes replacement)	
Emergency Services – Emergency Medical Condition	90% after Deductible	Paid at the Participating Provider level of benefits
Emergency Room – Non-Emergency Medical Condition	90% after Deductible	70% after Deductible
Fertility		
Basic Fertility Services (initial diagnosis and/or correction of underlying medical conditions)	Paid based on place of service	Paid based on place of service
Comprehensive Fertility Services (Progyny Only – TIN 27-2220139) Refer to the Eligible Medical Expenses and attachment 1 for more information.	Paid based on place of service	Not Applicable
Gender Affirming Care (see Eligible Medical Expenses)	Paid based on place of service	Paid based on place of service
Hearing Aids (**External/Non-Bone-Anchored**)	90% after Deductible	70% after Deductible
Maximum Benefit	1 hearing aid per hearing impaired ear every 24 months (includes repair and replacement)	
Home Health Care	90% after Deductible	70% after Deductible
Calendar Year Maximum Benefit	120 visits	

CDHP WITH HSA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospice Care	90% after Deductible	70% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	90% after Deductible	70% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	90% after Deductible	70% after Deductible
Outpatient	90% after Deductible	70% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Infusion Therapy (Outpatient)	90% after Deductible	70% after Deductible
Maternity (non-facility charges)*		
Preventive Prenatal, Breast Pumps and Breastfeeding Support (other than lactation consultations)	100%, Deductible waived	70% after Deductible
Lactation Consultations	100%, Deductible waived	100%, Deductible waived
All Other Prenatal and Postnatal Care	90% after Deductible	70% after Deductible
Delivery	90% after Deductible	70% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Medical and Surgical Supplies (including ostomy supplies and urinary catheters)	90% after Deductible	70% after Deductible
Medical Orthotic Maximum Benefit	A single purchase per type of orthotic every 3 years (includes replacement)	
Mental Disorders and Substance Use Disorders (including Autism services)		
Inpatient	90% after Deductible	70% after Deductible
Outpatient: Office Visits	90% after Deductible	Paid at the Participating Provider level of benefits*
All Other Outpatient Care	90% after Deductible	70% after Deductible
Autism and Autism Spectrum Disorder Services: Office Visits	90% after Deductible	Paid at the Participating Provider level of benefits*
Outpatient	90% after Deductible	70% after Deductible
*Office visits received from a Non-Participating Provider for treatment of a Mental Disorder and/or Substance Use Disorder will not be subject to Usual and Customary Charges, the Plan will pay the billed charges at the Participating Provider level of benefits.		
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		

CDHP WITH HSA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
MinuteClinic	100% after Deductible (Deductible waived for preventive services and routine care)	Not Applicable
Morbid Obesity (see Eligible Medical Expenses)	90% after Deductible	70% after Deductible
Nutritional Counseling		
Primary Care Physician (PCP)	90% after Deductible	Paid at the Participating Provider level of benefits
Specialist	90% after Deductible	Paid at the Participating Provider level of benefits
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Nutritional Supplements/Enteral Nutrition	90% after Deductible	70% after Deductible
Occupational Therapy (OT) (Outpatient)	90% after Deductible	70% after Deductible
Combined Calendar Year Maximum Benefit for All Other Conditions (Combined with Physical Therapy Calendar Year Maximum Benefit)	24 visits*	
***NOTE:** The Plan may allow additional visits when Medically Necessary and appropriate.		
Physical Therapy (PT) (Outpatient)	90% after Deductible	70% after Deductible
Combined Calendar Year Maximum Benefit for All Other Conditions (Combined with Occupational Therapy Calendar Year Maximum Benefit)	24 visits*	
***NOTE:** The Plan may allow additional visits when Medically Necessary and appropriate.		
Physician's Services		
Inpatient/Outpatient Services	90% after Deductible	70% after Deductible
Office Visit Charges:		
Primary Care Physician (PCP)	90% after Deductible	70% after Deductible
Specialist	90% after Deductible	70% after Deductible
Physician Office Surgery	90% after Deductible	70% after Deductible
Post-Cochlear Implant Aural Therapy (Outpatient)	90% after Deductible	70% after Deductible
Prescription Drugs/Pharmaceutical Products	90% after Deductible	70% after Deductible
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately, including preventive labs, x-rays or other preventive tests)	100%, Deductible waived	70% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%, Deductible waived	70% after Deductible
Private Duty Nursing (Outpatient)	90% after Deductible	70% after Deductible

CDHP WITH HSA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Prosthetics	90% after Deductible	70% after Deductible
Maximum Benefit	A single purchase per type of prosthetic every 3 years (includes replacement)	
Qualified Clinical Trials	Paid based on place of service	Paid based on place of service
Radiation Therapy (Outpatient – includes all related charges)	90% after Deductible	70% after Deductible
Respiratory/Pulmonary Therapy (Outpatient)	90% after Deductible	70% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	90% after Deductible	70% after Deductible
Combined Calendar Year Maximum Benefit	120 days	
Speech Therapy (ST) (Outpatient)	90% after Deductible	70% after Deductible
Calendar Year Maximum Benefit for All Other Conditions	60 visits*	
***NOTE:** The Plan may allow additional visits when Medically Necessary and appropriate.		
Surgery (Inpatient)		
Facility	90% after Deductible	70% after Deductible
Miscellaneous	90% after Deductible	70% after Deductible
Professional Services	90% after Deductible	70% after Deductible
Surgery (Outpatient) (does not include Surgery in the Physician's office)		
Facility	90% after Deductible	70% after Deductible
Miscellaneous	90% after Deductible	70% after Deductible
Professional Services	90% after Deductible	70% after Deductible
Telemedicine		
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)

CDHP WITH HSA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Temporomandibular Joint Dysfunction (TMJ)	90% after Deductible	70% after Deductible
Transplants		
Facility Charges	90% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
Professional Fees	90% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% after Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Travel and Lodging Expenses	100% after Deductible	Paid at the Participating Provider level of benefits
NOTE: Please refer to the Travel and Lodging Expenses benefit under Eligible Medical Expenses for a more detailed description of this benefit, including maximums.		
Urgent Care Facility	90% after Deductible	70% after Deductible
Vision/Orthoptic Therapy	90% after Deductible	70% after Deductible
Wig (see Eligible Medical Expenses)	90% after Deductible	Paid at the Participating Provider level of benefits
Maximum Benefit	1 wig every 2 Calendar Years	
All Other Eligible Medical Expenses	90% after Deductible	70% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – CDHP WITH HSA PLAN

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
CALENDAR YEAR DEDUCTIBLE (combined with major medical Deductible) Single Family	 $1,700 $3,400
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Copays – combined with major medical Out-of-Pocket) Single Family	 $3,500 $7,000
Retail Pharmacy: 30-day supply	
Generic Drug	Deductible, then 10% Copay, not to exceed $150
Preferred Drug	Deductible, then 10% Copay, not to exceed $150
Non-Preferred Drug	Deductible, then 10% Copay, not to exceed $150
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay, Deductible waived (100% paid)
Preventive Maintenance Drug	$0 Copay, Deductible waived (100% paid)
CVS Maintenance Choice Mandatory – Allow Opt Out: 90-day supply	
Generic Drug	Deductible, then 10% Copay, not to exceed $450
Preferred Drug	Deductible, then 10% Copay, not to exceed $450
Non-Preferred Drug	Deductible, then 10% Copay, not to exceed $450
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay, Deductible waived (100% paid)
Preventive Maintenance Drug	$0 Copay, Deductible waived (100% paid)
Mandatory Specialty Pharmacy Program: 30-day supply	
Generic Drug	Deductible, then 10% Copay, not to exceed $150
Preferred Drug	Deductible, then 10% Copay, not to exceed $150
Non-Preferred Drug	Deductible, then 10% Copay, not to exceed $150
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
Retail Pharmacy: 90-day supply	
Generic Drug	Deductible, then 10% Copay, not to exceed $450
Preferred Drug	Deductible, then 10% Copay, not to exceed $450
Non-Preferred Drug	Deductible, then 10% Copay, not to exceed $450
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay, Deductible waived (100% paid)
Preventive Maintenance Drug	$0 Copay, Deductible waived (100% paid)

BENEFIT DESCRIPTION	BENEFIT
Mail Order Pharmacy: 90-day supply	
Generic Drug	Deductible, then 10% Copay, not to exceed $450
Preferred Drug	Deductible, then 10% Copay, not to exceed $450
Non-Preferred Drug	Deductible, then 10% Copay, not to exceed $450
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay, Deductible waived (100% paid)
Preventive Maintenance Drug	$0 Copay, Deductible waived (100% paid)

NOTE: Certain Prescription Drug classes are subject to Step Therapy. (See the Prescription Drug Card Program section for further details regarding Step Therapy.)

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will pay the non-preferred Copay and will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

CVS Maintenance Choice Mandatory – Allow Opt Out
The Plan allows for 1 30-day fill of maintenance drugs at any retail pharmacy. After 1 fill, a 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy only or through the mail order program unless you call the Prescription Drug Program Administrator and opt out. If you opt out, you may continue to purchase a 30-day supply of maintenance drugs, however, you will not benefit from the savings of a 90-day supply. For additional information, please contact the Prescription Drug Card Program Administrator.

CVS True Accumulation Program
Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon, rebate or other manufacturer assistance.

Mandatory Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) or federal law as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan. The list of Preventive Drugs is updated periodically, the Covered Person should contact the Prescription Drug Card Program Administrator to obtain the most current information.

ELIGIBILITY FOR PARTICIPATION

Employee Eligibility
You are eligible to enroll in the Plan if you are a regular full-time Employee of the Employer who is scheduled to works 20 or more hours per week. If you meet the eligibility requirements, you are eligible to enroll for coverage under this Plan as of your date of hire with the Employer. Participation in the Plan will begin as of your date of hire provided all required election and enrollment forms are properly submitted to the Plan Administrator (refer to the "Timely Enrollment" section below).

You are not eligible to participate in the Plan if you are a part-time, temporary, leased or Seasonal Employee, an independent contractor, intern or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency), or a person covered by a collective bargaining agreement that does not provide for participation in this Plan.

NOTE: The Plan includes an automatic election feature. If you are a newly hired Employee who meets the eligibility requirements set forth above and you do not make an enrollment selection for an Employer-sponsored health plan (including affirmatively electing not to participate in a plan), you will automatically be enrolled in Employee-only coverage under this Plan. If you do not change your elections during annual enrollment, your coverage levels will continue from the previous year.

Dependent Eligibility
Your Dependents are eligible for participation in this Plan provided he/she is:

(1) Your Spouse.

(2) Your same or opposite sex Domestic Partner as defined below.

(3) Your or your Spouse's Child until the end of the month in which he/she attains age 26.

(4) You or your Spouse's Child age 26 or older, who is unable to be self-supporting by reason of mental or physical handicap and is incapacitated, provided the Child suffered such incapacity prior to the end of the month in which he/she attained age 26. Your Child must be unmarried and primarily dependent upon you for support. The Plan Sponsor may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental incapacity.

(5) A Child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

The below terms have the following meanings:

"Spouse" means any person who is lawfully married to you under any state law. This definition also includes a Spouse by reason of common law marriage when recognized in your state. The Plan Administrator may require documentation proving a legal marital relationship.

"Domestic Partner" means an unrelated individual of the same or opposite sex for which an Employee submits an affidavit of domestic partnership to the Employer. The affidavit must include the following statements:

(1) Both partners are at least 18 years of age.

(2) Both partners share a permanent residence and common necessities of life and intend to do so indefinitely.

(3) Each partner must not be currently married to, or a Domestic Partner of, another person under either statutory or common law .

(4) The partners are not related by blood or a degree of closeness that would bar or prohibit marriage in the state in which they reside.

(5) Both partners are legally and mentally competent to enter into a contract.

(6) The partners are financially interdependent.

The Plan Administrator reserves the right to require such evidence as it deems necessary that a Domestic Partner satisfies the above eligibility requirements.

For purposes of this Plan, an individual who qualifies as a Domestic Partner shall have all of the rights and benefits of an Employee's Spouse subject to all of the terms and conditions of this Plan except as otherwise provided herein.

"Child" means your natural born child, stepchild, legally adopted child (or a child placed with you in anticipation of adoption), or a child for whom you or your Spouse are the Legal Guardian. Coverage for a Child for whom you are the Legal Guardian will remain in effect until such Child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such Child has attained age 18 (or any other applicable age of emancipation of minors). The term "Child" shall include a Child of your Domestic Partner.

"Child placed with you in anticipation of adoption" means a Child that you intend to adopt, whether or not the adoption has become final, who would otherwise be eligible for enrollment if the Child was your natural born Child. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. The Child must be available for adoption and the legal process must have commenced.

"Legal Guardian" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree, or other order of any court of competent jurisdiction.

The Plan Administrator, in its sole discretion, shall have the right to require documentation necessary to establish an individual's status as an eligible Dependent.

When You and Your Dependents are Covered Employees
When both you and your Spouse are covered Employees, each of you must choose coverage as either an Employee or as a Dependent. You may not be covered under this Plan as both an Employee and a Dependent. Eligible Dependent Children of 2 covered Employees may not be enrolled as Dependents of both Employees, whether the Employees are married or unmarried. Your Dependents may not enroll in the Plan unless you are also enrolled.

Court Ordered Coverage for a Child
Federal law requires the Plan, under certain circumstances, to provide coverage for your Children. The details of these requirements are summarized below.

The Plan Administrator shall enroll for coverage (as of the date set forth in the QMCSO) under this Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your Child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no Child is eligible for Plan coverage, even if you are required to provide coverage for that Child under the terms of a separation agreement or court order, unless the Child is an eligible Child under this Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.

NOTE: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Timely Enrollment
Once you are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to the Plan Administrator within 31 days after satisfaction of the eligibility requirements. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Plan Administrator to deduct the required contribution from your pay. In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

If you fail to complete and submit the appropriate election and enrollment forms within the 31-day period described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience a Special Enrollment Event or a Status Change Event (described below).

Open Enrollment Period
You and your Dependents may enroll for coverage during the Plan's open enrollment period, designated by the Plan Sponsor and communicated to you prior to such open enrollment period. During this time, you will be permitted to make changes to any existing benefit elections. Benefit elections made during the open enrollment period will be effective prospectively as of January 1 and will remain in effect until the next open enrollment period unless you or your Dependent experiences a Special Enrollment Event or Status Change Event.

NOTE: The Plan includes an automatic election feature. If you do not make an election during the Open Enrollment Period, the elections for yourself and any Dependents will automatically carry forward to the next Plan Year. For example, if you and your Dependents were covered by this Plan in the current Plan Year and you do not make a new election, you and your Dependents will continue to be enrolled in this Plan for the following Plan Year.

Cost of Coverage
You and the Employer share the cost of the Plan. Your contribution amount depends, in part, on the coverage level you select. You must pay the required contribution amounts to have and maintain coverage under the Plan. If you fail to timely pay the required contributions (including those for COBRA continuation coverage) for coverage under the Plan, your coverage (and that of any Dependents) may be terminated, including retroactively.

NOTE: For federal income tax purposes, Domestic Partners and their children typically do not qualify as an Employee's tax dependents. Therefore, the value of the Employer's cost in covering a Domestic Partner (and any children) may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and the Domestic Partner's children may be paid using after-tax payroll deductions. Your contributions are subject to review and the Employer reserves the right to change your contribution amount from time to time in its sole discretion.

Special Enrollment Event
A special enrollment event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy or acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Each special enrollment event is more fully described below:

(1) **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if you are otherwise eligible to enroll for coverage under this Plan without regard to the Plan's limitations on enrollment periods and the other health coverage is lost as a result of one of the following:

   (a) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;

(b) Loss of eligibility under the non-COBRA health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or

(c) Employer contributions cease for the other non-COBRA health coverage.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent provided that you are otherwise eligible to enroll in the different benefit option.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 31 days after the date the other health coverage was lost. Coverage under the Plan will become effective no later than the first day of the first calendar month beginning after the date you submit the appropriate election and enrollment forms to the Plan Administrator.

(2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a state sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP or you or your Dependents become eligible for a state premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after you or your Dependents' eligibility for a state assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a state premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective no later than the first day of the first calendar month beginning after the date you submit the appropriate election and enrollment forms to the Plan Administrator.

(3) **Acquisition of a New Dependent.** If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to the Plan Administrator within 31 days after the date you acquire such Dependent.

(a) Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such Child's date of birth and will continue for the first 31 days after birth. If you wish to continue coverage beyond this 31-day period, you must complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after the Child's birth. Failure to enroll in the Plan within the 31-day period described above will result in no coverage under the Plan beyond the first 31 days after the Child's birth.

(b) Coverage for a newly acquired Dependent due to marriage will be effective on the date of marriage provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after your date of marriage. Failure to enroll in the Plan within the 31-day period described above will result in no coverage under the Plan.

(c) Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption) will be effective as of the date of adoption (or placement in anticipation of adoption) provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after adoption or placement in anticipation of adoption, as applicable. Failure to enroll in the Plan within the 31-day period described above will result in no coverage under the Plan.

Status Change Event

Generally, your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or a Status Change Event (as permitted by the PayPal Holdings, Inc. Welfare Benefit Plan)). If a Status Change Event occurs, you may make a new election under the Plan provided your new election is consistent with the Status Change Event.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 31 days after the Status Change Event. Coverage under the Plan will become effective on the date of the event provided you submit the appropriate election and enrollment forms to the Plan Administrator.

TERMINATION OF COVERAGE

Termination of Employee Coverage
Coverage under the Plan will automatically terminate on the earliest of the following dates, even if you are hospitalized or are otherwise receiving medical treatment on that date:

(1) The date the Plan terminates, in whole or in part.

(2) The last day of the month you stop making the required contributions.

(3) The date you report to active duty military service unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below.

(4) The last day of the month in which you cease to be eligible for coverage under the Plan.

(5) The last day of the month in which you terminate employment with the Employer or cease to be included in an eligible class of Employees.

(6) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud.

(7) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

(8) The last day of the month the Third Party Administrator receives written notice from the Employer to end your coverage, or the date requested in the notice, if later.

Termination of Dependent Coverage
Coverage under the Plan will automatically terminate on the earliest of the following dates, even if a Dependent is hospitalized or is otherwise receiving medical treatment on that date:

(1) The date the Plan terminates, in whole or in part.

(2) The date the Plan discontinues coverage for Dependents.

(3) The date your Dependent becomes covered as an Employee under the Plan.

(4) The date coverage terminates for the Employee.

(5) If you and/or your Dependents fail to make any contribution when it is due, the last day of the month you stop making the required contributions.

(6) The date the Dependent Spouse, Domestic Partner of an Employee or a Child of a Domestic Partner reports to active duty military service.

(7) The last day of the month in which a Dependent ceases to qualify as a Dependent as defined by the Plan.

(8) The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud.

(9) The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

(10) The last day of the month the Third Party Administrator receives written notice from the Employer to end the Dependents coverage, or the date requested in the notice, if later.

Retroactive Termination of Coverage
Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact, including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required Employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

If the Third Party Administrator or Employer find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, the Employer has the right to demand that you pay back all Plan benefits during the time you were incorrectly covered under the Plan. You will be provided at least 30 days' advance written notice before coverage may be rescinded.

Rehire Provision/Reinstatement of Coverage
After you become covered under the Plan, if your employment ends and you are rehired by the Employer within 30 days after your termination date, your coverage will take effect on the first day you report for employment with the Employer. The waiting period will be waived.

If your coverage resumes within the same Calendar Year, the Plan will consider coverage continuously in force for purposes of applying the Deductible, Out-of-Pocket Maximum, and Plan maximums.

If you were not covered under the Plan on the date of your termination or you are rehired by the Employer more than 30 days after your termination date, you will be treated as a new Employee and will be required to satisfy the eligibility and enrollment provisions to obtain coverage under the Plan.

Effect of Termination of Coverage
When your coverage ends, the Plan will still pay claims for Covered Expenses that you Incurred before your coverage ended. However, once your coverage ends, benefits are not provided for any items or services you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Continuation of Plan Coverage due to Approved Leave of Absence (Paid and Unpaid)
Medical and Prescription Drug coverage will be continued by your Employer for you and your Dependents in the event of an approved Leave of Absence, regardless of whether such leave is paid or unpaid. Coverage will continue as follows:

(1) In the event of an approved Leave of Absence, your coverage may continue for up to 12 months provided you continue to pay the premium. Continuation may be extended past 12 months if approved by the Employer.

If your leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will run concurrent with FMLA.

Coverage under this provision will continue in accordance with the same terms and conditions of an active Employee. If a COBRA qualifying event occurs, any period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

During a paid leave, your contributions will continue to be deducted from your pay on a pre-tax basis. During an unpaid leave, you will be invoiced for your contributions on an after-tax basis.

You may discontinue your coverage during an unpaid Leave Of Absence. In this case, when you return to work after the leave, and you re-enroll or your coverage is reinstated, your coverage will generally be the same as before the leave unless you experience an event that permits a mid-year election change or there is an intervening annual enrollment period.

Continuation of Coverage under the Family and Medical Leave Act (FMLA)
The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended, and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. During a paid leave, your contributions will continue to be deducted from your pay on a pre-tax basis. During an unpaid leave, you will be invoiced for your contributions on an after-tax basis. You may discontinue your coverage during an unpaid leave of absence. In this case, when you return to work after the leave, and you re-enroll or your coverage is reinstated, your coverage will generally be the same as before the leave unless you experience an event that permits a mid-year election change or there is an intervening annual enrollment period. Failure to make required payments within 30 days of the due date established by your Employer will result in the termination of coverage for you and/or your eligible Dependents.

If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for you and your covered Dependents if you return to work at the end of the FMLA leave.

Continuation of Coverage under State Family and Medical Leave Laws
To the extent this Plan is required to comply with a state leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such state leave law, as well as under FMLA. Such leaves may run concurrently, to the extent permitted by the FMLA and state leave law.

Continuation of Coverage under USERRA
You may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from employment more than 30 days due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Plan immediately prior to your leave for military service. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore, unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Plan Administrator to the Plan Administrator within 60 days after the date of your leave for military service. Coverage under the Plan will become effective as of the date of your leave for military service and will continue for the lesser of (a) 24 months (beginning on the date your absence for military service begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of the Employer. Your Employer will notify you of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee’s health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee’s eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should contact Your Benefits Resources (YBR) at (844) 474-6641 if you have questions about your rights to continue health coverage under USERRA.

ELIGIBLE MEDICAL EXPENSES

NOTE: Sex-specific eligible health services are covered when Medically Necessary and appropriate (and not specifically excluded as a non-covered service), regardless of a Covered Person's identified gender.

NOTE: Certain items and services are subject to medical management (precertification) (sometimes referred to as prior authorization). Please refer to the Medical Management Program section for details regarding the items and services that are subject to medical management and require precertification.

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

(1) Routine care or preventive services provided such services are ordered and performed by a Physician (or other eligible health care provider as described in this Plan) and not otherwise excluded under the Plan; or

(2) Due to Illness or Injury provided such services are ordered and performed by a Physician (or other eligible health care provider as described in this Plan), Medically Necessary and not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses Incurred at a Participating Provider will be reimbursed to the provider.

(1) **AccoladeCare:** AccoladeCare provides 24/7/365 access to a national network of U.S. board-certified Physicians who can resolve many of your medical issues. AccoladeCare services involve the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact.

For any questions with respect to AccoladeCare, please contact Accolade. Coverage under this benefit does not include consults from your regular Physician; it only includes coverage for consults to the extent the Physician who is consulted participates in the AccoladeCare program. To learn more about AccoladeCare, see the AccoladeCare contact information under General Plan Information section of the Plan.

AccoladeCare benefits include:

- 24/7/365 access to a Physician online or by phone
- Fast treatment
- Talk to an AccoladeCare Physician from anywhere: at home, work, or while traveling
- Save money by avoiding expensive urgent care or emergency room visits

Virtual care can be used for many of the same medical reasons you currently visit you Physician, such as:

<u>Urgent Medical Issues</u>

- Cold and flu
- Urinary tract infections
- Sinus and bacterial infections
- Rashes

<u>Ongoing Conditions</u>

- Diabetes
- High blood pressure
- Anxiety or depression
- Asthma
- Thyroid Disorders

Everyday Care

- Prescriptions and refills
- Birth control
- HIV prevention (PrEP)
- Preventive care and screenings

Virtual care should not be used for emergency or life-threatening situations. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(2) **Acupuncture:** Services by a licensed Doctor of Medicine, Doctor of Osteopathic Medicine or Acupuncturist. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(3) **Allergy Services:** Allergy testing, serum, and injections. Some allergy services may be payable under the Physician office visit benefit.

(4) **Ambulance Service:** Professional ambulance service to transport the Covered Person:

(a) To the nearest Hospital equipped to treat the specific Illness or Injury in an emergency situation; or

(b) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or

(c) To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or

(d) From the Hospital to the patient's home or to a Skilled Nursing Facility, Rehabilitation Facility, or any other type of convalescent facility nearest to the patient's home when there is documentation the patient required ambulance transportation.

Air ambulance is covered when terrain, distance or condition warrants. Professional ambulance charges for convenience are not covered.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(5) **Ambulatory Surgical Center:** Services and supplies provided by an Ambulatory Surgical Center. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(6) **Anesthetics:** Anesthetics and their professional administration.

(7) **Blood and Blood Derivatives:** Blood, blood plasma or blood components not donated or replaced.

(8) **Bone Anchored Hearing Aid:** Services and supplies related to a bone anchored hearing aid only when the Covered Person has either of the following criteria:

(a) Craniofacial anomalies resulting in abnormal or absent ear canals preventing the use of a wearable (non-implantable) hearing aid; or

(b) Hearing loss that is severe enough that it would not be remedied with a wearable (non-implantable) hearing aid.

Any maximum for hearing aids does not apply to Bone Anchored Hearing Aids (BAHA).

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(9) **Cardiac Rehabilitation:** Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(10) **CAR-T Cell Therapy:** For purposes of this Plan, CAR-T Cell Therapy is considered a transplant and is treated the same as any other transplant. Refer to the Aetna Institute of Excellence Program section of the Plan for further details on transplant coverage, including limitations with regard to eligible providers.

(11) **Cellular and Gene Therapy:** Cellular and Gene Therapy received on an Inpatient or outpatient basis at a Hospital or on an outpatient basis at an alternate facility or in a Physician's office.

(12) **Chemotherapy:** Services and supplies related to chemotherapy. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(13) **Chiropractic Care/Spinal Manipulation:** Skeletal adjustments, manipulation, or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(14) **Circumcision:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as a newborn expense.

(15) **Cleft Palate and Cleft Lip:** Services and supplies related to cleft palate and cleft lip. Cleft palate is defined as a birth deformity in which the palate (the roof of the mouth) fails to close, and cleft lip is defined as a birth deformity in which the lip fails to close. Eligible expenses include the following when provided by a Physician, or other professional provider:

(a) Oral and facial Surgery, surgical management and follow-up care by plastic surgeons and oral surgeons.

(b) Habilitative speech therapy.

(c) Otolaryngology treatment.

(d) Audiological assessments and treatment.

(e) Orthodontic Treatment.

(f) Prosthodontic treatment.

(g) Prosthetic treatment such as obturators, speech appliances and feeding appliances.

(16) **Cochlear Implants:** Services and supplies related to cochlear implants when Medically Necessary, and the related maintenance and adjustments. Benefits include post-cochlear implant aural therapy under the recommendation of a Physician.

(17) **Cognitive Therapy:** Restorative or rehabilitative cognitive therapy under the recommendation of a Physician for treatment following a post-traumatic brain Injury or stroke. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(18) **Contraceptives:** Contraceptive procedures and medications other than those considered preventive services, including, but not limited to: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants and any related office visit. Some contraceptives may be available under the Prescription Drug Card Program. The Plan does not cover contraceptive supplies or devices available without a Physician's prescription or contraceptives provided over-the-counter (unless the expense qualifies as a preventive service that the Plan is required to cover under federal law).

(19) **Cosmetic Procedures/Reconstructive Surgery:** Cosmetic/reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Illness, or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance. Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:

(a) For the correction of a Congenital Anomaly for a Dependent Child.

(b) Any other Medically Necessary Surgery related to an Illness or Injury.

(c) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:

(i) Reconstruction of the breast on which the mastectomy has been performed;

(ii) Surgery and reconstruction of the other breast to produce symmetrical appearance following a mastectomy (including reconstruction of the non-affected breast) and replacement of an existing breast impact when placement the initial implant followed a mastectomy; and

(iii) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Expense. You can contact Accolade for more information about benefits for mastectomy-related services.

(20) **COVID-19:**

COVID-19 Testing and Diagnosis: The Covered Person will not be responsible for the applicable Copay, Coinsurance, and/or Deductible for approved and authorized testing of COVID-19 and diagnosis of COVID-19 at a Physician's office (whether in-person or via telehealth), Urgent Care Facility, Emergency Room/ Department of a Hospital, alternate treatment facility, or other facility required by law, regardless of whether such item or service is provided by a Participating Provider or Non-Participating Provider. However, notwithstanding the foregoing, the Covered Person is responsible for the applicable Copay, Coinsurance, and/or Deductible for other services received during the visit.

(a) Testing must be provided at approved locations and in accordance with U.S. Centers for Disease Control and Prevention ("CDC") guidelines.

(b) Providers may be required to use specific HCPCS codes (or other codes) for COVID-19 testing.

NOTE: *This subsection will terminate at the end of the public health emergency period relating to the 2019 novel coronavirus (e.g., the public health emergency as a result of the 2019 novel coronavirus declared by the Secretary of Health and Human Service on January 31, 2020, as modified or extended) that is referenced in Section 6001(a) of the Families First Coronavirus Response Act, as amended (the "FFCRA").*

Certain Diagnostic Products, Tests, and Services for COVID-19: In accordance with the FFCRA and its implementing guidance, the Plan provides coverage, and does not impose any cost-sharing (including Deductibles, Copay, and Coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. § 1320b–5(g)):

(a) An in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such a test, that— (A) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. § 360(k), 360c, 360e, 360bbb–3); (B) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. § 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe; (C) is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID–19; or (D) other test that the Secretary of Health and Human Services determines appropriate in guidance.

(b) Items and services furnished to a Covered Person during health care provider office visits (which includes in-person visits and telehealth visits), Urgent Care Facility visits, and Emergency Room visits that result in an order for or administration of an in vitro diagnostic product described in the bullet point above, but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.

In accordance with Section 3202 of the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") and its implementing guidance, the Plan will reimburse the provider for the items and services described in this subsection with respect to a Covered Person as follows:

(a) If the Plan has a negotiated rate with such provider in effect before the public health emergency declared under section 319 of the Public Health Service Act (42 U.S.C. § 247d), such negotiated rate shall apply throughout the period of such declaration.

(b) If the Plan does not have a negotiated rate with such provider, the Plan shall reimburse the provider in an amount that equals the cash price for such service as listed by the provider on a public internet website, or the Plan may negotiate a rate with such provider for less than such cash price.

NOTE: *This subsection will terminate at the end of the public health emergency period relating to the 2019 novel coronavirus (e.g., the public health emergency as a result of the 2019 novel coronavirus declared by the Secretary of Health and Human Service on January 31, 2020, as modified or extended) that is referenced in Section 6001(a) of the FFCRA.*

Preventive Services for COVID-19: In accordance with Section 3203 of the CARES Act and its implementing guidance, the Plan will cover (without cost-sharing) any Qualifying Coronavirus Preventive Service, pursuant to section 2713(a) of the Public Health Service Act (42 U.S.C. 300gg–13(a)) (including the regulations under sections 2590.715–2713 of title 29, Code of Federal Regulations, section 54.9815–2713 of title 26, Code of Federal Regulations, and section 147.130 of title 45, Code of Federal Regulations (or any successor regulations)). The requirement described in this Section shall take effect with respect to a Qualifying Coronavirus Preventive Service on the Specified Date.

(a) The term "Qualifying Coronavirus Preventive Service" means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is—(A) an evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; or (B) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(b) The term "Specified Date" means the date that is fifteen (15) business days after the date on which a recommendation is made relating to the Qualifying Coronavirus Preventive Service.

(21) **COVID-19 Over-the-Counter (OTC) Tests:** Expenses related to OTC (over-the-counter) at home COVID-19 tests as determined by applicable and appropriate FFCRA and CARES acts, up to 8 tests per month per Covered Person. Additionally, OTC tests do not require a Physician's prescription, the Covered Person must purchase the test and submit a claim to the health plan for reimbursement. The Plan will pay for these types of tests the same as it would pay for any other COVID-19 testing service, subject to applicable terms of the Plan. This is in addition to any available benefits for OTC tests that are offered through the Prescription Drug Card Program.

NOTE: *This subsection will terminate at the end of the public health emergency period relating to the 2019 novel coronavirus (e.g., the public health emergency as a result of the 2019 novel coronavirus declared by the Secretary of Health and Human Service on January 31, 2020, as modified or extended) that is referenced in Section 6001(a) of the FFCRA.*

(22) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon for:

(a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.

(b) Emergency repair due to Injury to sound natural teeth, including the emergency replacement of sound natural teeth. Benefits for treatment of Accidental Injury are limited to the following:

(i) Emergency examination;

(ii) Diagnostic x-rays;

(iii) Endodontic (root canal) treatment;

(iv) Temporary splinting of teeth;

(v) Prefabricated post and core;

(vi) Simple minimal restorative procedures (fillings);

(vii) Extractions;

(viii) Post-traumatic crowns if such are the only clinically acceptable treatment; or

(ix) Replacement of lost teeth due to Injury with implant, dentures, or bridges.

(c) Surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth.

(d) Excision of benign bony growths of the jaw and hard palate.

(e) External incision and drainage of cellulitis.

(f) Incision of sensory sinuses, salivary glands, or ducts.

(g) Surgical extraction of:

(i) Bony, impacted teeth to treat cysts, tumors, and infections.

(ii) Teeth that will not erupt.

(iii) Teeth that cannot be removed without cutting into the bone.

(iv) Roots of a tooth without removing the tooth.

(v) Removal of teeth prior to cardiac Surgery, radiation therapy or transplant.

(h) Dental care (oral exam, x-rays, extractions, and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which benefits are available under the Plan, limited to:

(i) Transplant preparation.

(ii) Prior to the initiation of immunosuppressive drugs.

(iii) The direct treatment of cancer of cleft palate.

Expenses for treatment of congenitally missing, malposition or supernumerary (extra) teeth, even if part of a Congenital Anomaly will not be considered eligible.

Dental care that is required to treat the effects of a medical condition, but that is not needed to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or due to medication.

Benefits for general anesthesia and Hospital charges along with dental care provided to a Covered Person if the Covered Person:

(a) Is a child under the age of 18 who is diagnosed with a dental condition that requires certain dental procedures to be performed in a Hospital or alternate facility; or

(b) Is an individual who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

(c) Who requires the service be performed in a Hospital to monitor the patient due to a serious underlying medical condition, such as heart condition, blood disorder, etc.; or

(d) Who requires services due to Accidental Injury to sound natural teeth.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(23) **Developmental Delay:** Testing and Medically Necessary treatment of developmental delay, including therapy. This type of testing and/or treatment may also be referred to as habilitative care/habilitative services. For purposes of this Plan, habilitative services/developmental delays means Medically Necessary skilled health care services that help a Covered Person keep, learn or improve skills and functioning for daily living. Services/treatment must not be Custodial Care, and must be part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline. Developmental delays/habilitative services does not refer to autism or autism spectrum disorder services, refer to the Mental Disorder benefit for further details. Any developmental delays that meet the definition of a Mental Disorder or Substance Use Disorder are paid under the separate Mental Disorder and Substance Use disorder benefits.

(24) **Diabetic Education:** The following diabetic education and self-management programs: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with diabetes. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(25) **Diabetic Eye Exams and Foot Care:** Services related to Medically Necessary eye exams and foot exams for Covered Persons with diabetes to prevent or treat complications associated with the Illness. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(26) **Diabetic Supplies & Equipment:** All Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes that are not covered under the Prescription Drug Card Program. Additionally, this benefit includes insulin pumps and their supplies. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(27) **Diagnostic Testing, X-ray, and Laboratory Services:** Diagnostic testing, x-ray and laboratory services, and services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care. Additionally, benefits include services related to advanced imaging (limited to: MRI, MRA, CT and PET scans, bone density, scintimammography, capsule endoscopy, nuclear medicine). Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(28) **Dialysis:** Treatment of a kidney disorder by dialysis as an Inpatient in a Hospital or other facility or for expenses in an outpatient facility or in the Covered Person's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person's home as shown under the Durable Medical Equipment benefit. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(29) **Durable Medical Equipment:** The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs and other Durable Medical Equipment subject to the following:

(a) The equipment must be prescribed by a Physician and Medically Necessary; and

(b) The equipment will be provided on a rental basis; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price); and

(c) Benefits will be limited to standard models as determined by the Plan; and

(d) The Plan will pay benefits for only one of the following unless Medically Necessary due to growth of the Covered Person or if changes to the Covered Person's medical condition requires a different product, as determined by the Plan: a manual wheelchair, motorized wheelchair, or motorized scooter; and

(e) If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible subject to prior approval by the Plan. In all cases, repairs, or replacement due to abuse or misuse, as determined by the Plan, are not covered; and

(f) Speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly due to an Illness or Injury. Benefits for the purchase of these devices are available only after completing a required 3-month rental period; and

(g) Expenses for the rental or purchase of any type of air conditioner, air purifier or any other device or appliance will not be considered eligible.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(30) **Emergency Services/Emergency Room:** When you experience an Emergency Medical Condition, coverage for Emergency Services will continue until your condition is Stabilized and:

(a) Your attending Physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care; and

(b) You are in a condition to be able to receive from the Non-Participating Provider delivering services the notice and consent criteria with respect to the services; and

(c) Your Non-Participating Provider delivering the services meets the notice and consent criteria with respect to the services.

If you go to an emergency room for what is not an Emergency Medical Condition, the Plan may not cover your expenses. See the Medical Schedule of Benefits and the General Exclusions and Limitations for specific Plan details. If your Physician decides you need to stay in the Hospital (emergency admission) or receive follow-up care, these are not Emergency Services. Different benefits and requirements apply.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(31) **Fertility**:

<u>Basic Fertility Expenses:</u>

(a) Diagnosis and testing for fertility performed by the Employee or Spouse's Primary Care Physician (PCP) or OB/GYN, including any Surgical Procedure to correct the underlying medical cause of infertility.

(b) Diagnosis and testing for fertility performed by any other fertility Specialist must be received by a Progyny in-network provider or will not be covered.

Comprehensive Fertility Services (Progyny Only)

Fertility benefits are provided through Progyny to provide all-inclusive comprehensive coverage for cutting-edge fertility treatments to assist an Employee or Spouse wishing to have a child. Progyny's program includes a credentialed provider network, and a personalized concierge-style member support team (Patient Care Advocates) who offer education, support, and coordinated care.

Progyny's program does not require a medical diagnosis of infertility in order to access fertility treatment services, which ensures that members of the LGBTQ+ community and single parents by choice receive equitable access to coverage. Progyny offers a full suite of fertility treatment options.

If you have any questions about your fertility benefit, please call your dedicated Progyny Patient Care Advocate, or you can call the Progyny General Enterprise line at (844) 470-1752 or refer to Attachment 1.

(32) **Gender Affirming Care:** Services and supplies provided in connection with gender affirmation when you have been diagnosed with gender identity disorder or gender dysphoria by a qualified Physician. Benefits include non-surgical treatment (i.e. psychotherapy, cross-sex hormone therapy and puberty suppressing medications when administered by a Physician in an office and/or outpatient setting and laboratory testing to monitor the safety of hormone therapy; if the hormone therapy is dispensed from a pharmacy and self-administered benefits may be considered under the Prescription Drug Card Program) as well as Surgical Procedures for treatment of gender dysphoria/gender identity disorder when specific criteria have been met and an approved pre-determination from the Plan has been obtained.

(a) Hair Procedure Requirements: A Covered Person is eligible for:

(i) Electrolysis or laser hair removal of the beard or other facial hair; or

(ii) A hair transplantation.

When the Covered Person has met the following criteria/requirements and can provide medical documentation:

(iii) Persistent, well-documented gender dysphoria;

(iv) Capacity to make a fully informed decision and to consent for treatment;

(v) Must be 18 years or older;

(vi) If significant medical or mental health concerns are present, they must be reasonably well controlled;

(b) Requirements for Breast/Chest and Genital Surgical Procedures: A Covered Person must provide documentation of the following criteria/requirements to be eligible for breast/chest and genital Surgeries. Documentation will be reviewed through the pre-determination process.

(i) Persistent, well-documented gender dysphoria;

(ii) Capacity to make a fully informed decision and to consent for treatment;

(iii) Must be 18 years or older;

(iv) If significant medical or mental health concerns are present, they must be reasonably well controlled;

(v) The Covered Person must have completed at least 12 months of successful continuous full-time real-life experience in the desired gender;

(vi) The Covered Person must have completed continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated); and

(vii) The providers treatment plan, the treatment plan must align with current standards of care (as determined through the pre-determination process).

Please contact Accolade with questions on how you or your Physician can begin a pre-determination. **An approved pre-determination must be obtained before services are provided.**

Eligible Surgical Procedures: The following Surgeries for gender identity disorder or gender dysphoria will be covered for males, females, and non-binary gendered individuals when the above 7 criteria/requirements are met and pre-determination approval has been obtained:

(A) Bilateral mastectomy or breast reduction

(B) Clitoroplasty (creation of clitoris)

(C) Hysterectomy (removal of uterus)

(D) Labiaplasty (creation of labia)

(E) Metoidioplasty (creation of penis, using clitoris)

(F) Orchiectomy (removal of testicles)

(G) Penectomy (removal of penis)

(H) Urethroplasty (reconstruction of urethra)

(I) Vaginoplasty (creation of vagina)

(J) Penile prosthesis

(K) Phalloplasty (creation of penis)

(L) Salpingectomy.

(M) Salpingo-oophorectomy (removal of fallopian tubes and ovaries)

(N) Scrotoplasty (creation of scrotum)

(O) Testicular prosthesis

(P) Urethroplasty (reconstruction of urethra)

(Q) Vaginectomy (removal of vagina)

(R) Vaginoplasty (Creation of vagina)

(S) Vulvectomy (removal of vulva)

(T) Vasectomy.

(c) Requirements for Complementary and Reconstructive Procedures: A Covered Person must provide documentation of the following criteria/requirements to be eligible for complementary and reconstructive Surgical Procedures. Documentation will be reviewed through the pre-determination process.

(i) Persistent, well-documented gender dysphoria;

(ii) Capacity to make a fully informed decision and to consent for treatment;

(iii) Must be 18 years or older;

(iv) If significant medical or mental health concerns are present, they must be reasonably well controlled;

(v) The Covered Person must have completed at least 12 months of successful continuous full-time real-life experience in the desired gender; and

(vi) The Covered Person must have completed continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

Please contact Accolade with questions on how you or your Physician can begin a pre-determination. **An approved pre-determination must be obtained before services are provided.**

Eligible Surgical Procedures: The following ancillary Surgeries will be covered for males, females, and non-binary gendered individuals when the above 6 requirements are met:

(A) Voice modification therapy;

(B) Reduction of the thyroid chondroplasty (reduction of the adam's apple);

(C) Breast augmentation/insertion of breast prostheses;

(D) Voice modification Surgery;

(E) Facial feminization Surgery, including but not limited to: facial bone reduction, face “lift”, facial hair removal, and certain facial plastic reconstruction;

(F) Suction-assisted lipoplasty of the waist, hips or thighs;

(G) Body contouring;

(H) Brow lift;

(I) Calf implants;

(J) Cheek, chin and nose implants;

(K) Injection of fillers or neurotoxins;

(L) Lip augmentation;

(M) Lip reduction;

(N) Mastopexy;

(O) Pectoral implants for chest masculinization;

(P) Abdominoplasty;

(Q) Blepharoplasty; and

(R) Rhinoplasty.

If a Surgery or procedure is not listed above, then for purposes of this Plan the Surgery/Procedure will be considered Cosmetic and therefore will not be considered eligible. Additionally, the following services will not be considered eligible under this benefit:

(a) Skin resurfacing;

(b) Services received outside of the United States;

(c) Services related to the reversal of genital Surgery or Surgery to revise secondary sex characteristics will not be considered eligible.

NOTE: In addition to the above coverage information, please refer to the PayPal LGBTQ+ supplemental document for additional details.

(33) **Genetic Testing:** Diagnostic testing of Genetic Information and counseling when Medically Necessary. Genetic testing is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(34) **Hearing Aids (External/Non-Bone-Anchored):** Hearing aids required for the correction of a hearing impairment (including the fitting thereof) and related supplies. Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing. If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost. For purposes of this Plan, cochlear implants are not considered a hearing aid and will be paid under the cochlear benefit. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(35) **Home Health Care:** : Services provided by a Home Health Care Agency to a Covered Person who needs in-home non-Custodial Care due to the nature of the Covered Person’s condition and who’s Physician or other eligible provider prescribes such services. The following are considered eligible home health care services:

(a) Home nursing care;

(b) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);

(c) Visits provided by a medical social worker (MSW);

(d) Physical, occupational, speech, or respiratory/pulmonary therapy if provided by the Home Health Care Agency;

(e) Medical supplies, drugs and medications prescribed by a Physician;

(f) Laboratory services; and

(g) Nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each 4 hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, transportation services, housekeeping services and meals, etc., be considered an eligible expense.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(36) **Hospice Care:** Hospice care on either an Inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of 6 months or less.

Covered services include:

(a) Room and board charges by the Hospice.

(b) Other Medically Necessary services and supplies.

(c) Nursing care by or under the supervision of a registered nurse (R.N.).

(d) Home health care services furnished in the patient's home by a Home Health Care Agency for the following:

(i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and

(ii) physical and speech therapy.

(e) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.

(f) Nutritional counseling by a licensed dietician.

(g) Respite care.

(h) Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family within 6 months after the patient's death. For the purposes of bereavement counseling, the term "Patient's Immediate Family" means the patient's spouse, parents of a Dependent Child and/or Dependent Children who are covered under the Plan.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(37) **Hospital Services or Long-Term Acute Care Facility/Hospital:**

(a) Inpatient

Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units).

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

(b) Outpatient

Services and supplies furnished while being treated on an outpatient basis.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(38) **Infusion Therapy:** Services, supplies, and equipment necessary for infusion therapy provided:

(a) By a free-standing facility;

(b) By an outpatient department of a Hospital;

(c) By a Physician in his/her office; or

(d) In your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient infusion therapy services and supplies are Covered Expenses:

(a) The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;

(b) Professional services;

(c) Total parenteral nutrition (TPN);

(d) Chemotherapy;

(e) Drug therapy (includes antibiotic and antivirals);

(f) Pain management (narcotics); and

(g) Hydration therapy (includes fluids, electrolytes, and other additives).

Infusion therapy provided by a Home Health Care Agency will not be subject to the Home Health Care maximum benefit.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(39) **Lenses:** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants) will not be considered eligible.

(40) **Maternity:** Expenses Incurred by all Covered Persons for:

(a) Pregnancy.

(b) Preventive prenatal and breastfeeding support as identified under the preventive services section below.

(c) Services provided by a Birthing Center.

(d) Amniocentesis testing when Medically Necessary.

(e) Up to 2 ultrasounds per pregnancy (more than 2 only when it is determined to be Medically Necessary).

(f) When not prohibited by applicable state or local laws (including such laws that are not preempted by ERISA or other federal laws, elective induced abortions.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(41) **Medical and Surgical Supplies:** Casts, splints, trusses, braces, crutches, ostomy supplies, medical orthotics, prescribed compression garments, dressings cranial molding helmets and cranial banding, and other Medically Necessary supplies ordered by a Physician.

Ostomy supplies are limited to the following: pouches, face plates and belts; irrigation sleeves, bags, and catheters; and skin barriers. Urologic supplies for indwelling catheters are limited to: urinary drainage bags and insertion trays (kits), anchoring devices and irrigation tubing sets.

Eligible expenses for medical orthotics will be payable as shown in the Medical Schedule of Benefits.

(42) **Mental Disorders:** Care, supplies and treatment of a Mental Disorder including, but not limited to treatment for autism, ADD and ADHD and family counseling.

Benefits include, but are not limited to: Inpatient treatment, treatment in a Residential Treatment Facility, partial hospitalization/day treatment, intensive outpatient treatment and outpatient treatment. Inpatient treatment and Residential Treatment Facility services include room and board in a semi-private room (a room with two or more beds), unless a private room is Medically Necessary or a semi-private room is unavailable.

Additionally, Covered Expenses includes, but are not limited to: diagnostic evaluations, assessment and treatment planning, treatment and/or procedures, medication management and other associated treatments, individual, family, and group therapy, provider-based case management services and crisis intervention.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(43) **MinuteClinic:** Eligible virtual visits provided through MinuteClinic Virtual Care. Walk-in clinic health services provided at MinuteClinic for:

(a) Scheduled and unscheduled visits for minor Illnesses and Injuries;

(b) Routine vaccinations and immunizations administered with the scope of the clinic's license; and

(c) Screening and monitoring services.

Expenses for health examinations needed for employment, to go to a school, camp, or sporting event, or to join in a sport or other recreational activity will not be covered under the MinuteClinic benefit but may be payable under other provisions of the Plan.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(44) **Morbid Obesity:** Charges for care and treatment of Morbid Obesity (including surgical treatment), and weight loss or dietary control. Coverage for endogenous obesity will be limited to bariatric Surgery when Medically Necessary.

(45) **Nutritional Counseling:** Services related to nutritional counseling for a covered Illness when patient self-management is a part of the treatment for the Illness and there is lack of knowledge regarding the Illness which requires the help of a trained professional. Nutritional counseling is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(46) **Nutritional Supplements/Enteral Nutrition:** Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life for Covered Persons who are or will become malnourished or suffer from disorders, which left untreated will cause chronic disability or intellectual disability. Covered Expenses include rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation, and special dietary treatment when prescribed by a Physician for Covered Persons with

inherited metabolic diseases, such as phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietician.

(47) **Occupational Therapy:** Rehabilitative occupational therapy rendered by a qualified Physician or a licensed occupational therapist under the recommendation of a Physician. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(48) **Off-Label Drug Use:** Services and supplies related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

(a) The named drug is not specifically excluded under the General Exclusions and Limitations section of the Plan; and

(b) The named drug has been approved by the FDA; and

(c) The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and

(d) If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer.

(49) **Physical Therapy:** Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician. This includes Medically Necessary aquatic therapy (hydrotherapy or pool therapy) for musculoskeletal conditions when provided by a physical therapist or other recognized, licensed provider. Eligible expenses include the professional charges for physical therapy modalities administered in a pool, which require direct one-on-one patient contact. Charges for aquatic exercise programs or separate charges for use of a pool are not covered. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(50) **Physician's Services:** Services of a Physician for medical care or Surgery.

(a) Services performed in a Physician's office on the same day for the same or related diagnosis. Services include, but are not limited to: examinations, supplies, injections, x-ray, and laboratory tests (including the reading or processing of the tests), cast application and minor Surgery.

(b) For multiple or bilateral surgeries performed during the same operative session which are not incidental or not part of some other procedure and which add significant time or complexity (all as determined by the Plan) to the complete procedure, the charge considered will be: (i) 100% for the primary procedure; (ii) 50% for the secondary procedure, including any bilateral procedure; and (iii) 50% for each additional covered procedure. This applies to all Surgical Procedures, except as determined by the Plan.

(c) For surgical assistance by an Assistant Surgeon, the charge will be 25% of the corresponding Surgery.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(51) **Podiatry:** Treatment for the following foot conditions: (a) bunions when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed or treatment of ingrown toenails; (d) any Medically Necessary Surgical Procedure required for a foot condition. In addition, orthopedic shoes when an integral part of a leg brace will also be covered, as well as the purchase, fitting and repair of custom-fitted foot orthotics when determined to be Medically Necessary by the attending Physician.

(52) **Pre-Admission Testing:** Outpatient pre-admission testing performed prior to a scheduled Inpatient hospitalization or Surgery.

(53) **Prescription Drugs/Pharmaceutical Products:** Prescription Drugs, injectables or supplies used for the treatment of a covered Illness or Injury, which are dispensed through the Physician's office, infusion center or other clinical setting, the Covered Person's home by a third party, or take-home Prescription Drugs from a Hospital are covered under the major medical benefits of this Plan and separate from the Prescription Drug Card Program benefits. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Your Prescription Drug Card Program Administrator may have certain provisions regarding Specialty Drug coverage. In those cases, those drugs will only be payable under the major medical benefits if those drugs fall outside any Specialty Pharmacy Program, as applicable (as noted in the Prescription Drug Card Program section).

(54) **Preventive Services and Routine Care:** The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:

(a) Preventive Services

(i) Evidence-Based Preventive Services

Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (the "Task Force") with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer (including 3D mammography), the recommendations of the Task Force issued in 2016 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.

(ii) Routine Vaccines/Immunizations

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(iii) Prevention for Children and Adolescents

With Respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(iv) Prevention for Women

With respect to women, such additional preventive care, and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services). Those guidelines generally include the following:

(A) Well-woman visits. Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The inclusion of a well-woman visit is not meant to limit the coverage for any other preventive service described elsewhere in this Plan document that might be administered as part of the well-woman visit.

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman. In the event a provider bills a "maternity global rate", the portion of the claim that will be considered for prenatal visits and therefore, preventive care, is 40% of the "maternity global rate". As a result, 60% of the "maternity global rate" will be considered for delivery and postnatal care and the normal cost-sharing provisions would apply. Items not considered preventive (and therefore subject to normal cost-sharing provisions) include Inpatient admissions, high risk specialist units, ultrasounds, amniocentesis, fetal stress tests, delivery including anesthesia and certain pregnancy diagnostic lab tests.

(B) Screening for gestational diabetes.

(C) Human papillomavirus (HPV) testing. High-risk HPV DNA testing in women with normal cytology results. Screening is limited to women age 30 or older and is limited to 1 screening every 3 Calendar Years.

(D) Counseling annually for sexually transmitted infections (including for the human immunodeficiency virus (HIV)) and screening annually for HIV for all sexually active women. Limited to 2 counseling sessions per Calendar Year.

(E) Screening and counseling annually for interpersonal and domestic violence.

(F) Contraceptive methods and counseling, as prescribed by your Physician. All FDA approved contraceptive methods (see Preventive Drugs section below), sterilization procedures and patient education and counseling for women with reproductive capacity. Contraceptive counseling is limited to 2 visits per 12-month period.

For purposes of the above, the sterilization procedures to be considered preventive include any FDA approved sterilization implants and surgical sterilization either abdominally, vaginally or laparoscopically. Eligible charges for a sterilization procedure and all ancillary services will be covered when sterilization is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed as such. However, complications arising following a sterilization procedure are not covered as preventive services. Covered Expenses do not include charges for a sterilization procedure to the extent the procedure was not billed separately by the provider or because it was not the primary purpose of the procedure. To the extent sterilization is part of another procedure and/or is not a separate line on the bill, the sterilization procedure is not a Covered Expense.

(G) Breastfeeding support, supplies, and counseling in conjunction with each birth, including the following:

(1) Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby's date of birth). Lactation consultation is limited to 6 cumulative visits per 12-month period.

(2) Breastfeeding equipment will be covered, subject to the following:

(i) Rental of a Hospital grade electric pump while the baby is Hospital confined; and

(ii) Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested during pregnancy or during the duration of breastfeeding, provided the Covered Person remains continuously enrolled in the Plan.

(3) For women using a breast pump from a prior pregnancy, one new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding.

For a detailed listing of women's preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.hrsa.gov/womens-guidelines. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such preventive services to the extent required by such guidelines.

(v) Preventive Drugs means items which have been identified by the U.S. Department of Health and Human Services (HHS) or other applicable regulatory agency as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits. For a paper copy, please contact Accolade. To the extent the above does not cover any preventive service required to be covered by the U.S. Department of Health and Human Services (HHS) the above shall be deemed to be amended to cover such preventive service to the extent required by the HHS.

(b) Routine Care

Routine care including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or immunizations (including flu vaccines), well child care, pap smears, mammograms, colon exams and PSA testing. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness.

The above routine care items are covered in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.

(55) **Private Duty Nursing (Outpatient):** Private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.) for outpatient private duty nursing when care is Medically Necessary and not Custodial in nature. Charges covered for outpatient nursing care billed by a Home Health Care Agency are shown under Home Health Care Services and Supplies. Outpatient private duty nursing care not billed by a Home Health Care Agency must be supported by a certification and a treatment plan from the attending Physician. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Expenses related to Inpatient private duty nursing will not be considered eligible.

(56) **Prosthetic Devices:** Artificial limbs, eyes, or other prosthetic devices when Medically Necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs, or replacement due to abuse or misuse, as determined by the Plan, are not covered. This section only refers to external prosthetic devices; prosthetic devices that are internal and/or implantable are considered a Covered Expense when Medically Necessary and appropriate and will be considered as part of the Surgical Procedure that is performed to implant/place the internal prosthetic.

If more than one prosthetic device can meet your functional needs, benefits are limited to the device that meets the minimum specifications for the Covered Persons needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If a Covered Person purchases a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and the Covered Person may be responsible for paying any difference in cost.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(57) **Qualified Clinical Trial Expenses:** Expenses that are, except as excluded below, healthcare items and services for the treatment of cancer or any other life threatening condition for a qualifying individual enrolled in a Qualified Clinical Trial that are otherwise consistent with the terms of the Plan and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

For purposes of this section, a “life threatening condition” means any condition or disease from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and a “qualifying individual” means any Covered Person who is eligible to participate in a Qualified Clinical Trial according to the trial protocol for treatment of cancer or any other life threatening condition that makes his or her participation in the program appropriate, as determined based on either (i) a conclusion of a referring health care professional or (ii) medical and scientific information provided by the Covered Person.

Notwithstanding the above, Qualified Clinical Trial expenses do not include any of the following:

(a) Costs associated with managing the research associated with the Qualified Clinical Trial; or

(b) Costs that would not be covered for non-Experimental and/or Investigational treatments; or

(c) Any item or service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(58) **Radiation Therapy:** Radium and radioactive isotope therapy treatment. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(59) **Reconstructive Surgery:** See Cosmetic Procedures/Reconstructive Surgery.

(60) **Rehabilitation Facility:** Inpatient care in a Rehabilitation Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (c) is not for Custodial Care.

See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(61) **Respiratory/Pulmonary Therapy:** Respiratory/pulmonary therapy under the recommendation of a Physician. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(62) **Routine Newborn Care:** Routine newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the mother's expense.

If the newborn is ill, suffers an Injury or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

(63) **Second Surgical Opinion:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required.

(64) **Skilled Nursing Facility:** Skilled nursing care in a Skilled Nursing Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (c) is not for Custodial Care.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(65) **Sleep Disorders:** Sleep disorder treatment and sleep studies that are Medically Necessary.

(66) **Speech Therapy:** Restorative or rehabilitative speech therapy rendered by a qualified Physician or a licensed speech therapist under the recommendation of a Physician, necessary because of loss or impairment due to an Illness, Injury or Surgery or therapy to correct a Congenital Anomaly. Speech therapy to treat stuttering, stammering, or other articulation disorders will not be covered. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(67) **Sterilization:** Elective sterilization procedures (this does not include reversal of sterilization). Elective sterilization procedures are covered in addition to and to the extent they are not otherwise included for coverage under the preventive services section of the Plan.

(68) **Substance Use Disorders:** Care, supplies, and treatment of a Substance Use Disorder, including family counseling.

Benefits include, but are not limited to: Inpatient treatment, treatment in a Residential Treatment Facility, partial hospitalization/day treatment, intensive outpatient treatment and outpatient treatment. Inpatient treatment and Residential Treatment Facility services include room and board in a semi-private room (a room with two or more beds), unless a private room is Medically Necessary or a semi-private room is unavailable.

Additionally, Covered Expenses include, but are not limited to: diagnostic evaluations, assessment and treatment planning, treatment and/or procedures, medication management and other associated treatments, individual, family, and group therapy, provider-based case management services and crisis intervention.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(69) **Surgery:**

Outpatient: Services and supplies related to Surgery and/or Surgical Procedures when received on an outpatient basis (either at an Ambulatory Surgical Center or outpatient Hospital). Additionally, benefits include all outpatient scopic procedures (including both diagnostic and therapeutic). Eligible expenses for outpatient Surgery will be payable as shown in the Medical Schedule of Benefits.

Inpatient: Services and supplies related to Surgery and/or Surgical Procedures when received on an Inpatient basis when Medically Necessary and appropriate (depending on the complexity of the Surgical Procedure and patient status), benefits include Surgery for congenital heart disease as well as any other Illness or Injury that requires an Inpatient admission to perform Surgery. Eligible expenses for Inpatient Surgery will be payable as shown in the Medical Schedule of Benefits.

(70) **Telemedicine:** Services related to the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact by a covered provider. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(71) **Temporomandibular Joint Dysfunction (TMJ):** Services and supplies for the evaluation and treatment, including surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).

The treatment of jaw joint disorders (TMJ) includes conditions of structures linking the jawbone and skull and complex muscles, nerves and other tissues related to the temporomandibular joint. Benefits include (but are not limited to):

(a) Diagnosis: exams, radiographs and applicable imaging studies and consultation;

(b) Non-surgical treatment: clinical exams, oral appliances (orthotic splints), arthrocentesis and trigger-point injections; and

(c) Surgical Procedures when radiographic evidence shows joint abnormality, non-surgical treatment has not resolved the symptoms and pain is moderate or severe. Surgical Procedures include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations and FDA-approved TMJ prosthetic replacements when all other treatment has failed.

Benefits do not include the following services: surface electromyography; doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(72) **Transplants (Cornea Only):** Services and supplies in connection with Medically Necessary non-Experimental and/or non-Investigational cornea transplant procedures.

(a) If both the donor and the recipient are covered under this Plan, eligible expenses Incurred by each person will be treated separately for each person.

(b) If the recipient is covered under this Plan and the donor is not covered, eligible expenses Incurred by the donor will be considered eligible if not covered by the donor's plan.

(c) If the donor is covered under this Plan and the recipient is not covered, eligible expenses Incurred by the donor will not be covered.

(d) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology, and pathology fees for the removal of the organ and a Hospital's charge for storage or transportation of the organ.

Exclusions:

(a) Non-human and artificial organ transplants.

(b) Lodging expenses, including meals.

(c) Expenses related to the Covered Person's travel.

(d) The purchase price of any organ, tissue or any similar items which are sold rather than donated.

(e) Transplants which are not medically recognized and are Experimental and/or Investigational in nature.

NOTE: All non-cornea transplants must be received at an Aetna Institute of Excellence (IOE) provider, refer to the Aetna Institute of Excellence (IOE) section of the Plan for full details.

(73) **Travel and Lodging Expenses:** Expenses related to travel (transportation) and lodging for eligible Covered Expenses, subject to the following conditions:

(a) There is no Participating Provider available locally. The Covered Person must be unable to locate a Participating Provider within a 30-mile radius from the Covered Person's residence (as reflected on the Plan's records); and

(b) The service that travel and lodging is being utilized for must be a Covered Expense as shown in the Eligible Medical Expenses.

Travel and lodging reimbursement is subject to the following reimbursement conditions:

(a) Travel allowances. Travel is reimbursed between the patient's residence and the Participating Provider for direct route, round trip (air, train, shuttle, ferry, taxi (not limos or car services), or bus) transportation costs (coach class only). If traveling by the Covered Person's vehicle to the facility, mileage, parking, and toll cost will be reimbursed per IRS guidelines for medical transportation. Transportation must be primarily for and essential to the diagnosis, cure, mitigation, treatment, or prevention of an Illness, or for the purpose of affecting any structure or function of the body. The patient and companion must travel on the same day.

(b) Lodging allowances. Reimbursement of expenses Incurred by the patient and any companion for hotel lodging away from the patient's residence is reimbursed at a rate of $50 per night per person, to a maximum of $100 per night. Lodging cannot be lavish or extravagant and must be primarily for and essential to medical care. Lodging cannot have a significant element of personal pleasure, recreation, or vacation. To be eligible for a lodging allowance, medical care must provided by a Physician in a licensed Hospital or in a medical care facility that is related to, or equivalent of, a licensed hospital.

(c) Overall maximum. Travel and lodging reimbursements are limited to $10,000 per lifetime,. This is a combined maximum for the patient and the companion(s).

(d) Companions. One companion is permitted per adult and 2 parents or guardians are permitted per Child.

(e) The Covered Person must save transportation and lodging receipts to submit for reimbursement. To receive this travel and lodging benefit, all transportation and lodging expenses must satisfy the requirements set forth in federal tax law. To submit a claim for travel and lodging benefits, you may be required to complete a travel and lodging reimbursement form, provide information regarding the transportation and lodging expenses you incurred, submit copies of all receipts, and provide other information that is requested. Contact Accolade for more information and to obtain the reimbursement form.

Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Covered Person if the reimbursement exceeds the per diem rate.

The following are excluded :

(a) Meals and/or groceries;

(b) Alcoholic beverages;

(c) Deposits;

(d) Phone calls, newspapers, or movie rentals;

(e) Personal care items and/or souvenirs;

(f) Vehicle rental;

(g) Cleaning supplies; and

(h) Fuel.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

NOTE: This benefit does not include any travel and lodging expenses related to a transplant procedure covered under the Plan. See the Aetna Institute of Excellence (IOE) section of the Plan for information regarding any travel and lodging benefits available through the IOE program.

(74) **Urgent Care Facility:** Services and supplies provided by an Urgent Care Facility. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(75) **Vision/Orthotic Therapy:** Services and supplies related to Medically Necessary vision therapy/orthoptic therapy. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(76) **Wigs:** Purchase of a scalp hair prosthesis when Medically Necessary and necessitated due to hair loss. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

AETNA INSTITUTE OF EXCELLENCE (IOE) PROGRAM

The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses
Once it has been determined that you or one of your eligible Dependents may require an organ transplant, you, or your Physician should call the Medical Management Program Administrator to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements (refer to the Medical Management Program section). Organ means solid organ; stem cell; bone marrow and tissue.

Expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered at the Participating Provider level only if performed in a facility that has been designated as an IOE facility or that is an Aetna Participating Provider facility that has a single case rate agreement between an Aetna Participating Provider and Aetna for the type of transplant in question. Any treatment or service related to transplants that are provided by a facility that is not specified as an IOE network facility or that is not an Aetna Participating Provider facility that has a single case rate agreement between an Aetna Participating Provider and Aetna, even if the facility is considered a Participating Provider for other types of services, will not be covered. Please read each section below carefully.

Covered Transplant Expenses
Covered transplant expenses include the following:

(1) Charges for activating the donor search process with national registries.

(2) Compatibility testing of prospective organ donors that are immediate family members. For purposes of this section an “immediate” family member is defined as a first-degree biological relative. These are your biological parent, sibling, or child.

(3) Inpatient and outpatient expenses directly related to a transplant.

(4) Charges made by a Physician or a transplant team.

(5) Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.

(6) Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant services are typically Incurred during the 4 phases of transplant care described below. Expenses Incurred for one transplant during these 4 phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date the patient is discharged from the Hospital or outpatient facility for the admission or visits related to the transplant, whichever is later.

The 4 phases of one transplant occurrence and a summary of covered transplant expense during each phase are as follows:

(1) Pre-transplant evaluation/screening. Pre-transplant evaluation screening includes all transplant-related professional and technical components required for assessment, evaluation, and acceptance into a transplant facility’s transplant program.

(2) Pre-transplant candidacy screening. Pre-transplant candidacy screening includes Human Leukocyte Antigen (HLA) typing/compatibility testing of prospective organ donors that are immediate family members.

(3) Transplant event. A transplant event includes Inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more Surgical Procedures or medical therapies for a transplant; Prescription Drugs provided during your Inpatient stay or outpatient visits, including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your Inpatient stay or outpatient visits; cadaveric and live donor procurement.

(4) Follow-up care. Follow-up care includes all covered transplant expenses; home health care services; home infusion services and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

One Transplant Occurrence
The following are considered one transplant occurrence:

(1) Heart.

(2) Lung.

(3) Heart/Lung.

(4) Simultaneous Pancreas Kidney (SPK).

(5) Pancreas.

(6) Kidney.

(7) Liver.

(8) Intestine.

(9) Bone marrow/stem cell transplant.

(10) Multiple organs replaced during one transplant Surgery.

(11) Tandem transplants (stem cell).

(12) Sequential transplants.

(13) Car-T Cell Therapy

(14) Re-transplant of same organ type within 180 days of first transplant.

(15) Any other single organ transplant, unless otherwise excluded under the Plan.

More Than One Transplant Occurrence
The following are considered more than one transplant occurrence:

(1) Autologous blood/bone marrow transplant followed by allogeneic blood/bone marrow transplant (when not part of a tandem transplant).

(2) Allogeneic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).

(3) Re-transplant after 180 days of the first transplant.

(4) Pancreas transplant following a kidney transplant.

(5) A transplant necessitated by an additional organ failure during the original transplant Surgery/process.

(6) More than one transplant when not performed as part of a planned tandem or sequential transplant (i.e., a liver transplant with subsequent heart transplant).

(7) CAR-T and T Cell receptor therapy for FDA-approved treatments.

Limitations
Transplant coverage does not include charges for the following:

(1) Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.

(2) Services and supplies furnished to a donor when recipient is not a Covered Person.

(3) Home infusion therapy after the transplant occurrence.

(4) Harvesting or storage of organs without the expectation of immediate transplant for an existing Illness.

(5) Harvesting and/or storage of bone marrow, tissue, or stem cells without the expectation of transplantation within 12 months for an existing Illness.

(6) Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

Travel and Lodging Expenses
Travel and lodging expenses will be covered under the Plan subject to the conditions described below.

(1) Distance requirement. The IOE facility must be more than 100 miles away from the patient's residence (as reflected on the Plan's records).

(2) Travel allowances. Travel is reimbursed between the patient's home and the facility for round trip (air, train, or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking, and toll cost will be reimbursed per IRS guidelines for medical transportation. If traveling by auto to the facility, mileage, parking, and toll cost will be reimbursed per IRS guidelines.

(3) Lodging allowances. Reimbursement of expenses Incurred by the patient and any companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person, to a maximum of $100 per night. Lodging cannot be lavish or extravagant and must be primarily for and essential to medical care. Lodging cannot have a significant element of personal pleasure, recreation, or vacation.

(4) Overall maximum. Travel and lodging reimbursements are limited to $10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the patient, companion, and donor.

(5) Companions. One companion is permitted per adult and 2 parents or guardians are permitted per Child.

(6) The Covered Person must save transportation and lodging receipts to submit for reimbursement. To receive this travel and lodging benefit, all transportation and lodging expenses must satisfy the requirements set forth in federal tax law. To submit a claim for travel and lodging benefits, you may be required to complete a travel and lodging reimbursement form, provide information regarding the transportation and lodging expenses you incurred, submit copies of all receipts, and provide other information that is requested. Contact Accolade for more information and to obtain the reimbursement form.

(7) Additionally, the following services are not covered as part of the travel and lodging benefit: meals and/or groceries, alcoholic beverages, deposits, phone calls, newspapers or movie rentals, personal care items and/or souvenirs, vehicle rental, cleaning supplies, and fuel.

ALTERNATE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternate treatment plan, in which case those charges Incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternate benefits at its sole discretion and only when and for so long as it determines that alternate treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternate treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations, or other terms of the Plan.

(1) **Administrative Services:** Expenses for completion of claim forms and shipping and handling will not be considered eligible.

(2) **Adoption:** Expenses related to adoption will not be considered eligible.

(3) **After Termination Date:** Expenses which are Incurred after the termination date of your coverage under the Plan will not be considered eligible.

(4) **Alternative Treatments:** Expenses related to art therapy; aromatherapy; music therapy; dance therapy; animal assisted therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health will not be considered eligible.

(5) **Anti-Kickback:** Expenses related to charges that are prohibited by federal anti-kickback or self-referral statutes will not be considered eligible.

(6) **Athletic Performance Enhancement:** Expenses primarily to enhance athletic capabilities will not be considered eligible.

(7) **Autopsy:** Expenses related to autopsies and other coroner services and transportation services for a corpse will not be considered eligible.

(8) **Biofeedback:** Expenses related to biofeedback will not be considered eligible.

(9) **Cardiac Rehabilitation:** Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

(10) **Chelation Therapy:** Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning.

(11) **Christian Science:** Expenses for services ordered or provided by a Christian Science practitioner will not be considered eligible.

(12) **Close Relative:** Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative will not be considered eligible.

(13) **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible.

(14) **Convenience Items:** Expenses for personal hygiene and convenience items, including but not limited to television, telephone, beauty/barber service, guest service, supplies, equipment and similar incidental services and supplies for personal comfort (e.g. air conditioners, air purifiers and filters and dehumidifiers, batteries and battery chargers, car seats, chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners, exercise equipment, home modifications such as elevators, handrails and ramps, hot and cold compresses, hot tubs, humidifiers, jacuzzis, mattresses, medical alert systems, motorized beds, music devices, personal computers, pillows, power-operated vehicles, radios, saunas, stair lifts and stair glides, strollers, safety equipment, treadmills, vehicle modifications such as van lifts, video players, and whirlpools) will not be considered eligible.

(15) **Cosmetic Procedures:** Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under Eligible Medical Expenses.

Cosmetic procedures includes, but are not limited to: scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); skin abrasion procedures performed as a treatment for acne; liposuction or removal of fat deposits considered undesirable (including fat accumulation under the male breast and nipple); treatment for skin wrinkles or any treatment to improve the appearance of the skin; treatment for spider veins; sclerotherapy treatment of veins; hair removal; treatment of benign gynecomastia; removal of hanging skin on any part of the body (e.g. abdominoplasty and brachioplasty).

This exclusion does not apply to those procedures that are specifically listed as a Covered Expense under the Eligible Medical Expenses section of the Plan (or those that may be considered Reconstructive as determined by the Plan).

(16) **Counseling:** Expenses for religious, marital, or relationship counseling will not be considered eligible, except as specified under Eligible Medical Expenses.

(17) **Court-Ordered:** Expenses for any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation will not be considered eligible, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.

(18) **Cranial Molding Helmets and Cranial Banding:** Expenses for cranial molding helmets and cranial banding will not be considered eligible, except when used to avoid the need for Surgery, and/or to facilitate a successful surgical outcome.

(19) **Custodial Care:** Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

(20) **Dental Care:** Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia, or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses. Removal of impacted teeth will not be considered eligible.

(21) **Devices:** Expenses related to devices used as safety items, to assist performance in sports related activities, over-the-counter orthotic braces, enuresis alarms, non-wearable external defibrillator, ultrasonic nebulizers, diagnostic or monitoring equipment purchased for home use (unless otherwise specified under Eligible Medical Expenses), powered and non-powered exoskeleton devices and devices and computers to help in communication and speech except for speech aid devices and trachea-esophageal voice devices that are Medically Necessary due to lack of speech that is a direct result of an Illness or Injury will not be considered eligible.

(22) **Enzyme Replacement Therapy:** Expenses related to Enzyme Replacement Therapy will not be considered eligible.

(23) **Exercise Programs:** Expenses for exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(24) **Experimental and/or Investigational:** Expenses for treatment, procedures, devices, drugs, or medicines which are determined to be Experimental and/or Investigational will not be considered eligible, except for Off-Label Drug Use or when such expenses are considered Qualified Clinical Trial Expenses.

(25) **Foot Care:** Expenses for routine foot care, treatment of weak, unstable, or flat feet will not be considered eligible, unless for metabolic or peripheral vascular disease.

(26) **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

(27) **Growth Hormones:** Expenses for growth hormones will not be considered eligible, except as specified under the Prescription Drug Card Program.

(28) **Hair Loss:** Expenses for hair loss, hair transplants, wigs or any drug that promises hair growth, whether or not prescribed by a Physician, will not be considered eligible, except as specified under Eligible Medical Expenses. This exclusion does not apply to the Medically Necessary treatment of alopecia areata.

(29) **Hearing Exams:** Expenses for routine hearing examinations will not be considered eligible. This exclusion does not apply to any expenses otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(30) **Homeopathic Treatment:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

(31) **Hypnotherapy:** Expenses for hypnotherapy will not be considered eligible.

(32) **Illegal Occupation/Felony:** Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

(33) **Impulse Control Disorders:** Expenses for impulse control and conduct disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorders will not be considered eligible, outside the initial assessment.

(34) **Intracellular Micronutrient Testing:** Expenses related to intracellular micronutrient testing will not be considered eligible.

(35) **Language Services:** Expenses related to foreign language and sign language interpretation services offered by or required to be provided by a provider will not be considered eligible.

(36) **Long Term Storage:** Expenses for long term storage of more than 30 days will not be considered eligible. Examples include cryopreservation of tissue, blood, and blood products.

(37) **Maintenance Therapy:** Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

(38) **Massage Therapy:** Expenses for massage therapy or Rolfing will not be considered eligible, except when part of an overall patient treatment plan and the services are provided by an eligible provider.

(39) **Medically Necessary:** Expenses which are determined not to be Medically Necessary will not be considered eligible.

(40) **Missed Appointments:** Expenses for missed appointments will not be considered eligible.

(41) **No Legal Obligation:** Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's Plan to be primary.

(42) **Non-Covered Procedures:** Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.

(43) **Not Performed Under the Direction of a Physician:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

(44) **Not Recommended by a Physician:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

(45) **Nutritional Supplements:** Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as otherwise covered as a preventive service or as specified under Eligible Medical Expenses.

(46) **Obesity:** Expenses for surgical and non-surgical care and treatment of obesity including weight loss or dietary control, whether or not it is in any case a part of a treatment plan for another Illness, will not be considered eligible, except as otherwise covered as a preventive service or as specified under the Morbid Obesity benefit in the Eligible Medical Expenses section of the Plan.

(47) **Occupational Therapy:** Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.

(48) **Operated by the Government:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

(49) **Outside the United States (U.S.):** Expenses for services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible.

(50) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan. Additionally, this exclusion will not apply to over-the-counter COVID home tests as specified in the Eligible Medical Expenses section of the Plan.

(51) **Plan Maximums:** Expenses for charges in excess of Plan maximums will not be considered eligible.

(52) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Plan will not be considered eligible.

(53) **Private Duty Nursing (Inpatient):** Expenses for Inpatient private duty nursing services will not be considered eligible.

(54) **Psychosurgery (Lobotomy):** Expenses related to psychosurgery (lobotomy) will not be considered eligible.

(55) **Radioactive Contamination:** Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.

(56) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities (outside the initial assessment); behavior modification services; vocational testing or training; any form of non-medical self-care or self-help training, including any related diagnostic testing; health club memberships; adventure therapy, wilderness therapy and outdoor therapy or any similar programs will not be considered eligible. Diabetic education is considered eligible as specified under Eligible Medical Expenses. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.

(57) **Refractive Errors:** Expenses for radial keratotomy, Lasik Surgery, or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.

(58) **Required by Law:** In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

(59) **Riot/Revolt:** Expenses resulting from a Covered Person’s participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(60) **Services Not Permitted Under Applicable State or Local Laws:** Some state or local laws restrict the scope of health care services that a provider may render. In such cases, the Plan will not cover such health care services.

(61) **Sexual Dysfunction/Impotence:** Expenses for services, supplies or drugs related to sexual dysfunction/ impotence not related to organic disease will not be considered eligible, except as specified under the Prescription Drug Card Program. Expenses for sex therapy will not be considered eligible.

(62) **Sleep Therapy:** Expenses for treatment, services and supplies for sleep therapy will not be considered eligible.

(63) **Smoking Cessation:** Expenses for smoking and tobacco cessation programs, including smoking/tobacco deterrents will not be considered eligible, unless otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(64) **Snoring:** Expenses related to medical and surgical treatment of snoring will not be considered eligible except when provided as a part of a treatment for documented obstructive sleep apnea. Oral appliances for snoring will not be considered eligible.

(65) **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.

(66) **Sterilization:** Expenses for the reversal of elective sterilization will not be considered eligible.

(67) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan and for any Covered Person other than the Employee and Spouse will not be considered eligible, including but not limited to pre-pregnancy, conception, prenatal, childbirth and postnatal expenses. This exclusion does not apply to preventive services for any Covered Person as described under the Eligible Medical Expenses section of the Plan.

(68) **Third Party Exams:** Expenses related to physical, psychiatric, or psychological exams, testing, all forms of vaccinations and immunizations when required for school, sports, camp, travel, career or employment, insurance, marriage, adoption or required to get or maintain a license of any type will not be considered eligible. This exclusion does not apply to preventive services as described under the Eligible Medical Expenses section of the Plan.

(69) **Transplants:** Expenses for transplants performed outside the Aetna Institute of Excellence (IOE) Program will not be considered eligible, except for cornea transplants as specified under Eligible Medical Expenses. Please refer to the Aetna Institute of Excellence (IOE) Program section.

(70) **Travel:** Expenses for travel will not be considered eligible, except as specified under Eligible Medical Expenses.

(71) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.

(72) **Vision Care:** Expenses for vision care, including routine eye exams, professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages and as otherwise covered as a preventive service under the Eligible Medical Expense section of the Plan.

(73) **War:** Expenses for the treatment of Illness or Injury resulting from actively participating in a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities, or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

(74) **Weekend Admissions:** Expenses for care and treatment billed by a Hospital for non-Emergency Medical Condition admissions on a Friday, Saturday or Sunday will not be considered eligible, unless Surgery is scheduled within 24 hours.

(75) **Workers' Compensation:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Workers' Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Workers' Compensation or similar law and have reached the maximum reimbursement paid under Workers' Compensation or similar law will not be eligible for payment under this Plan.

PRESCRIPTION DRUG CARD PROGRAM

Eligible expenses include Prescription Drugs and medicines prescribed by a Physician or authorized prescriber and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician; diabetic supplies; fertility medication; sexual dysfunction/impotence medication; growth hormones; and contraceptives (regardless of intended use). See the Prescription Drug Schedule of Benefits for any cost-sharing provisions, if applicable.

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 30-day or 90-day supply. Maintenance drugs of more than a 30-day supply must be purchased either at a CVS retail pharmacy or through the mail order program.

When using the mail order program, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Expenses for certain medications that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under the medical benefits section of the Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

NOTE: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for certain medications that are not covered under the Prescription Drug Card Program). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will pay the Non-Preferred Drug Copay and will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

CVS Maintenance Choice Mandatory – Allow Opt Out
The Plan allows for 1 30-day fill of maintenance drugs at any retail pharmacy. After 1 fill, a 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy only or through the mail order program unless you call the Prescription Drug Program Administrator and opt out. If you opt out, you may continue to purchase a 30-day supply of maintenance drugs, however, you will not benefit from the savings of a 90-day supply. For additional information, please contact the Prescription Drug Card Program Administrator.

CVS True Accumulation Program
Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon, rebate or other manufacturer assistance.

Mandatory Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Step Therapy

What is Step Therapy?
Certain Prescription Drug classes are subject to Step Therapy. Step Therapy is a type of prior authorization. In most cases, you must first try a less expensive drug on the formulary (also called a drug list) that has been proven effective for most people with your condition before you can move up a "step" to a more expensive drug. This might mean trying a similar, more affordable Brand Name Drug. The more affordable drugs in the first phase are known as "Step 1" Prescription Drugs. Please note the formulary may change at any time. You will receive notice when necessary.

However, if you have already tried the more affordable drug and it didn't work or if your Physician believes it is Medically Necessary for you to be on a more expensive drug, he or she can contact the Prescription Drug Card Program Administrator to request an exception. If your Physician's request is approved, the Plan will cover the more expensive drug. The more expensive drugs are known as "Step 2" Prescription Drugs.

Step Therapy is a program especially for people who take Prescription Drugs regularly for ongoing conditions like arthritis and high blood pressure.

In Step Therapy, drugs are grouped in categories based on cost:

- Front-line drugs - the first step - are Generic Drugs proven to be safe, effective, and affordable. These drugs should be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.

- Back-up drugs - Step 2 and Step 3 drugs - are Brand Name Drugs. There are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Back-up drugs typically cost more than front-line drugs.

How does Step Therapy work?
The next time the Physician writes a prescription, ask the Physician if a Generic Drug listed by the Plan as a front-line drug is appropriate. It makes good sense to ask for these drugs first because, for most everyone, they work as well as Brand Name Drugs - and they almost always cost less.

If the Covered Person already tried a front-line drug, or his or her Physician decides one of these drugs isn't appropriate, then the Covered Person's Physician can prescribe a back-up drug. The Covered Person should ask his or her Physician if one of the lower-cost Brand Name Drugs (Step 2 drugs) listed by the Plan is appropriate. Remember, the Covered Person can always get a higher-cost Brand Name Drug at a higher Copay if the front-line or Step 2 back-up drugs are not appropriate.

If a Covered Person is currently using a medication that requires Step Therapy he or she may continue using that medication. If the Covered Person is trying to fill a medication for the first time in 6 months, he or she may be required to use the first-line therapy before the Step Therapy medication can be filled. Please contact the Prescription Drug Card Program Administrator for more information on the Step Therapy program.

Failure to use the Step Therapy program may result in the Covered Person being responsible for the entire cost of the drug.

Brand Name Drug: Means a trade name medication.

Generic Drug: A Prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Non-Preferred Drug: Any Brand Name Drugs that do not appear on the list of Preferred Drugs.

Preferred Drug: A list of Brand Name Drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists, and other health care professionals. The list of Brand Name Drugs is subject to periodic review and modification based on a variety of factors such as, but not limited to, Generic Drug availability, Food and Drug Administration (FDA) changes, and clinical information. The Prescription Drug Card Program Administrator will have a list of Preferred Drugs available.

Prescription Drug: Any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription"; (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) or federal law as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan. The list of Preventive Drugs is updated periodically, the Covered Person should contact the Prescription Drug Card Program Administrator to obtain the most current information.

Preventive Maintenance Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as preventive maintenance services used to treat the prevention of conditions relating to:

(1) Hypertension.

(2) Heart failure.

(3) Heart disease.

(4) Liver disease and/or bleeding disorder.

(5) Diabetes.

(6) Asthma.

(7) Conditions resulting from osteoporosis and/or osteopenia.

(8) Stroke.

(9) Depression.

(10) Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy.

For a list of Preventive Maintenance Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan. The list of Preventive Drugs is updated periodically, so you should contact the Prescription Drug Card Program Administrator to obtain the most current information.

Specialty Drug means those Prescription Drugs, medicines, agents, substances, and other therapeutic products that include one or more of the following particular characteristics:

(1) Address complex, chronic diseases with many associated co-morbidities (e.g., cancer, rheumatoid arthritis, hemophilia, multiple sclerosis);

(2) Require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and to limit waste;

(3) Limited pharmaceutical supply chain distribution as determined by the applicable drug's manufacturer; and/or

(4) Relative expense.

COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event".

Qualified Beneficiary
In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary".

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

COBRA-like Continuation Coverage for Domestic Partners
A Domestic Partner of an Employee generally is not entitled to continue coverage under COBRA; however, the Plan Sponsor has chosen to extend COBRA-like coverage to Domestic Partners and to the Child of a Domestic Partner. COBRA-like coverage is identical to a continuation of coverage under COBRA offered to a Spouse and any Dependent Child of an Employee. In the description of federal COBRA below, whenever the term:

(1) "Spouse" is used and wherever "qualified beneficiary" when referring to a Spouse is used, the term "Domestic Partner' as defined by the Plan also applies.

(2) "Dependent Child" is used, and wherever "qualified beneficiary" when referring to a Dependent Child is used, the Dependent Child of a Domestic Partner also applies.

(3) "Divorce" is used, termination of a domestic partnership applies.

(4) "COBRA coverage" is used, COBRA-like continuation coverage applies.

Qualifying Event
If you are a covered Employee, you, your Spouse and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:

(1) Your hours of employment are reduced; or

(2) Your employment ends for any reason other than your gross misconduct.

You, your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your Spouse and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your Spouse may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

If you are the Spouse and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

(1) Your spouse/parent-Employee dies;

(2) Your spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(3) You/your parents become divorced or legally separated.

Your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such Spouse and/or Dependent Child provide notice of the qualifying event to the COBRA Administrator and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and their obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months provided you provide notice of the qualifying event to the COBRA Administrator and elect to enroll in COBRA within 60 days following the later of; (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Extension of 18-Month Continuation Coverage Period
If you or a covered family member are determined to be disabled by the Social Security Administration (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th[t] day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to the COBRA Administrator on a date that is both within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice and before the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify the COBRA Administrator within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. This extension may be available to your Spouse and any Dependent Child receiving COBRA continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), get divorced or separated, or if a Dependent Child stops being eligible under the Plan as Dependent Child. This extension is only available if the second qualifying event would have caused your Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred. To qualify for this extension in coverage, notification must be given to your Employer within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Notice Requirement
The notice must be postmarked (if mailed) or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

(1) Name and address of the covered Employee or former Employee;

(2) Name and address of your Spouse, former Spouse, and any Dependent Children;

(3) Description of the qualifying event; and

(4) Date of the qualifying event.

In addition to the information above, if you, your Spouse, or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

(1) Name of person deemed disabled;

(2) Date of disability determination; and

(3) Copy of SSA determination letter.

If you cannot provide a copy of the SSA's determination by the deadline, complete and provide the notice as instructed and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage will be available until the copy of the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

Notice must be sent to the COBRA Administrator at:

Your Benefit Resources (YBR)
YBR Customer Care Center Address:
PayPal, P.O. Box 1380
Carol Stream, IL 60132-1380
(844) 474-6641
www.ybr.com/benefits/paypal

Termination of COBRA Continuation Coverage
COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however, coverage may end before the end of the maximum period on the earliest of the following events:

(1) The date the Plan Sponsor ceases to provide any group health plan coverage;

(2) The date on which the qualified beneficiary fails to pay the required contribution;

(3) The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first); or

(4) The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage
Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you may be required to pay up to 150% of the actual cost of coverage you elect for the 11-month extension period.

Additional Information
Additional information about COBRA continuation coverage is available from the COBRA Administrator, who is identified above.

Current Addresses
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.

Other Options
You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Enrollment in Medicare Instead of COBRA Continuation Coverage after Plan Coverage Ends
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

(1) The month after your employment ends; or

(2) The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

CLAIM PROCEDURES

NOTE: The following Claims and Appeals Procedures section only applies to medical claims that are denied (considered an adverse benefit determination) through your medical plan. For information regarding an appeal for a denied precertification, refer to Accolade. For information regarding appeals for a denied Prescription Drug or a denied prior authorization to a Prescription Drug, refer to CVS/Caremark. The following appeals information may only be utilized for medical claims as described below.

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your Participating Provider will file your claim for you. You may need to file a claim yourself for Non-Participating Providers. You may file the claim yourself by submitting the required information to:

Meritain Health, Inc.
P.O. Box 853921
Richardson, TX 75085-3921
(800) 925-2272

Most claims under the Plan will be “post service claims.” A “post service claim” is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

(1) The date of service;

(2) The name, address, telephone number and tax identification number of the provider of the services or supplies;

(3) The place where the services were rendered;

(4) The diagnosis and procedure codes;

(5) The amount of charges (including Network repricing information);

(6) The name of the Plan;

(7) The name of the covered Employee; and

(8) The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a “claim” since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing
All claims must be filed with the Claims Fiduciary within 24 months following the date services were Incurred. Claims filed after this time period will be denied.

Procedures for all Claims
The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e., you and your covered Dependents) must follow the procedures outlined in this section. There are 4 different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

(1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Claims Fiduciary will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Claims Fiduciary receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Claims Fiduciary will notify you as soon as possible, but not later than 24 hours after the Claims Fiduciary receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Fiduciary will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Claims Fiduciary's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if the initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

(2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, the Claims Fiduciary will notify you of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies. If such a claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the Claims Fiduciary will notify you of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim.

The Plan will continue to provide coverage pending the outcome of an appeal in accordance with Department of Labor regulations and requirements.

(3) **Pre-Service Claims.** For a pre-service claim, the Claims Fiduciary will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Claims Fiduciary needs additional time to process a claim, the Claims Fiduciary may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Claims Fiduciary notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Claims Fiduciary expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if receipt of the benefit is conditioned is conditioned, in part or in whole, on approval of the benefit in advance of obtaining medical care.

(4) **Post-Service Claims.** For a post-service claim, the Claims Fiduciary will notify you of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Claims Fiduciary needs additional time to process a claim, the Claims Fiduciary may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Claims Fiduciary notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension

will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is not a pre-service claim or an urgent care claim.

Approval of Initial Claim
If a claim is approved, the Claims Fiduciary will provide you with written or electronic notice of such approval. The notice will include:

(1) The amount of benefits to which you are entitled;

(2) The duration of such benefit;

(3) The time the benefit is to commence; and

(4) Other pertinent information concerning the benefit.

Manner and Content of Notice of Initial Adverse Determination
If the Claims Fiduciary makes an adverse benefit determination, it must provide to you in writing or by electronic communication:

(1) An explanation of the specific reasons for the adverse benefit determination;

(2) A reference to the specific provisions of the Plan upon which the adverse benefit determination is based;

(3) A description of any additional information or material that you must provide in order to perfect the claim;

(4) An explanation of why the additional material or information is necessary;

(5) A description of the Plan's appeal procedures and the time limits that apply to such procedures;

(6) A statement describing your right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action under ERISA Section 502(a) if the claim is denied on appeal;

(7) If an internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, either (a) the specific rule, guideline, protocol, or other similar criterion, or (b) a statement that such a rule, guideline, protocol, or other similar criterion will be provided upon your request and without charge;

(8) If the adverse benefit determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge; and

(9) If the adverse benefit determination relates to an urgent care claim, a description of the expedited appeal process.

Any notice of adverse benefit determination also will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A description of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an adverse benefit determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than 3 days after the oral notification.

Internal Review of Initial Adverse Benefit Determination
If you submit a claim for Plan benefits and it is initially denied (in whole or in part), you may request a review of that denial under the procedures described below.

You have 180 days after you receive notice of an initial adverse benefit determination within which to file a written notice of appeal to the Claims Fiduciary. For a request for a second level appeal, you have 60 days after you receive notice of an adverse benefit determination at the first level of appeal to request a second level appeal of the adverse benefit determination.

If you request a review of an adverse benefit determination within the applicable time period, the Plan Administrator may hold a hearing or otherwise ascertain such facts as it deems necessary and will render a decision which shall be binding on both parties. In deciding the appeal:

(1) The Plan will provide a review that does not afford deference to the adverse benefit determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse benefit determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse benefit determination.

(2) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse benefit determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the initial claim, nor a subordinate of any such individual.

(3) The Plan will identify to the Claimant any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial claim, without regard to whether the advice was relied upon in making the adverse benefit determination.

(4) For a requested review of an adverse benefit determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly expeditious method.

(5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information, and records relating to the claim and to submit issues and comments relating to the claim in writing to the Claims Fiduciary (or Insurer, if applicable). The reviewer will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(6) You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan’s deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.

(7) The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

(8) The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initial adverse benefit determinations (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P.O. Box 660908
Dallas, TX 75266-0908

Deadline for Internal Review of Initial Adverse Benefit Determinations

(1) Urgent Care Claims. The Plan provides for 2 levels of appeal for urgent care claims. For each level of appeal, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives your request for review of the initial adverse benefit determination (or of the first-level appeal adverse benefit determination).

(2) Pre-Service Claims. The Plan provides for 2 levels of appeal for a pre-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives your request for review of the initial adverse benefit determination (or of the first-level appeal adverse benefit determination).

(3) Post-Service Claims. The Plan provides for 2 levels of appeal for a post-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse benefit determination (or of the first-level appeal adverse benefit determination).

Manner and Content of Notice of Decision on Internal Review of Initial Adverse Benefit Determinations

Upon completion of its review of an initial adverse benefit determination (or a first-level appeal adverse benefit determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse benefit determination, the notice will include:

(1) A description of the Plan’s decision;

(2) The specific reasons for the decision;

(3) The relevant Plan provisions or insurance contract provisions on which its decision is based;

(4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits (whether a document, record, or other information is relevant to a claim will be determined by reference to 29 C.F.R. § 2560.503 1(m)(8));

(5) A statement describing your right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action under ERISA Section 502(a);

(6) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination on review, either (a) the specific rule, guideline, protocol, or other similar criterion, or (b) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination will be provided without charge to you upon request;

(7) If the adverse benefit determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request; and

(8) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your state insurance regulatory agency."

Any notice of adverse benefit determination will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A description of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Calculation of Time Periods
For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of an adverse benefit determination) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

If the Plan Administrator determines that special circumstances require an extension of time to review an initial claim, the Plan Administrator will provide you with written or electronic notice of the extension before the first day of the extension. The notice of the extension will include an explanation of the special circumstances requiring an extension of time and the date by which the Plan expects to render a determination.

The Plan Administrator's ability to extend the time for deciding an initial claim is subject to the following limitations:

(1) For a Post-Service Claim, no more than one extension of 90 days.

(2) For a Pre-Service Claim, no more than one extension of 15 days.

(3) For an Urgent Care Claim, no extension are allowed.

Adverse Benefit Determination
For purposes of the Plan's claim procedures, an "adverse benefit determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate. Adverse benefit determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Plan's Failure to Follow Procedures
If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy (including any available external review process) under state or federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "*de minimis* violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a

specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "*de minimis* violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

External Review of Adverse Benefit Determinations
If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse benefit determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with federal law.

Note that the federal external review process (including the expedited external review process described later in these procedures) is not available for review of all internal adverse benefit determinations. Specifically, federal external review is not available for review of an internal adverse benefit determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. Also, the federal external review process is available only for:

(1) An adverse benefit determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan's determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and

(2) A rescission of coverage; and

(3) An adverse benefit determination for that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in Sections 9816 and 9817 of the Internal Revenue Code and Treasury Regulations §§ 54.9816-4T through 54.9816-5T and 54.9817-1T (relating to preventing surprise medical bills and ending surprise air ambulance bills); and

(4) As otherwise required by applicable law.

For any adverse benefit determination for which external review is available, the federal external review requirements are as follows:

(1) You have 4 months following the date you receive notice of the Plan’s final internal adverse benefit determination within which to request an external review. The request for an external review must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P.O. Box 660908
Dallas, TX 75266-0908

(2) Within 5 business days following the date the Plan receives your external review request the Claims Fiduciary will complete a preliminary review. The Claims Fiduciary will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

   (a) If the request is complete and the claim is eligible for external review, the notice will state the claim is eligible and ready for external review.

   (b) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the Employee Benefits Security Administration.

   (c) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the

preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(3) Following the Claims Fiduciary's preliminary review, if the request is eligible for external review, the Claims Fiduciary will assign an independent review organization (IRO) that is accredited by URAC (a nonprofit organization promoting healthcare quality by accrediting healthcare organizations) or a similarly nationally recognized accrediting organization as soon as administratively feasible to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Claims Fiduciary will forward to the IRO all information and materials relevant to the final internal adverse benefit determination.

(4) The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit in writing, within 10 business days from the date of receipt of the notice, additional information, which the IRO must then consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Claims Fiduciary. The Claims Fiduciary, based upon any new information received, may reconsider its final internal adverse benefit determination. Reconsideration by the Claims Fiduciary will not delay the external review process. If the Claims Fiduciary does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

(5) Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Expedited External Review

You may request an expedited external review if you have received:

(1) A decision on an initial claim involving either urgent care or concurrent care, have a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

(2) A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay or health care item or service for which you received Emergency Services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

(1) A request for an expedited external review must be accompanied by a written statement from Your physician that your medical condition meets the criteria above

(2) Immediately following the date the Claims Fiduciary receives the external review request the Claims Fiduciary will complete a preliminary review. The Claims Fiduciary will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.

   (a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.

   (b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(3) Following the Claims Fiduciary's preliminary review, if the request is eligible for external review, the Claims Fiduciary will assign an independent review organization (IRO) to make a determination on the request for external review. The Claims Fiduciary will promptly forward to the IRO, by any available expeditious method (e.g., telephone, facsimile, etc.), all information and materials relevant to the final internal adverse benefit determination.

(4) The IRO must provide notice to the claimant and the Claims Fiduciary (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Claims Fiduciary. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO's notice is required to contain the following information:

   (a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

   (b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

   (c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

   (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

   (e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

   (f) A statement that judicial review may be available to you; and

   (g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination

A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

Statute of Limitations for Plan Claims
Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 3 years after the you are notified of the final review/appeal decision by the Claims Fiduciary. If you want to bring a legal action against the Plan, the Employer, or the Claims Fiduciary, you must do so within 3 years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the Plan, the Employer, or the Claims Fiduciary. You cannot bring any legal action against the Plan or Employer to recover benefits until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. You cannot bring any legal action against the Plan, the Employer, or the Claims Fiduciary for any reason unless you first complete all the steps in the appeal process described in this section.

All decisions by the Plan Administrator and Claims Fiduciary will be afforded the maximum deference permitted by law.

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Claims Fiduciary. However, in connection with a claim involving urgent care or services rendered by a Participating Provider, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Claims Fiduciary, in writing, to the contrary.

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator or Claims Fiduciary may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition for coverage.

Appeals Rights for Prescription Drugs and Precertification Requests
Covered Persons may be eligible to appeal denied claims for Prescription Drugs that are dispensed at a Pharmacy (those that should be obtained through the Prescription Drug Card Program) and denied precertifications (review of Medical Necessity prior to Surgery, hospitalization, tests and/or other procedures). These services are often used in conjunction with this medical Plan, however, appeals for those services, along with applicable rules, guidelines and appropriate steps for appealing a denied Prescription Drug claim and/or precertification request must be initiated with the appropriate party/company.

If you experience a denied Prescription Drug claim (i.e. the Pharmacist at your Pharmacy tells you a drug is not covered), you should contact your Prescription Drug Card Program Administrator at the number on the back of your ID card or the number as shown on the General Plan Information page, a customer service representative from the Prescription Drug Card Program Administrator can then explain your appeal rights.

Additionally, if a precertification (sometimes referred to as a prior authorization, notification or other terms that describe the Medical Necessity review process) is denied (i.e. your Physician tells you a precertification has been denied), but a claim has not been submitted yet and/or the procedure, test, Surgery or hospitalization has not been performed yet, you should call Accolade at the number listed on the back of your ID card or the number as shown on the General Plan Information section of this document, a customer service representative can explain how you initiate an appeal for a denied precertification.

COORDINATION OF BENEFITS

Benefits Subject to This Provision
This provision applies to all benefits provided under any section of this Plan.

Excess Insurance
If at the time of Injury, Illness, disease, or disability there is available or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under the Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

(1) Any primary payer besides the Plan;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third-party;

(4) Workers' Compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Vehicle Limitation
When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title, or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan shall pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

Allowable Expenses
"Allowable expenses" shall mean any Medically Necessary item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

Other Plan
"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

(1) Group, blanket, or franchise insurance coverage;

(2) Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;

(3) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance or employee benefit organization plans;

(4) Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;

(5) Coverage under any Health Maintenance Organization (HMO); or

(6) Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle accident and any other medical and liability benefits received under any automobile policy.

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no other plan involved. When this Plan is secondary, this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.

Order of Benefit Determination
For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim:

(1) A plan without a coordinating provision will always be the primary plan.

(2) The plan covering the person directly rather than as an employee's dependent is primary and the other plans are secondary.

(3) Active/laid-off employees or retirees: The plan which covers a person as an active employee (or as that employee’s dependent) determines its benefits before the plan which covers a person as a laid-off or retired employee (or as that employee’s dependent). If the plan which covers that person has not adopted this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

(4) Dependent Children of parents not separated or divorced or unmarried parents living together: The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent and if as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(5) Dependent Children of separated or divorced parents or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:

(a) The plan of the parent with custody pays first;

(b) The plan of the spouse of the parent with custody (the step-parent) pays next;

(c) The plan of the parent without custody pays next; and

(d) The plan of the spouse of the non-custodial parent pays last.

Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the Child’s health care expenses, the benefits of the plan that covers the Child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

(6) If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without notice to any person, release to, or obtain from any insurance company or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision. Each person claiming benefits under this Plan must give the Plan any facts needed to apply the coordination of benefits rules and determine benefits payable. If you do not provide the Plan the information needed to apply the coordination of benefits rules and determine the benefits payable, your claim for benefits will be denied.

Facility of Payment
Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan, Third Party Administrator or Prescription Drug Card Program Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery
Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations, or exclusions or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, Third Party Administrator, or Prescription Drug Card Program Administrator, as applicable, has the right to recover any such erroneous payment. Without limiting the foregoing, the Plan has a right to recover benefits it has paid on your or your Dependent's behalf that were: made in error, due to a mistake in fact, or due to a misrepresentation of facts.

A Covered Person, provider, another benefit plan, insurer or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator, Third Party Administrator, or Prescription Drug Card Program Administrator, as applicable, shall have discretion in deciding whether to obtain payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator, Third Party Administrator or Prescription Drug Card Program Administrator, as applicable, shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator, Third Party Administrator or Prescription Drug Card Program Administrator, as applicable, shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for any other Injury or Illness) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator, Third Party Administrator or Prescription Drug Card Program Administrator, as applicable, may also, in its sole discretion, deny or reduce future benefits (including future benefits for any other Injury or Illness) under any other group benefits plan maintained by the Plan Sponsor, to the extent permitted by applicable laws. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, most recent edition of the ICD or CPT standards, Medicare guidelines, HCPCS standards or other standards approved by

the Plan Administrator, Third Party Administrator or Prescription Drug Card Program Administrator, as applicable. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's reasonable attorneys' fees and costs, regardless of the action's outcome.

Further, a Covered Person and/or the Covered Person's dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns ("Plan Participants") shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s) or damages arising from another party's act or omission for which the Plan has not already been reimbursed.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

(1) In error;

(2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

(3) Pursuant to a misstatement made to obtain coverage under this Plan within 2 years after the date such coverage commences;

(4) With respect to an ineligible person;

(5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or

(6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Medicaid Coverage
You or your Dependent's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of you or your Dependent. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of such person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

Coordination of Benefits with Medicaid
In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

Coordination of Benefits with Medicare
When Medicare is the primary payer, the Plan will be the secondary payer and base its payment upon benefits allowable by Medicare. For purposes of this "Coordination of Benefits with Medicare" section, a Spouse does not include a Domestic Partner.

When you, your Spouse or Dependents (as applicable) are eligible for or entitled to Medicare and covered by the Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non-discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over, and rules concerning working disabled individuals (as discussed below).

In accordance with federal law, the following rules apply in determining whether Medicare or Plan coverage is primary health care coverage:

(1) The Working Aged Rule: Medicare benefits are secondary to benefits payable under the Plan for individuals entitled to Medicare due to being age 65 or over and who have Plan coverage as a result of his or her current employment status (or the current employment status of a Spouse of any age). When you or your Spouse become entitled for Medicare due to the attainment of age 65, you or your Spouse may still be eligible for benefits provided under the Plan based on your current employment status.

If, as a result, you have or your Spouse has primary coverage under the Plan, the Plan will pay the portion of your Incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

(2) The Working Disabled Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the Plan as a result of his or her current employment status (or the currently employment status of a family member). That is, if you or your Dependents are covered by the Plan based on your current employment status, Medicare benefits are secondary for you or your covered Dependents entitled to Medicare on the basis of disability (other than end- stage renal disease). In this case the Plan is primary.

(3) End-Stage Renal Disease Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease ("ESRD") or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a 3-month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to 3 months, subject to applicable law. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. Accolade can provide you with more detailed information on how this rule works.

(4) Domestic Partners: If an Employee’s Domestic Partner is covered by the Plan and the Domestic Partner is enrolled in Medicare, the Plan is the secondary payer. The plan pays secondary to Medicare for any Medicare-eligible Domestic Partner, even if the Domestic Partner is not enrolled in Medicare.

Medicare and COBRA
For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan’s Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

Coordination of Benefits with TRICARE
The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

NOTE: The Plan has a right to subrogation, third-party recovery, and reimbursement. References to "you" or "your" in this section shall include you, your estate, and your heirs and beneficiaries unless otherwise stated.

Payment Condition

(1) The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where any party besides the Plan is or may be responsible for expenses arising from an incident, and/or other insurance or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

(2) The Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or his or her attorney from any source and said funds shall be held in trust until such time as the obligations under this Subrogation, Third-Party Recovery and Reimbursement Section are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits, the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

(3) In the event a Covered Person settles, recovers, or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

(4) If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

(5) By participating in this Plan, you agree you will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner.

Subrogation

(1) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation, or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person fails to so pursue such rights or action. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Injury, Illness, disease, disability, or Accident for which any third party is considered responsible.

(2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person has or may have against any Coverage and/or party causing the Illness, Injury, disease, disability, or Accident to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement or proposed settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

(3) The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

(4) The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims if the Covered Person fails to file a claim or pursue damages against:

(a) The responsible party, its insurer, or any other source on behalf of that party;

(b) A person or entity alleged to have caused you to suffer an Injury, Illness, disease, or disability, or who is legally responsible for the Injury, Illness, disease, disability, or Accident;

(c) Any indemnifier of any person or entity alleged to have caused or who caused the Injury, Illness, disease, disability, or Accident;

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

(e) Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to an Injury, Illness, disease, disability, or Accident you allege or could have alleged were the responsibility of any third party;

(f) Any person or entity that is liable for payment to you on any equitable or legal liability theory;

(g) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(h) Any policy of insurance from any insurance company or guarantor of a third party;

(i) Workers' Compensation or other liability insurance company; or

(j) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement (Recovery)

(1) The Plan shall be entitled, under its subrogation and reimbursement rights, to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, made whole doctrine, "collateral source" rule, claim of unjust enrichment, or any other similar legal or equitable theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources or any source. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved up to the amount of benefits paid by the Plan and any expenses incurred in obtaining the recovery. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with the Plan. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

(2) No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

(3) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law or equity. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights or subrogation rights.

(4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

(5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease, or disability.

Covered Person is a Trustee Over Plan Assets

(1) Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury, Illness, disease, disability, or Accident. By virtue of this status, the Covered Person understands that he/she is required to:

   (a) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

   (b) Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

   (c) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment, or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

   (d) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

(2) To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, costs or expenses (including court, mediation, arbitration, dispute resolution, or similar costs and expenses), for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

(3) No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Illness, disease or disability, there is available or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan's "Coordination of Benefits" section.

The Plan's benefits shall be excess to any of the following:

(1) The responsible party, its insurer, or any other source on behalf of that party;

(2) A person or entity alleged to have caused you to suffer an Injury, Illness, disease, or disability, or who is legally responsible for the Injury, Illness, disease, disability, or Accident;

(3) Any indemnifier of any person or entity alleged to have caused or who caused the Injury, Illness, disease, disability, or Accident;

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

(5) Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to an Injury, Illness, disease, disability, or Accident you allege or could have alleged were the responsibility of any third party;

(6) Any person or entity that is liable for payment to you on any equitable or legal liability theory;

(7) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(8) Any policy of insurance from any insurance company or guarantor of a third party;

(9) Workers' Compensation or other liability insurance company; or

(10) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds
Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien or the Plan's right to subrogation and reimbursement.

Wrongful Death
In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply (including, but not limited to, personal representative of your estate, your heirs, and your beneficiaries), and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment. In the case of your death, the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

Obligations
(1) It is the Covered Person's obligation at all times, both prior to and after payment of benefits by the Plan:

(a) To notify the Plan, in writing, of any potential legal or equitable claim(s) you may have against any third party for acts which caused benefits to be paid or become payable;

(b) To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and cooperating in trial to preserve the Plan's rights;

(c) To provide the Plan with pertinent information (and respond to requests for information) regarding the Illness, disease, disability, Injury, or Accident, including Accident reports, settlement information and any other requested additional information;

(d) To take such action and execute and/or deliver such documents as the Plan or its agents or designees may require facilitating enforcement of its subrogation and reimbursement rights;

(e) To make court appearances, when so required;

(f) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

(g) To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received;

(h) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

(i) To not settle or release, without the prior written consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;

(j) To obtain the Plan's written consent before releasing any party from liability or payment of medical expenses;

(k) To instruct his/her attorney to ensure that the Plan or its authorized representative is included as a payee on any settlement draft;

(l) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

(m) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

(2) If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury, Illness, disease, disability, or Accident, out of any proceeds, judgment, settlement, or other funds or recovery received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

(3) The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons' cooperation or adherence to these terms.

(4) The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including but not limited to ambulance providers, hospitals, or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

(5) The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent.

(6) The Plan's rights to recovery will not be reduced due to your own negligence.

(7) No allocation of damages, settlement funds, or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides express written consent to the allocation.

(8) If any third party causes or is alleged to have caused you to suffer an Injury, Illness, disease, disability, or Accident while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered by this Plan.

Offset

If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds. Additionally, the Plan has the right to terminate your coverage under the Plan, deny future payment of Plan benefits, take legal action against you, and/or set off from any future Plan benefits the value of benefits the Plan has paid relating to any Injury, Illness, disease, disability, or Accident alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

Minor Status

(1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Sponsor or its designee retains sole, full, and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable state subrogation laws.

DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section provided, however, that any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

Accident means a non-occupational sudden and unforeseen event, definite as to time and place or a deliberate act resulting in unforeseen consequences.

Air Ambulance means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Ambulatory Surgical Center means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations. An Ambulatory Surgical Center is described in Section 1833(i)(1)(A) of the Social Security Act.

Ancillary Services means items and services provided by Non-Participating Providers or other non-Network providers at a Network facility that are any of the following:

(1) Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;

(2) Provided by assistant surgeons, hospitalists, and intensivists;

(3) Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary of the Department of Health and Human Services;

(4) Provided by such other specialty practitioners as determined by the Secretary of the Department of Health and Human Services;

(5) Provided by a Non-Participating Provider when no other Participating Provider is available; and

(6) Provided by a Non-Participating Provider if there is no Participating Provider who can furnish the item or service at the Network facility.

Assistant Surgeon means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have one Assistant Surgeon, or 2 Assistant Surgeons if Medically Necessary. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

Birthing Center means a place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year means January 1 – December 31.

Close Relative means a Covered Person's spouse, parent (including step-parents), sibling, child, grandparent, or in-law.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

Coinsurance has the same meaning as set forth in the section of this Plan entitled “General Overview of the Plan”.

Congenital Anomaly means a physical developmental defect that is present at birth.

Copay has the same meaning as set forth in the section of this Plan entitled “General Overview of the Plan”.

Cosmetic means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

Covered Expense means:

(1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.

(2) For Prescription Drug expenses, any Prescription Drugs, or medicines eligible for coverage under the Prescription Drug Card Program.

Covered Expenses are determined in accordance with the Third Party Administrator’s, Medical Management Program Administrator’s, or Prescription Drug Card Program Administrator’s, as applicable, reimbursement policy guidelines or as required by law. The Third Party Administrator, Medical Management Program Administrator, or Prescription Drug Card Program Administrator, as applicable, develops the reimbursement policy guidelines, in its discretion, following evaluation and validation of all provider billings in accordance with standardly accepted medical billing practices.

Covered Person means, individually, a covered Employee and each of his or her Dependents who are covered under the Plan.

Custodial Care means care, or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Dependent is a Covered Person, other than the Employee**,** who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility for Participation" section of the Plan. References to Dependent are for convenience only and do not necessarily mean that the Covered Person is an Employee’s dependent for federal, state, local, or other tax purposes.

Domestic Partner is defined in the "Eligibility for Participation" section of the Plan.

Durable Medical Equipment means equipment that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose with respect to an Illness or Injury;

(3) Is not implantable within the body;

(4) Generally is not useful to a person in the absence of an Illness or Injury; and

(5) Is appropriate for use in the home.

Emergency Department of a Hospital includes a hospital outpatient department that provides Emergency services.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 any of the following:

(1) Placing the health of the Covered Person (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 means, with respect to an Emergency Medical Condition:

(1) An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency.

(2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, “to stabilize” has the meaning as given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(3) Emergency Services include items and services otherwise covered under the Plan when provided by a Non-Participating Provider or facility (regardless of the department of the Hospital in which the items or services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency Medical Condition unless the following conditions are met:

   (a) The attending emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-emergency medical transportation to an available Participating Provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

   (b) The provider or facility furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law with respect to such items and services.

   (c) The patient (or an authorized representative of the patient) is in such a condition, as determined by the attending emergency Physician or treating provider using appropriate medical judgment, to receive information as stated in b) above and to provide informed consent in accordance with applicable law. For purposes of this paragraph c), an authorized representative is an individual authorized under state law to provide consent on behalf of the patient, provided that the individual is not a provider affiliated with the facility or an employee of the facility, unless such provider or employee is a family member of the patient.

   (d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by applicable state law.

   (e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied..

Employee is defined in the "Eligibility for Participation" section of the Plan. Additionally, to be considered an Employee, an individual must be classified and treated by the Employer as its common-law employee (and not an independent contractor) for payroll purposes, regardless of whether the individual is subsequently reclassified as an employee of the Employer in a court order, in a settlement of an administrative or judicial proceeding, or in a determination by the Internal Revenue Service, the Department of the Treasury, or the Department of Labor. An Employee must live and/or work in the United States.

Employer means the PayPal Holdings, Inc., or any successor thereto.

ERISA means the Employee Retirement Income Security Act of 1974, as may be amended from time to time.

Experimental and/or Investigational means services, supplies, care, and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Third Party Administrator or Medical Management Program Administrator, as applicable, as set forth below.

The Third Party Administrator or Medical Management Program Administrator, as applicable, must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Third Party Administrator or Medical Management Program Administrator, as applicable, shall be guided by a reasonable interpretation of Plan provisions and applicable law. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Third Party Administrator or Medical Management Program Administrator, as applicable, will be final and binding on the Plan. In addition to the above, the Third Party Administrator or Medical Management Program Administrator, as applicable, will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

(1) If the drug or device is not approved by the U.S. Food and Drug Administration (FDA) for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or

(2) If the drug, device, medical treatment or procedure or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed, and approved by the treating facility's Institutional Review Board or other body serving a similar function or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational. Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational. Physician orders for devices with these indications will be evaluated according to applicable medical policies; or

(3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational; or

(4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the FDA for general use.

Expenses for drugs, devices, services, medical treatments, or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment, or procedure is covered under the Plan will be made by and in the sole discretion of the Third-Party Administrator or Medical Management Program Administrator, as applicable.

Off-Label Drugs and Qualified Clinical Trials are not subject to Experimental and/or Investigational provisions as shown in the Eligible Medical Expenses and General Exclusions and Limitations sections of the Plan.

FMLA means the Family and Medical Leave Act of 1993, as may be amended from time to time.

Genetic Information means, with respect to any individual, information about (i) such individual's genetic tests, (ii) the genetic tests of family members of such individual, and (iii) the manifestation of a disease or disorder in family members of such individuals. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility) and (2) establishing contribution or premium accounts for coverage under the Plan.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

Hospice means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, 7 days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with 4 years of full-time clinical experience, at least 2 of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

Hospital means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home, or a similar institution.

Independent Freestanding Emergency Department means a health care facility that:

(1) Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and

(2) Provides any Emergency Services.

Illness means a non-occupational bodily disorder, disease, physical sickness, pregnancy (including childbirth and miscarriage), Mental Disorder or Substance Use Disorder.

Incurred means the date the service is rendered, or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury means physical damage to the body, caused by an external force and which is due directly and independently of all other causes, to an Accident.

Inpatient means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

Intensive Care Unit means a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit.” It has: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special lifesaving equipment which is immediately available at all times; (3) at least 2 beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Leave of Absence means a Leave of Absence of an Employee that has been approved by the Employer, as provided for in the Employer’s rules, policies, procedures, and practices.

Legal Guardian is defined in the "Eligibility for Participation" section of the Plan.

Lifetime Maximum means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits.

Long-Term Acute Care Facility/Hospital (LTACH) means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, 7 days a week basis. The severity of the LTACH patient’s condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc.; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; and (5) education for the patient and family to manage their present and future healthcare needs.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

Medically Necessary/Medical Necessity means treatment is generally accepted by medical professionals in the United States as proven, effective, and appropriate for the condition based on recognized standards of the health care specialty involved.

(1) "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.

(2) “Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness, or a clinical condition.

(3) "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan. Additionally, services and/or supplies that are mainly for a Covered Persons convenience and/or their Physician or other health care providers convenience are not considered Medically Necessary.

All criteria must be satisfied. When a Physician or other health care provider recommends or approves certain care or treatment, it does not mean that care is Medically Necessary. The Third Party Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion, shall be within the Third Party Administrator's sole discretion.

Medicare means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services. The fact that a condition is listed in the current edition of the International Classification of Diseases does not mean that treatment for the condition is a Covered Expense.

Morbid Obesity is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Non-Participating Emergency Facility means an Emergency Department of a Hospital, or an Independent Freestanding Emergency Department (or a Hospital, with respect to services that pursuant to 29 C.F.R. § 2590.716-4(c)(2)(ii) are included as Emergency Services), that does not have a contractual relationship directly or indirectly with the Plan, with respect to the furnishing of an item or service under the Plan.

Orthodontic Treatment means the corrective movement of teeth to treat a handicapping malocclusion of the mouth.

Out-of-Pocket Maximum has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

Participating Emergency Facility means any emergency department of a Hospital, or an Independent Freestanding Emergency Department (or a Hospital, with respect to services that pursuant to 29 C.F.R. § 2590.716-4(c)(2)(ii) are included as Emergency Services), that has a contractual relationship directly or indirectly with the Plan setting forth the terms and conditions on which a relevant item or service is provided to a participant or beneficiary under the Plan. A single case agreement between an emergency facility and the Plan that is used to address unique situations in which a participant or beneficiary requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating Health Care Facility means any health care facility that has a contractual relationship directly or indirectly with the Plan setting forth the terms and conditions on which a relevant item or service is provided to a participant or beneficiary under the Plan. A single case agreement between a health care facility and the Plan that is used to address unique situations in which a participant or beneficiary requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating Provider means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Physician means a legally licensed Physician who is acting within the scope of the individual's license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Nurse Practitioner, Physician's Assistant, Speech Therapist, Speech Pathologist and Licensed Midwife (if covered by the Plan). An employee of a

Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan. The fact that a provider is described as a Physician does not mean that benefits for services from that provider are available to you under the Plan..

Plan means the PayPal Holdings, Inc. – CDHP with HSA Plan.

Plan Administrator means the administrator of the Plan in accordance with ERISA. Information regarding the Plan Administrator is set forth in the General Plan Information section.

Plan Sponsor means PayPal Holdings, Inc.

Plan Year means the period from January 1 - December 31 each year.

Prescription Drug is defined in the "Prescription Drug Card Program" section of the Plan.

Preventive Maintenance Drug is defined in the "Prescription Drug Card Program" section of the Plan.

Primary Care Physician (PCP) means a licensed Physician practicing in one of the following fields: (1) family practice; (2) general practice; (3) internal medicine; (4) obstetrics and gynecology; or (5) pediatrics.

Provider of Air Ambulance Services means an entity that is licensed under applicable State and Federal law to provide Air Ambulance services.

Qualified Clinical Trial means 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 condition and is described in (1), (2) or (3) below:

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

   (a) The National Institutes of Health;

   (b) The Centers for Disease Control and Prevention;

   (c) The Agency for Health Care Research and Quality;

   (d) The Centers for Medicare & Medicaid Services;

   (e) A cooperative group or center of one of the entities described in (a) through (d) above;

   (f) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants; or

   (g) The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if (i) the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Qualifying Payment Amount means, with respect to a sponsor of a group health plan, the amount calculated using the methodology described in paragraph (c) of 29 C.F.R. § 2590.716-6.

Recognized Amount means, with respect to an item or service furnished by a Non-Participating Provider or Nonparticipating Emergency Facility:

(1) Subject to paragraph (3) of this definition, in a State that has in effect a specified State law, the amount determined in accordance with such law.

(2) Subject to paragraph (3) of this definition, in a State that does not have in effect a specified State law, the lesser of:

  (a) The amount that is the Qualifying Payment Amount; or

  (b) The amount billed by the provider or facility.

(3) In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies with respect to the Plan; the Non-Participating Provider or Nonparticipating Emergency Facility; and the item or service, the amount that the State approves under the All-Payer Model Agreement for the item or service.

Reconstructive Surgery means Surgery that is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve or restore physiological functioning of the involved part of the body. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists, and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

Rehabilitation Facility means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed under applicable state law as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) nursing services are available 24 hours a day; and (8) the confinement is not for Custodial Care or maintenance care.

Residential Treatment Facility means a facility that provides 24-hour treatment for Mental Disorders or Substance Use Disorders on an Inpatient basis. It must provide at least the following: room and board; medical services; nursing and dietary services; patient diagnosis, assessment, and treatment; individual, family and group counseling; and educational and support services. A Residential Treatment Facility is recognized if it is accredited for its stated purpose by the Joint Commission and carries out its stated purpose in compliance with all relevant state and local laws.

Semi-Private Room means a Hospital room shared by 2 people or with 2 or more beds. When an Inpatient stay in a Semi-Private Room is a Covered Expense, the difference in cost between a Semi-Private Room and a private room is a benefit only when a private room is Medically Necessary in terms of generally accepted medical practice, or when a Semi-Private Room is not available.

Skilled Care means skilled nursing, teaching, and rehabilitation services when:

(1) They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.

(2) A Physician orders them.

(3) They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.

(4) They require clinical training in order to be delivered safely and effectively.

(5) They are not Custodial Care, as defined in this section.

Skilled Nursing Facility is a facility that meets all of the following requirements:

(1) It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally disabled, Custodial, or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Special Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 31-day eligibility period and who later enrolls in the Plan due to a Special Enrollment Event.

Specialist means a licensed Physician that provides services to a Covered Person within the range of their specialty (e.g., cardiologist, neurologist, etc.).

Specialty Drug is defined in the "Prescription Drug Card Program" section of the Plan.

Spouse is defined in the "Eligibility for Participation" section of the Plan.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment for 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 Medical Condition of a pregnant woman who is having contractions (1) there is adequate time to effect a safe transfer to another Hospital before delivery; and (2) transfer will not pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services. The fact that a condition is listed in the current edition of the International Classification of Diseases does not mean that treatment for the condition is a Covered Expense.

Surgery or **Surgical Procedure** means any of the following:

(1) The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;

(2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

(3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

(4) The induction of artificial pneumothorax and the injection of sclerosing solutions;

(5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

(6) Obstetrical delivery and dilation and curettage; or

(7) Biopsy.

Third Party Administrator means Meritain Health, Inc., P.O. Box 853921, Richardson, TX 75085-3921.

Urgent Care Facility means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as may be amended from time to time.

Usual and Customary Charge (U&C) means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual that will be subject to a Usual and Customary determination by the Third Party Administrator. Subject to the rest of this definition, the Usual and Customary Charge means the lesser of the charge by other providers in the same geographic area or billed charges for the same or comparable service or supply. From time to time, the Plan may enter into an agreement with a Non-Participating Provider (directly or indirectly through a third party) which sets the rate the Plan will pay for a service or supply. In these cases the Usual and Customary Charge will be the rate established in such agreement with the Non-Participating Provider.

The Plan may reduce the Usual and Customary Charge by applying reimbursement policies administered by the Plan's Third Party Administrator. These reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

(1) The duration and complexity of a service;

(2) Whether multiple procedures are billed at the same time, but no additional overhead is required;

(3) Whether an Assistant Surgeon is involved and necessary for the service;

(4) If follow up care is included;

(5) Whether there are any other characteristics that may modify or make a particular service unique; and

(6) When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

The reimbursement policies utilized are based on review of the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which are otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas.

The Usual and Customary Charge for covered services will be based on the median contract rate when a Covered Person had no control over the services performed by a Non-Participating provider who is under agreement with a Network facility or when the Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider.

PLAN ADMINISTRATION

Delegation of Responsibility
The Plan Sponsor is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of the Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

Authority to Make Decisions
The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of the Third Party Administrator, Medical Management Program Administrator and Prescription Drug Card Program Administrator to provide certain claims processing, appeals, and other services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator, Third Party Administrator, Medical Management Program Administrator and Prescription Drug Card Program Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator, Third Party Administrator, Medical Management Program Administrator and Prescription Drug Card Program Administrator, as applicable, will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights and to decide questions of Plan interpretation and those of fact and law relating to the Plan. The decisions of the Plan Administrator, Third Party Administrator, Medical Management Program Administrator and Prescription Drug Card Program Administrator, as applicable, as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if Third Party Administrator, Medical Management Program Administrator and Prescription Drug Card Program Administrator, as applicable, decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

The duties of the Plan Administrator include the following:

(1) To administer the Plan in accordance with its terms;

(2) To determine all questions of eligibility, status, and coverage under the Plan;

(3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;

(4) To make factual findings;

(5) To decide disputes which may arise relative to a Covered Person's rights;

(6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials; or, alternatively, to appoint a qualified administrator to carry out these functions on the Plan Administrator's behalf;

(7) To keep and maintain the Plan documents and all other records pertaining to the Plan;

(8) To appoint and supervise the Third Party Administrator, Medical Management Program Administrator, and Prescription Drug Card Program Administrator to pay claims and adjudicate appeals;

(9) To perform all necessary reporting as required by applicable federal or state law that has not been delegated to another person;

(10) To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;

(11) To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and

(12) To perform each and every function necessary for or related to the Plan's administration.

Amendment or Termination of Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

MISCELLANEOUS INFORMATION

Assignment of Benefits
No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in ERISA Section 609(a) and in the Plan's QMCSO procedures.

Clerical Error
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to you and/or your Dependents have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws
This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions, or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

Cost of the Plan
The Plan Sponsor is responsible for funding the Plan from its general assets and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan, including, but not limited to, payment of Plan expenses from the Employer’s general assets. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Plan Sponsor, in its sole discretion.

Interpretation of this Document
The use of masculine pronouns in this Plan shall apply to persons of each sex and gender unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, “you” and “your” throughout this Plan applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

Minimum Essential Coverage
This Plan provides “minimum essential coverage” within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance. and whether it provides “minimum value” within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g., the Plan provides at least 60% actuarial value).

No Contract of Employment
This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Release of Information
In accordance with applicable laws, for the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator, Third Party Administrator, Medical Management Program Administrator and Prescription Drug Card Program Administrator, as applicable, may, without the consent of or notice to any person, use, release, or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In accordance with applicable laws, the Plan Administrator, Third Party Administrator,

Medical Management Program Administrator and Prescription Drug Card Program Administrator, as applicable may use your individually identifiable health information to administer the Plan and pay claims and as otherwise permitted or required by law. In so acting, the Plan Administrator, Third Party Administrator, Medical Management Program Administrator and Prescription Drug Card Program Administrator, as applicable shall be free from any liability that may arise with regard to such action; however, each such party at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator, Third Party Administrator, Medical Management Program Administrator and Prescription Drug Card Program Administrator, as applicable, such information as may be necessary to implement this provision.

By accepting benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan Administrator, Third Party Administrator, Medical Management Program Administrator, , and Prescription Drug Administrator, as applicable, with all information or copies of records relating to the services provided to you. The Plan Administrator, Third Party Administrator, Medical Management Program Administrator and Prescription Drug Card Program Administrator, as applicable, have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents, whether or not they have completed submission of the Employee's online enrollment

The Plan Administrator, Third Party Administrator, Medical Management Program Administrator and Prescription Drug Card Program Administrator, as applicable, have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as required to do by law or regulation.

Workers' Compensation
This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers' Compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive Workers' Compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from Workers' Compensation. The Plan will exercise its right to recover and/or subrogate against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

(1) The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

(2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;

(3) The amount of Workers' Compensation benefits due specifically to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier; or

(4) The health care expense is specifically excluded from the Workers' Compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when you file a claim for coverage under Workers' Compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers' Compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

Incentives to You or to Providers
The Plan encourages each Covered Person to seek Covered Expenses from a Participating Provider as it will result in the greatest benefit to you as well as to the Plan. When you receive Covered Expenses from a Participating Provider, the provider of services has entered into an agreement with the Network to provide services at a discount, the discount benefits both yourself and the Plan and you cannot be 'balance-billed' for it. Additionally, you will benefit from better Plan benefits (Participating Provider Deductibles, Coinsurance amounts and Copays), which may save you and the Plan money. As stated under General Overview of the Plan, there is no requirement for you to receive Covered Expenses from a Participating Provider, however, you will receive the greatest benefit if you do so.

Reimbursement Policies
Each Participating Provider has a contract set forth with the Network, this contract is an agreement between the Network and the provider of services to provide certain health care services at a discounted rate. When the Third Party Administrator receives claims for services rendered from a Participating Provider, the contracted discount amount is subtracted from the overall billed amount, the claims processor then processes the claims at the Participating Provider benefit level, less the contracted discount amount.

Temporary Extension of Certain Plan Administration Time Frames Relating to COVID-19
Definitions. For purposes of this Section:

(1) **Agencies** means the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, and Department of the Treasury.

(2) **National Emergency** means the March 13, 2020 Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak and the separate letter dated March 13, 2020 determining, under Section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121 et seq., that a national emergency exists nationwide beginning March 1, 2020, as the result of the COVID-19 outbreak.

(3) **Outbreak Period** means the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency or such other date announced by the Agencies.

Extension of Certain Time Frames. The provisions of this Section apply notwithstanding anything in the Plan to the contrary. Subject to the one-year statutory duration limitation in ERISA Section 518 and Code Section 7508A, and subject to future guidance from the Agencies, the Plan will follow to the guidance the Agencies issued on May 4, 2020 entitled Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak (the "COVID-19 Extension"), as subsequently amended, modified, or clarified. In general, this means that the Plan will temporarily disregard the Outbreak Period for all Covered Persons, qualified beneficiaries, and claimants in determining the following periods and dates:

(1) The period to request a HIPAA special enrollment;

(2) The 60-day election period for COBRA continuation coverage;

(3) The date for making COBRA premium payments;

(4) The date for individuals to notify the Plan of certain COBRA qualifying events or determinations of disability;

(5) The date within which individuals may file a benefit claim under the Plan's claims procedures;

(6) The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedures;

(7) The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination; and

(8) The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.

Additionally, the Outbreak Period shall be disregarded when determining the date for providing a COBRA election notice.

If you have questions, contact Accolade.

NOTE: This subsection will terminate at the time specified by applicable law and guidance issued by one or more of the Agencies.

STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, you and your Dependents are entitled to certain rights and protections under ERISA. ERISA provides that you and your eligible Dependents are entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons and beneficiaries. No one, including your Employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you a daily penalty up to the statutory maximum amount until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, a medical child support order or a national medical support notice, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA PRIVACY AND SECURITY PRACTICES

This Plan is a component of the PayPal Holdings, Inc. Health and Welfare Benefits Plan (the "Wrap Plan"). The Wrap Plan includes a description of certain rules that apply to this Plan and the Plan Sponsor regarding uses and disclosures of your health protected health information under HIPAA. The Notice of Privacy Practices, which is provided to you separately, also summarizes how the Wrap Plan and Plan can use and disclose your Protected Health Information. Refer to those documents for more information. You can receive copies of those documents, free of charge, by contacting the Plan Administrator.

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

GENERAL PLAN INFORMATION

Name of Plan:	The name of this Plan is the PayPal Holdings, Inc. CDHP with HSA Plan. This Plan is a component of the PayPal Holdings, Inc. Welfare Benefit Plan (the "Wrap Plan").
Plan Sponsor: **(Named Fiduciary)**	PayPal Holdings, Inc. 2211 North First Street San Jose, CA 95131 (408) 967-8935
Plan Administrator:	PayPal Holdings, Inc. 2211 North First Street San Jose, CA 95131 (408) 967-8935
Plan Sponsor EIN:	47-2989869
Plan Year:	January 1 - December 31
Plan Number:	The Plan Number for the PayPal Holdings, Inc. Welfare Benefit Plan is 501. This Plan is a component of the PayPal Holdings, Inc. Welfare Benefit Plan and does not have a separate Plan Number.
Meritain Health, Inc. Group Number:	18848
Plan Administration:	The Plan is a self-funded welfare plan and the administration is provided through one or more third party administrators.
Plan Type:	Welfare benefit plan providing medical and Prescription Drug benefits.
Plan Funding:	All benefits are paid from the general assets of the Employer.
Contributions:	The cost of coverage under the Plan is funded in part by Employer contributions and in part by Employee contributions.
Claims Fiduciary / Third Party Administrator:	Meritain Health, Inc. P.O. Box 853921 Richardson, TX 75085-3921 (800) 925-2272
COBRA Administrator:	Your Benefit Resources (YBR) YBR Customer Care Center Address: PayPal, P.O. Box 1380 Carol Stream, IL 60132-1380 (844) 474-6641 www.ybr.com/benefits/paypal
Medical Management Program Administrator:	Accolade 660 W Germantown Pike, Suite 500 Plymouth Meeting, PA 19462 (866) 406-1309
AccoladeCare Program Administrator:	AccoladeCare (866) 518-1774 member.accolade.com

Prescription Drug Card Program Administrator:	Scrip World, LLC/CVS Caremark (844) 287-1297 www.caremark.com
Agent for Service of Legal Process:	PayPal Holdings, Inc. 2211 North First Street San Jose, CA 95131 (408) 967-8935
No Trust:	The Plan does not use a trust and therefore does not have any trustees.

The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Plan Administrator.

IMPORTANT LEGAL NOTICES

Notice Regarding the Women's Health and Cancer Rights Act of 1998 ("WHCRA")
Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Accolade for more information.

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

Nondiscrimination, Accessibility and Getting Help in Other Languages or Formats
You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

Albanian: Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.

Amharic: ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711

Arabic: لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة م عرّف العضوية الخاصة بخطتك الصحية، واضغط على 0 . الهاتف النصي (TTY) 711

Armenian: Թարգմանիչ պահանջէլու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամնէրի հէռախոսահամարով, սեղմե՛ք 0: TTY 711

Bantu-Kirundi: Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711

Bisayan-Visayan (Cebuano): Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711

Bengali-Bangala: অনুবাদকের অনুকরাধ থাকে, আপনার স্বাস্থ্য পররেল্পনার আই রি োিড এ তারেোভূক্ত ও ের রদকত হকব না এমন টেরেক ান নম্বকর ট ান েরুন। (০) শূণ্য চাপুন। TTY 711

Burmese: သင့်ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခကြေးငွေမယူဘဲ ရယူပိုင်ခွင့်ရှိသည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန် သင့်ကျန်းမာရေးအစီအစဉ် ID ကတ်တွင် ဖော်ပြထားသော အခမဲ့အဖွဲ့ဝင်ဖုန်းနံပါတ်ကို ခေါ်ဆိုပါ၊ 0. TTY 711 ကိုနှိပ်ပါ။

Cambodian-Mon-Khmer: អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដ េមបីដសនើស ំអ្នកបកប្រប សូមទូរស័ពទដៅដលខឥតដេញថ្លៃសំរាប់សមាជិក បុ លមានកត់ដៅកនុងប័ណ្ណ ID គំដរាងស ខភាពរបស់អ្នក រួ េដ េយេ េ 0។ TTY 711

Cherokee: Ꮎ ᎠᏎᏯ ᎮᎵ ᏗᏟᏃᎮᏗ ᏗᏎᏍᏗ ᏥᎪᏪᎳ ᎢᏳ ᏣᏤᎵ ᏙᎯ ᎮᏒ ᏗᏗᎪᏙᏗ ᎠᏟᏍᏙᏗ ᏆᎾᏲᏍᏗᎢ, ᏲᏐᏅᏍᏓ 0. TTY 711

Chinese: 您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711

Choctaw: Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711

Cushite-Oromo: Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711

Dutch: U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711

French: Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d’affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.

French Creole-Haitian Creole: Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711

German: Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711

Greek: Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Gujarati: તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાાં માહિતી મેળવિાનો અવિકાર છે. દુભાવષયા માટે વિનાંતી કરિા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નાંબર ઉપર કોલ કરો, ૦ દબાવો. TTY 711

Hawaiian: He pono ke kōkua ‘ana aku iā ‘oe ma ka maopopo ‘ana o kēia ‘ike ma loko o kāu ‘ōlelo pono‘ī me ka uku ‘ole ‘ana. E kama‘ilio ‘oe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ‘ole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.

Hindi: आप के पास अपनी भाषा में सहायता एवं जानकारी नन:शुल्क प्राप्त करने का अधिकार है। दुभाषषए के लिए अनुरोि करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोि-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711

Hmong: Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.

Ibo: Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n’efu n’akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.

Ilocano: Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711

Indonesian: Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711

Italian: Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Japanese:　ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID　カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。

Karen:
နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒၣ်နဝဲလၢတလိာ်ဟ့ၣ်အပူၤဘၣ်န့ၣ်လီၤ.လၢတၢ်ကဃ့န့ၢ်ပှၤကတိၤကျိးထံတၢ်တဂၤအဂီၢ်ကိးဘၣ်လီတဲစိအကျိၤလၢကရၢဖိအတလိာ်ဟ့ၣ်အပူၤလၢအအိၣ်လၢနတၢ်အိၣ်ဆူၣ်အိၣ်ချ့အတၢ်ရဲၣ်တၢ်ကျဲၤအကးအလိၤဒီးဆီၣ်လီၤနီၣ်ဂံၢ် 0 တက့ၢ်.TTY 711

Korean: 귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711

Kru- Bassa: Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711

Kurdish-Sorani: مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت

وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی

نووسراو لەناو ئای دی کارتی پێناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711

Laotian: ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫ ຼືອແລະຂ ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບ ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂ ຮ້ອງນາຍພາສາ,ໂທພຣີຫາຫມາຍເລກໂທລະສັບສ າລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711

Marathi: आपल्याि◌ा आपल्या भाषेत षवनामूल्य मदत आणि माहहती लमळण्याचा अधिकार आहे. दूभाषकास षवनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरीि सूचीबध्द केि◌े◌ल्या सदस्यास षवनामूल्य फोन नंबरवर संपकड करण्यासाठी दाबा 0. TTY 711

Marshallese: Eor aṃ maroñ ñan bok jipañ im meļeļe ilo kajin eo aṃ ilo ejjeļọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrļok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711

Micronesian-Pohnpeian: Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.

Navajo: T'áá jíík'eh doo bą́ąh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit'iz7 'ats'77s bee baa'ahay1 bee n44hozin7g77 bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíílchił. TTY 711

Nepali: तपाईंले आफ् नो भाषामा ननिःशुल्क सहयोग र जानकारी प्राप्त गने अनिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोि गनन, तपाईंको स्वास््य योजना पररचय कार्नमा सूचीकृत टोल-फ्री सदस्य फोन नम् बरमा सम्पकन गनुनहोस्, 0 निच् नुहोस्। TTY 711

Nilotic-Dinka: Yin nɔŋ löŋ bë yi kuɔny në wɛ̈rëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.

Norwegian: Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711

Pennsylvania Dutch: Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. TTY 711

Persian-Farsi: شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید .برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید .TTY 711

Punjabi: ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵ ਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਵਦਿੱਤੇ ਗਏ ਟਾਿੱਲ ਫ਼ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀ ਾਈ 711 ਤੇ ਕਾਿੱਲ ਕਰੋ, 0 ਦਿੱਬੋ|

Polish: Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711

Portuguese: Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711

Romanian: Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711

Russian: Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711

Samoan- Fa’asamoa: E iai lou āiā tatau e maua atu ai se fesoasoani ma fa’amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa’atalosagaina se tagata fa’aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.

Serbo-Croation: Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.

Spanish: Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711

Sudanic-Fulfulde: Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo’’u 0. TTY 711.

Swahili: Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711

Syriac-Assyrian
ܐܝܬܠܘܟܘܢ ܐܚܝܠܘܬܘܟܘܢ ܕܡܩܒܠܬܘܢ ܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ
ܡܓܢܢܐܝܬ ܠܡܫܐܠܬܐ ܡܢ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܕܬܠܝܦܘܢ ܕܐܝܠܗ
ܒܟܪܛܝܣ ܐܝܕ ܦܠܢܐ ܕܚܘܠܡܢܐ ܘܕܘܫ 0 .TTY 711

Tagalog: May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711

Telugu: ఎల ెంటి ఖర్చు లేక ెండా మీ భాషలో సాయాంబు మరియు సమ చార్ ప ెందడానికి మీక హక ు ఉంది. ఒకవేళ దుబాషి కావాలాంటే, మీ హెల్త్ పాాన్ ఐడి కార్చు మీద జాబితా చేయబడ్ు టోల్త ఫ్రీ న ెంబర్చక ఫోన్ చేసి, 0 ప్రీస్ చేసోం. TTY 711

Thai: คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจาตัวสาหรับแผนสุขภาพของคุณ แล้วกด 0 สาหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711

Tongan- Fakatonga: ‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711

Trukese (Chuukese): Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.

Turkish: Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711

Ukrainian: У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711

Urdu: آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی

ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ

TTY 711 کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔

Vietnamese: Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711

Yiddish: איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט TTY 711 . קארטל , דרוקט ID 0 דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן

Yoruba: O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá òǵbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ ‘0’. TTY 711

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.

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.

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

(1) 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.

(2) Your health plan generally must:

   (a) Cover emergency services without requiring you to get approval for services in advance (prior authorization).

   (b) Cover emergency services by out-of-network providers.

   (c) 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.

   (d) 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 contact the federal agencies responsible for enforcing the federal balance billing laws at: (800) 985-3059.

Visit: https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

ATTACHMENT 1 – PROGYNY

The Benefits described below are administered by Progyny, independent of Meritain.

Progyny Overview	Progyny is the premier fertility benefit designed to provide all-inclusive comprehensive coverage for cutting-edge fertility treatments to assist any member wishing to have a child. Progyny's program includes a credentialed provider network, and a personalized concierge-style member support team (Patient Care Advocates) who offer education, support, and coordinated care. Progyny's program does not require a medical diagnosis of infertility in order to access fertility treatment services, which ensures that members of the LGBTQ+ community and single parents by choice receive equitable access to coverage. Through Progyny's benefit, members have access to a full suite of fertility treatment options, which may include (but may not be limited to): Artificial Insemination (IUI), Cryopreservation of oocytes and sperm, FDA Bloodwork and Testing, Fresh IVF Cycle, Frozen Embryo Transfer (FET), Frozen Oocyte Transfer (includes fertilization of previously frozen oocytes and transfer), IVF Freeze-All, Patient Care Advocate (PCA) Concierge Support, pre-authorized fertility medications (via Progyny Rx), PGT-A (PGS, or Pre-implantation Genetic Screening) to assess embryo viability, PGT-M (PGD, or Pre-implantation Genetic Diagnosis), Pregnancy Gap Coverage (Pregnancy monitoring coverage until the in-network fertility clinic releases the member into the care of the member's OBGYN medical provider), Donor Tissue and Tissue Transportation (transportation of member's previously frozen reproductive tissue to in-network facilities).
Fertility Benefits	
Fertility Benefit	Your Progyny Benefit allows for: ■ 3 Progyny SMART Cycles per lifetime subject to all applicable plan copay, coinsurance, and deductible requirements. You must contact Progyny to confirm eligibility and utilize a Progyny Network Provider to access your benefit. To begin your infertility treatment plan, please contact Progyny at (833) 838-5850.
Fertility Benefit Exclusions	■ All charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to fees for laboratory tests. ■ Home ovulation prediction kits.

	■ Dependent child (under age 26). ■ Non-genetic disorder reproductive treatments done for purposes of gender selection. ■ Services and supplies furnished by an out of network provider. ■ Fertility Services following a voluntary sterilization procedure. ■ Treatments considered experimental by the American Society of Reproductive Medicine.
PayPal Adoption Benefits	
Adoption **Reimbursement Benefit**	PayPal will reimburse Adoption up to $25,000 per employee and Surrogacy up to $25,000 per employee. Please refer to PayPal's Adoption Assistance Policy for more information.
Adoption Eligible Expenses	■ Application fees. ■ Home studies. ■ Agency and placement fees. ■ Legal fees and court costs. ■ Immigration, immunization and translation fees. ■ Transportation, meals, lodging. ■ Parent, child and family adoption counseling. ■ Costs incurred by registered domestic partner that lives in a state that allows same-sex second parent or co-parent to adoption his or her partner's child. ■ Visa and passport fees for adopted child. ■ Medical assessment of the child. ■ Temporary foster care expenses. ■ Fees associated with the adoption of a child through a legally recognized surrogate arrangement.

Adoption Ineligible Expenses	■ Expenses related to adoptions that are in violation of federal or state law or otherwise not legally recognized. ■ Expenses related to personal items such as food or clothing for the birth parents or child during or after the adoption. ■ Expenses related to a surrogate parenting relationship. ■ Expenses related to items for which an eligible employee has already been reimbursed by an employer program or otherwise. ■ Expenses incurred prior to the eligible employee's date of hire or after the employee ceases to be an eligible employee. ■ Expenses incurred while the employee is on a personal leave unless such leave is directly associated with the adoption. ■ Expenses related to voluntary donations or contributions.
PayPal Surrogacy Benefits	
Surrogacy/Donor Reimbursement Benefit	PayPal will reimburse Adoption up to $25,000 per employee and Surrogacy up to $25,000 per employee. Please refer to PayPal's Surrogacy Assistance Policy document for more information.
Surrogacy/Donor Eligible Expenses	■ Court costs, legal, and attorney's fees. ■ Surrogacy agency fees. ■ Gestational carrier, egg, or sperm donor screening costs ■ Donor fertility costs and fees not covered by another source. ■ IVF costs related to surrogacy or egg/sperm donation not covered by another source. ■ Pregnancy medical expenses related to surrogacy not covered by another source. ■ Travel expenses for the intended parents related to surrogacy.

Surrogacy/Donor Ineligible Expenses	■ Voluntary donations or contributions ■ Surrogacy or donation arrangements that are not legally recognized ■ Costs for personal items, such as food and clothing for the parents or child ■ Fees paid to the surrogate for her services ■ Long-term (more than 30 days) storage of blood, umbilical cord, reproductive materials or other material (e.g. cryopreservation of tissue, blood, and blood products) ■ Any expenses that violate state or federal law ■ Costs paid using funds received from any federal, state, or local program ■ Expenses allowed as a credit or deduction under any other federal income tax rule ■ Expenses already paid or reimbursed by another employer or other party ■ Fees associated with the adoption of a child through a legally recognized surrogate arrangement - These expenses are eligible for reimbursement under the Adoption Assistance Program.
Pharmacy Benefits	
Pharmacy Benefit	Infertility medications are provided through Progyny and require authorization through Progyny. You must contact Progyny at (833) 838-5850 and speak with a Patient Care Advocate to authorize your infertility treatment.
Covered Fertility Drugs	Progyny utilizes a drug formulary for coverage. The formulary is subject to change. Please contact Progyny at (833) 838-5850 to confirm covered medications.
Fertility Drug Exclusions	Progyny utilizes a drug formulary for coverage. The formulary is subject to change. Please contact Progyny at (833) 838-5850 to confirm covered medications.