Benefits Handbook Date April 1, 2023

Surest Copay Plan

Marsh McLennan

Surest Copay Plan

Selecting a medical plan option for 2023 involves three key choices for eligible individuals.

- Select one of three medical plan design options. A range of coverage levels and costs are offered.
- Select coverage for:
  - yourself only — Employee
  - yourself and your spouse or domestic partner — Employee + Spouse
  - yourself and your child or children — Employee + Child(ren)
  - yourself, your spouse or domestic partner, and children — Family
- Select your medical plan THIRD PARTY ADMINISTRATOR (or carrier with respect to the insured programs):
  - All eligible individuals resident in any state except Hawaii may choose from among:
    - Aetna
    - Anthem BlueCross BlueShield (Anthem BCBS)
    - Surest

Note: This section of the Benefits Handbook provides information about the Surest Copay Plan administered medical option only.

Information about the Aetna and Anthem BlueCross BlueShield administered medical plan options is covered in a separate section of the Benefits Handbook.

  - Eligible individuals resident in CA, CO, GA, MD, VA, OR, WA, and Washington DC have an additional choice to consider:
    - Kaiser Permanente (Kaiser)

Information about the Kaiser administered medical plan options is covered in a separate section of the Benefits Handbook.

  - Eligible individuals who are resident in Hawaii, may only choose between:
    - HMSA's Health Plan Hawaii Plus (HMO)

SPD and Plan Document

This section provides a summary of the Medical Plan (the "Plan"), Surest COPAY Plan as of January 1, 2023.

This section, together with the *Administrative Information* section and the applicable section about participation, forms the Summary Plan Description and plan document of the Plan.

In this document references to Marsh & McLennan Companies mean Marsh McLennan and references to Marsh & McLennan Agency LLC mean Marsh McLennan Agency.

- HMSA's Preferred Provider Plan (PPP)

Information about the Hawaii medical plan options is covered in a separate section of the Benefits Handbook.

All medical plan options described in this section of the Benefits Handbook offer:

- comprehensive health services
- the freedom to select between a health care provider that participates in your chosen medical plan third party administrator's network, generally at a lower cost to you, or a provider that does not participate in your chosen medical plan third party administrator's network, generally at a higher cost to you.

Note: Be sure to read about Health Care Flexible Spending Accounts (HCFSAs), Health Savings Accounts (HSAs) and Limited Purpose Health Care Flexible Spending Accounts (LPHCFSAs). Understanding these tax-advantaged arrangements may be important to your selection of a medical plan.

A Note about ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that governs many employer-sponsored plans including this medical plan. Your ERISA rights in connection with this Plan are detailed in the *Administrative Information* section.

Contents

The Plan at a Glance

The Surest COPAY Plan provides medical care and PRESCRIPTION DRUGS for a copay. There is no DEDUCTIBLE or coinsurance. You'll pay a copay based on the provider you use and the covered service you receive. When you need care, you can look up your copay for an office visit, test or procedure *before* you make an appointment, so you can compare costs and know up front what your care will cost you based on the provider and service you select.

The copays will vary based on the covered service, the provider and whether the provider is in-network. To view copays under the Plan, go to Benefits.Surest.com, the Surest mobile app or call Surest Member Services at + 1 866 683 6440.

The chart below outlines some important Plan features and coverage information, including the copay range, if applicable. Additional information is provided throughout this section of the Benefits Handbook including the "How the Plan Works" on page 6 and "Detailed List of Covered Services" on page 43.

Plan feature	Surest Copay Plan
Annual Deductible	***In-network:*** Employee: None Family[1]: None ***Out-of-network:*** Employee: None Family[1]: None
Out-of-Pocket Maximum (including copays)	***In-network:*** Employee: $2,200 Family[1]: $4,400[2] ***Out-of-network:*** Employee: $4,400 Family[1]: $8,800[2]
Plan Coinsurance	***In-network:*** None ***Out-of-network:*** None
Physician office visits	
Preventive Visit	In-network: Covered at 100% Out-of-network: $60 copay / visit
Primary Care Physician (PCP)/Specialist Visit	In-network: $5 to $40 copay / visit Out-of-network: $120 copay / visit
Specialist Visit	In-network: $5 to $40 copay / visit Out-of-network: $120 copay / visit

Plan feature	Surest Copay Plan
Treatments/Tests/Therapies: Refer to the Surest mobile app or **Benefits.Surest.com** website for coverage and copay information or call Surest Member Services. Copays may vary based on provider, location and treatment, test, or therapy.	
Hospital Facility	
Inpatient	In-network: up to $1,800 copay / stay Out-of-network: up to $3,400 copay / stay
Outpatient	In-network: $50 to $300 copay / visit Out-of-network: $900 copay /visit
Emergency Room (waived if admitted)	In and Out-of-network: $250 copay / visit
Prescription drugs	There is a CVS Caremark® Retail Pharmacy Network for 30-day supply (acute) and CVS Caremark® Retail and CVS Caremark® Mail Order for 90-day supply (maintenance) Prescription drugs.
Retail Prescriptions (30-day supply)	
▪ Generic	$10 copay[3]
▪ Formulary Brand	$30 copay[3]
▪ Non-Formulary Brand	$60 copay[3]
CVS Caremark® Retail and CVS Caremark® Maintenance Choice Program Mail-order Prescriptions[4] (90-day supply)	
▪ Generic	$25 copay[3]
▪ Formulary Brand	$75 copay[3]
▪ Non-Formulary Brand	$150 copay[3]
Prescription Drug Programs	There are prescription drug programs available as part of the medical plan option. For information on Rx Savings Solutions, PrudentRx, Transform Diabetes® Care, WW Digital Program and Hello Heart, refer to “Prescription Drug Programs” on page 35.

Plan feature	Surest Copay Plan
Contact Information for Third Party Administrator:	Contact for Medical Service: Surest (Claims Administrator) P.O. Box 211758 Eagan, MN 55121 Phone: +1 866 683 6440 Website: Benefits.Surest.com Group #: 78800361 Contact for Prescription Service: CVS Caremark® (Prescription Drug Benefits Manager) Phone: +1 844 449 0362 Website (for members): www.caremark.com CVS Caremark® Group #: 21CW Marsh McLennan does not administer claims under this plan. For medical claims, the Claims Administrator's decisions are final and binding. For prescription drug claims, the Prescription Drug Benefits Manager's decisions are final and binding.

1 "Family" applies to all coverage levels except Employee-Only.

2 Not "True" Family: When a covered family member meets his or her individual out-of-pocket maximum, the out-of-pocket maximum is satisfied for that covered family member only, but not for the other covered family members. When the family out-of-pocket maximum is met, the out-of-pocket maximum is satisfied for every covered family member whether or not they have met their own individual out-of-pocket maximums. The family out-of-pocket maximum can only be met by a combination of covered family members, as amounts counted toward individual out-of-pocket maximums count toward the larger family out-of-pocket maximum.

3 A mandatory program, the PrudentRx prescription drug program, will apply for eligible specialty medications for complex conditions on the PrudentRx Drug List. If you do not speak with PrudentRx, do not enroll in any copay assistance as required by a manufacturer, or do not choose to participate in the PrudentRx program, i.e. opt out, **you'll be responsible for paying the 30% coinsurance cost for each specialty prescription medication, and the costs will NOT count towards either out-of-pocket maximum.** The PrudentRx Drug List is available at www.caremark.com. For drugs not on the PrudentRx Drug List, standard mail order copays will apply. For more information, refer to "Are there mandatory discount or copay assistance programs applicable for specialty prescription drugs?" on page 31 and "Prescription Drug Programs" on page 35.

4 In addition to mail order, you will be able to fill a 90-day supply of your maintenance medications at a CVS Caremark® retail pharmacy, at the same cost as you would through the mail order program. For all maintenance medications, after the first three fills, you must fill a 90-day supply either at a CVS Caremark® retail pharmacy or through the CVS Caremark® Maintenance Choice Mail Order program otherwise, the maintenance medication will not be covered, you will pay 100% of the full cost for all subsequent fills, and the cost does not accumulate towards the out-of-pocket maximum.

Participating in the Plan

You are eligible to participate in the Plan if you meet the eligibility requirements described in the *Participating in Healthcare Benefits* section.

You have the option to cover your family members who meet the eligibility requirements that are described in the *Participating in Healthcare Benefits* section.

Retiree Eligibility

Certain retirees and their ELIGIBLE FAMILY MEMBERS that are not yet deemed to be eligible for MEDICARE may also be eligible for coverage under this plan. For information on the eligibility requirements, how to participate and the cost of coverage, see the *Participating in Pre-65 Retiree Medical Coverage* section.

Enrollment

To participate in this Plan, you must enroll for coverage. You may enroll only:

- within 30 days of the date you become eligible to participate
- during Annual Enrollment (generally in October with respect to coverage for the following calendar year)
- within 60 days of a qualifying change in family status that makes you eligible to enroll
- within 30 days of losing other coverage that you had relied upon when you waived your opportunity to enroll in this Plan.

Enrollment procedures for you and your ELIGIBLE FAMILY MEMBERS are described in the *Participating in Healthcare Benefits* section.

Cost of Coverage

You and the Company share the cost of coverage for both you and your ELIGIBLE FAMILY MEMBERS.

The cost of your coverage depends on the plan option and level of coverage you choose. The cost may change each year.

You can choose from four levels of coverage. Cost for each coverage level for eligible Marsh McLennan Employees (other than Marsh & McLennan Agency LLC – Northeast (MMA-Northeast) or Security Insurance Services of Marsh & McLennan Agency LLC) is shown below.

Coverage Level	Semi-monthly Cost	Weekly Cost
Employee Only	$177.11	$81.74
Employee + Spouse/Domestic Partner	$442.53	$204.24
Employee + Child(ren)	$354.22	$163.48
Employee + Family	$637.35	$294.16

Medical rates are not available for employees of MMA-Northeast, or Security Insurance Services of Marsh & McLennan Agency LLC. For contribution rates, contact HR Services at +1 866 374 2662, any business day, from 8:00 a.m. to 8:00 p.m. Eastern time.

See the *Participating in Healthcare Benefits* section for more information on the cost of your coverage, such as information about taxes.

Imputed Income for Domestic Partner Coverage

If you cover your domestic partner or your domestic partner's children, there may be imputed income for the value of the coverage for those family members. See the *Participating in Healthcare Benefits* section for more information on imputed income for domestic partner coverage.

Section 152 Dependents

If your domestic partner (or his or her child(ren)) qualifies as a dependent under IRS Section 152, imputed income does not apply.

The table below shows the imputed income amounts for all eligible Marsh McLennan Employees (including MMA-Northeast and Security Insurance Services of Marsh & McLennan Agency LLC):

Imputed Income Rates

Imputed Income for Domestic Partner Coverage Hawaii HMO Plan		
Coverage Level	**Semi-monthly**	**Weekly**
Employee + Domestic Partner (non-qualified)	$457.83	$211.31
Employee + Child(ren) (non-qualified)	$327.03	$150.94
Employee + Domestic Partner (non-qualified) & Child(ren)	$490.53	$226.40
Employee + Domestic Partner & Child(ren) (Domestic Partner and Child(ren) non-qualified)	$817.56	$377.34

ID Cards

If you are enrolled in employee only coverage, you will automatically be sent one ID card for your medical coverage. You will be sent additional ID cards if you enroll family members in the Plan. Each ID card will list the employee's name and the names of up to five covered family members. If you have more than five family members, you will receive additional ID card(s) that include the remaining covered family members.

You will be sent your ID card(s) within two to four weeks of your enrollment.

You may request additional ID cards directly from the Claims Administrator.

There is a separate ID card for prescription drug coverage. For information on prescription drug ID cards, refer to "Prescription Drugs" on page 26.

How the Plan Works

This plan helps you and your family to pay for medical care and PRESCRIPTION DRUGS. As a PARTICIPANT, you may choose, each time you need medical treatment, to use:

- Any PHYSICIAN, hospital or lab, or
- A provider who participates in the UnitedHealthcare Choice Plus (Broad Network) and has agreed to charge reduced fees to the Plan members. Using the network is more cost effective than using non-network providers because their fees are typically less than those charged by non-network providers.

If you use an in-network provider, you do not need to submit a claim form. IN-NETWORK PROVIDERS bill the Claims Administrator directly.

- Generally, the Plan's reimbursement is 100% after COPAY for in-network providers and 100% after copay of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS.

See the "Detailed List of Covered Services" on page 43 for more detailed information.

Certain expenses are not covered or reimbursed by the Plan, such as your share of the amounts above the reasonable and customary charge.

Some services have specific limits or restrictions; see individual service for more information.

Refer to the "What's Not Covered" on page 50 to find out about the services that are not covered under the Plan.

Benefits are only paid for MEDICALLY NECESSARY charges or for specified wellness care expenses.

Prior authorization may be required in order to receive coverage for certain services. It is the Plan participant's responsibility (not the provider or facility) to obtain prior authorization for out-of-network services. For more information on the prior authorization process and applicable services, refer to the description under "Utilization Review" on page 10.

The Plan has no deductible or coinsurance. Medical services and prescription drugs are subject to a copay. You pay a copay based on the care you receive and the provider you chose. A copay is the flat dollar amount you pay for covered services and prescription drugs under the Plan. Copays count toward an out-of-pocket maximum (the maximum amount you will pay in out-of-pocket expenses during the plan year).

When you need care, you'll be able to research providers and view copays for providers, procedures, and treatment options *before* you make an appointment. The copays will vary based on the covered service, the provider and whether the provider is in-network.

To locate in-network providers, search for medical services, see the amount you will pay for care (copay amounts), compare costs for treatments and procedures, call Member Services at +1 866 683 6440, visit the Surest Mobile App or Benefits.Surest.com. See the *Networks* section for search instructions.

You pay a copay for prescription drugs depending on the tier of the drug (i.e., generic, formulary brand or non-formulary brand drug). For information on covered medications with CVS Caremark® and the costs, visit www.caremark.com.

Flexible Spending Accounts

If you are a PARTICIPANT in the Surest COPAY Plan, you can elect a Flexible Spending Account (FSA) that allows you to put aside money before taxes are withheld so that you can pay for eligible medical, dental and vision expenses that are not reimbursed by any other coverage that you and your qualifying family members have.

For details about the FSA, see the *Health Care Flexible Spending Account* section.

Out-of-Pocket Maximums

The maximum amount you have to pay toward the cost of the medical care you receive in the course of one year (excluding your per paycheck contributions to participate in the Plan).

Plan feature	Surest Copay Plan
Out-of-pocket maximum	***In-network:*** Employee: $2,200 Family[1]: $4,400[2] ***Out-of-network:*** Employee: $4,400 Family[1]: $8,800[2]

1 "Family" applies to all coverage levels except Employee-Only.

2 Not "True" Family: When a covered family member meets his or her individual out-of-pocket maximum, the out-of-pocket maximum is satisfied for that covered family member only, but not for the other covered family members. When the family out-of-pocket maximum is met, the out-of-pocket maximum is satisfied for every covered family member whether or not they have met their own individual out-of-pocket maximums. The family out-of-pocket maximum can only be met by a combination of covered family members, as amounts counted toward individual out-of-pocket maximums count toward the larger family out-of-pocket maximum.

Prescription drug expenses apply toward the out-of-pocket maximum, with the exception of specialty medications covered under the PrudentRx Program, as described under "Are there mandatory discount or copay assistance programs applicable for specialty prescription drugs?" on page 31.

The out-of-pocket maximum doesn't apply to:

- Amounts exceeding Plan limits
- Amounts in excess of a reasonable and customary charge

- Prior authorization penalties
- Services not covered by the Plan
- Amounts exceeding the network negotiated price for PRESCRIPTION DRUGS.

Your copays apply towards your out-of-pocket maximum.

Do in-network claims apply toward the in-network out-of-pocket maximum?

Yes. In-network claims apply toward the in-network out-of-pocket maximum.

Do in-network claims apply toward the out-of-network out-of-pocket maximum?

No. In-network claims do not apply toward the out-of-network out-of-pocket maximum.

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Yes. Out-of-network claims apply toward the in-network out-of-pocket maximum.

How does the annual out-of-pocket maximum (limit) work for family members?

The Plan will begin reimbursing benefits for a covered family member at 100% once he or she has met the individual out-of-pocket maximum (even if the entire family out-of-pocket maximum has not been met).

How does the annual out-of-pocket maximum (limit) work for family members?

The Plan will begin reimbursing benefits for a covered family member at 100% once he or she has met the individual out-of-pocket maximum (even if the entire family out-of-pocket maximum has not been met).

Network

The Surest COPAY plan uses the UnitedHealthcare Choice Plus Broad network which is available nationwide.

Is there a network of doctors and hospitals that I have to use?

Using the network is not mandatory, but generally, you will pay less out-of-pocket when using an in-network provider.

Copays will be higher when you use OUT-OF-NETWORK PROVIDERS.

In the event that you receive care from an out-of-network doctor (such as an anesthesiologist) while being treated at an in-network facility, benefits will be paid at the in-network level.

The network includes general practitioners, as well as specialists and hospitals. These network providers are selected by and contracted with the Claims Administrator.

Depending on the geographic area and the service you receive, you may have access through Surest's SHARED SAVINGS PROGRAM to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Services, when applicable. Shared Savings is a program in which Surest Copay Plan may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider, and there's no balance billing in these instances. There are some instances where a non-Network provider may bill you for the difference between the billed amount and the rate determined by Surest Copay Plan. If this happens you should call the number on your ID Card.

Important Information about Network Providers

Surest is your Claims Administrator if you live within the United States.

You must access a Surest Copay Plan Network Provider in order to receive the Network level of benefits.

Where can I get a directory that lists all the doctors and hospitals in the network?

The doctors and hospitals in the network are listed in a provider directory. The Claims Administrator provides an online directory of providers or you may call the Claims Administrator.

Network provider lists can change, so take the time to review the networks to determine which networks your health care providers participate in before choosing a THIRD PARTY ADMINISTRATOR and network.

Important: In-network participating providers can change at any time; therefore, the network information you gather may not be accurate for all or part of the plan year. You will NOT be permitted to change your medical plan election during the plan year, even if any or all of your providers stop participating in any network at any point during the plan year.

Call Member Services at +1 866 683 6440 or visit Benefits.Surest.com. On the Surest website:

1. Click on the **Search coverage and providers icon** on the home page or click on the Search icon on the top left of the home page.
2. Enter your **ZIP** code on the top right of the search page. Tip: make sure the ZIP code reflects the area where the provider is located.
3. Use search field "**Search procedures, specialties, conditions or practitioners**" and enter the provider's name.

Is there a network of providers for mental health treatment?

There is a network of mental health providers. Providers in the network are listed in a provider directory. The Claims Administrator provides an online directory available at Benefits.Surest.com or the Surest mobile app. You may also call Surest Member Services at +1 866 683 6440.

Network provider lists can change, so take the time to review the networks to determine which networks your health care providers participate in before choosing a third party administrator and network.

Important: In-network participating providers can change at any time; therefore, the network information you gather may not be accurate for all or part of the plan year. You will NOT be permitted to change your medical plan election during the plan year, even if any or all of your providers stop participating in any network at any point during the plan year.

Is there a network of pharmacies?

There is a pharmacy network associated with this Plan. You may use a pharmacy in the network as well as out-of-network to receive coverage under this Plan.

Note that when you go to a pharmacy that's out-of-network, you need to submit a claim form for reimbursement. Refer to "How do I file a prescription drug claim form?" on page 63 for more information.

The Prescription Drug Benefits Manager, CVS Caremark®, provides an online directory of network pharmacies available at www.caremark.com.

To locate an in-network retail pharmacy:

- Go to www.caremark.com.
- Login or create an account.
- Plan & Benefits.
- Pharmacy Locator.

Or call CVS Caremark® at +1 844 449 0362 for more information.

Utilization Review

Which utilization review services are offered?

The Plan offers prior authorization and case management review.

You may obtain more information about these review services by calling the Claims Administrator.

What is Prior Authorization?

Select services require prior authorization or pre-admission notification. Prior authorization is required by service type, regardless of whether the service is rendered by in-network or OUT-OF-NETWORK PROVIDERS.

IN-NETWORK PROVIDERS are responsible for obtaining prior authorization for select Covered Health Services and are responsible for pre-admission notification for planned INPATIENT admissions and post-admission notification at least 24 hours of admission of EMERGENCY inpatient admissions. Inpatient stays will be reviewed for Medical Necessity, length of stay, and level of care. All acute inpatient rehabilitation (AIR) admissions, long-term acute care (LTAC) admissions, and SKILLED NURSING FACILITY (SNF) admissions are subject to Medical Necessity review pre-admission.

If you have questions about prior authorization or pre-admission notification, please contact Surest Member Services.

If you are using an out-of-network provider, you are responsible for ensuring that any necessary prior Authorizations and pre-admission notifications have been obtained or the services may not be covered by the Surest Plan. Only certain out-of-network Covered Health Services are available for benefits (e.g., ambulance, emergency room, observation stay). Contact Surest Member Services prior to obtaining services to determine whether prior authorization is required or ask your provider to contact the pre-certification number on your member ID card.

If your prior authorization or pre-admission notification is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request expedited review).

The prior authorization list is subject to change without notice. The most current information can be obtained by having your provider contact the pre-certification number on your member ID card or call Surest Member Services.

What services require prior authorization?

The following types of medical expenses require prior authorization or benefit determination, according to the Claims Administrator’s medical policies:

- Acute care hospitalizations (planned)
- Acute inpatient rehabilitation
- Applied behavioral analysis
- Air transportation for non-emergency
- Bariatric surgery
- Bone growth stimulators
- BRCA testing

- Cardiovascular procedures (select)
- Chemotherapy (select)
- Clinical trials
- Cochlear implant surgery
- Coverage with Evidence Development
- Durable medical equipment, orthotics, and prosthetics (select)
- Gender affirming surgery
- Genetic and molecular tests (select)
- Injectable medications (select)
- Intensity-modulated radiation therapy
- Long-term acute care
- MR-guided focused ultrasound
- Organ transplants
- Orthognathic surgery
- Partial hospitalization
- Potentially Cosmetic and RECONSTRUCTIVE surgery
- PRIVATE DUTY NURSING
- Proton beam therapy
- RESIDENTIAL TREATMENT facilities
- Skilled Nursing Facilities
- Sleep apnea procedures
- Sleep studies
- Spinal surgeries (select)
- Vein procedures
- Ventricular assist devices

Do I need to obtain prior authorization for my maternity coverage?

No. Prior authorization within 48 hours is not required for the initial hospital admission.

You must notify the prior authorization service if the mother or her newborn stay in the hospital longer than 48 hours after a vaginal delivery or 96 hours after a Cesarean birth. This notification must occur within 24 hours of the determination to extend the stay.

When do I obtain prior authorization?

In-network providers are responsible for obtaining Prior Authorization for select Covered Health Services and are responsible for Pre-Admission Notification for planned inpatient admissions and post-admission notification within at least 24 hours of an Emergency inpatient admission.

Note: If you are using an out-of-network provider, you are responsible for ensuring prior authorization for your service.

How do I obtain prior authorization?

Initiate the prior authorization process by calling the Claims Administrator at the toll-free number on the back of your ID card.

What happens if I fail to obtain prior authorization?

If you are using an out-of-network provider, you are responsible for ensuring that any necessary prior authorizations and pre-admission notifications have been obtained, or the services will not be covered by the Plan and you will be responsible for all costs billed by the provider.

What approvals do I need if I am going into the hospital?

All inpatient services require pre-admission Notification if planned, and notification within 24 hours of admission if an emergency.

Clinical Support

The Surest COPAY Plan has licensed clinical advocates and nurse case managers to help manage members' complex health care needs. Surest clinical advocates help to assist members with finding providers, providing treatment decision support, and overall care navigation. Surest nurse case managers work with members to understand their needs, set personal goals for care, and ensure needed support is provided. Nurses may guide members through treatment, explain options, advocate for members with their care team, and answer questions about members' care. Members can call Surest Member Services at + 1 866 683 6440 for more information on clinical support.

Nurse case managers work with the patient's PHYSICIAN to identify available resources and develop a treatment plan and may even recommend services and equipment. Situations that may benefit from case management include severe illnesses and injuries such as:

- Head trauma
- Organ transplants
- Burn cases
- Neo-natal high-risk infants
- Multiple fractures
- HIV-related conditions
- Brain injuries
- Cancer
- Prolonged illnesses
- Degenerative neurological disorders (e.g. multiple sclerosis).

The nurse can be involved from the earliest stages of a major condition to help the patient. This service gives you access to a knowledgeable professional who will use his or her experience to assist you and your physician in considering your treatment options.

What's Covered

Pre-existing Conditions

There are no exclusions, limitations or waiting periods for PRE-EXISTING CONDITIONs for you or any covered family members.

Are immunizations for business travel covered under the Plan?

No, the Plan does not cover immunizations for business travel.

Is acupuncture covered under the Plan?

The Plan covers acupuncture when it is a form of Alternative Treatment as long as it is rendered by a certified/licensed individual.

Coverage is limited to 30 visits per year.

Are insulin pump supplies covered under the medical coverage?

Yes. Insulin pump supplies are covered under the medical and prescription drug coverage. Any disposable syringes used in conjunction with insulin pump treatment would be covered under the prescription drug benefits.

Can a prosthetic device be replaced?

The Plan covers the replacement of prosthetic devices when MEDICALLY NECESSARY. The Plan does not cover replacements due to loss or misuse. Prior authorization may be required for select durable medical equipment.

Are wigs covered?

Scalp/cranial hair prostheses (wigs) are a Covered Health Service for scalp/head wound, burns, injuries, alopecia areata, cancer, and undergoing chemotherapy or radiation therapy; and are limited to a maximum benefit of $300 per PARTICIPANT per plan year for in-network and OUT-OF-NETWORK PROVIDERS combined.

Preventive/Wellness Care

How is preventive/wellness care covered?

The Plan covers PREVENTIVE/WELLNESS CARE at:

- 100% for IN-NETWORK PROVIDERS and $60 COPAY / visit for OUT-OF-NETWORK PROVIDERS. Contact the Claims Administrator for specific details.

What services are considered preventive/wellness care?

The Plan considers PHYSICIAN, testing and diagnostic fees for the following specific wellness expenses to be preventive/wellness care:

- Pediatric preventive care services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations up to age 18.
- Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once-a-year visits from 24 months to age six.
- Routine physical exams.
- Routine screenings for certain cancers and other conditions.
- Routine screening colonoscopy is covered as preventive with a diagnosis of family history.
- Routine immunizations. Age limits may apply.
- Routine lab tests, pathology, and radiology.
- Hearing and vision screening limited to one exam per Plan Year for children up to age of 21.
- Routine pre-natal and post-natal services.
- One routine postnatal care exam provided during the period immediately after childbirth that includes a health exam, assessment, education, and counseling.

- Preventive contraceptive methods and counseling for women.
  - Includes certain approved contraceptive methods for women with reproductive capacity, including contraceptive drugs, devices, and delivery methods.

Does the Plan cover outpatient physician services?

The Plan covers charges for OUTPATIENT office visits at:

- $5 to $40 copay / visit (PCP and Mental Health/Substance Use Disorder Out Patient provider) (based on provider and location) or $5 to $40 copay / visit (SPECIALIST) per in-network office visit (based on provider and location) and $120 copay / visit for out-of-network providers.

Does the Plan cover gynecology visits?

The Plan covers one routine gynecological exam each calendar year at:

- 100% for in-network providers and $60 copay / visit for out-of-network providers.

If the visit to the gynecologist is for treatment of a medical condition, it is not considered routine care and will be covered at:

- $5 to $40 copay (PCP) per office visit (based on provider and location) for in-network providers $120 copay / visit for out-of-network providers.

Does the Plan cover mammograms?

The Plan covers routine mammograms (including 3D mammograms) at:

- 100% for in-network providers and out-of-network providers.

There are no age or frequency limitations. It is recommended that members follow the American Cancer Society guidelines for age and frequency to determine when to receive preventive care services.

Does the Plan cover Pap smears?

The Plan covers one routine Pap smear each calendar year at:

- 100% for in-network providers and $60 copay / visit for out-of-network providers.

If your doctor recommends a non-routine Pap smear as a follow up to a medical diagnosis, the Plan covers the visit at:

- $5 to $40 copay / visit (based on provider and location) for in-network providers and $120 copay / visit for out-of-network providers.

Does the Plan cover prostate specific antigen (PSA) tests and routine Annual Digital Rectal exams?

The Plan covers routine prostate specific antigen (PSA) tests for covered males (age 40 and older) and routine Annual Digital Rectal Exam (DRE).

- 100% for in-network providers and $60 copay / visit for out-of-network providers.

If your doctor recommends a non-routine DRE test as a follow-up to a medical diagnosis, the Plan covers your DRE test at:

- $5 to $40 copay / visit (based on provider and location) for in-network providers and $120 copay / visit for out-of-network providers.

Maternity

Who is eligible for maternity coverage?

Maternity coverage is available to eligible covered participants.

Is maternity coverage subject to prior authorization?

No. Prior authorization within 48 hours is not required for the initial hospital admission.

You must notify the prior authorization service if the mother or her newborn stay in the hospital longer than 48 hours after a vaginal delivery or 96 hours after a Cesarean birth. This notification must occur within 24 hours of the determination to extend the stay.

Does the Plan cover prenatal visits?

Note that routine prenatal care, as defined by the Department of Health and Human Services, is covered with no cost sharing in-network.

The Plan covers routine prenatal and postnatal visits, including labs and tests at:

- $0 COPAY / visit for in-network.
- $60 copay / visit for OUT-OF-NETWORK PROVIDERS.

What will the Plan pay for the doctor's charge for delivering the baby?

The Plan covers charges for delivery of the baby at:

- $275 to $950 copay / stay (based on provider and location) for IN-NETWORK PROVIDERS and $2,850 copay / stay for out-of-network providers. There is only one copay for all Covered Health Services related to childbirth/delivery, including the newborn, unless discharged after the mother. If a newborn baby is discharged after the mother, another copay will apply to the baby's services.

What will the Plan pay for the doctor's charge for examining the baby?

The Plan covers the charges for your baby's first examination in the hospital at:

- $275 to $950 copay (based on provider and location) for in-network providers and $2,850 copay for out-of-network providers. There is only one copay for all Covered Health Services related to childbirth/delivery, including the newborn, unless discharged after the mother. If a newborn baby is discharged after the mother, another copay will apply to the baby's services.

A child is covered at birth as long as the baby meets the child eligibility requirements and is enrolled within 60 days of the birth. Eligibility requirements are described in the *Participating in Healthcare Benefits* section.

What will the Plan pay for hospital charges for the mother and the baby?

The Plan covers hospital charges for maternity admissions at:

- $275 to $950 copay (based on provider and location) for in-network providers and $2,850 copay for out-of-network providers. There is only one copay for all Covered Health Services related to childbirth/delivery, including the newborn, unless discharged after the mother. If a newborn baby is discharged after the mother, another copay will apply to the baby's services.

The Plan covers newborn nursery care at:

- $275 to $950 copay (based on provider and location) for in-network providers and $2,850 copay for out-of-network providers. There is only one copay for all Covered Health Services related to childbirth/delivery, including the newborn, unless discharged after the mother. If a newborn baby is discharged after the mother, another copay will apply to the baby's services.

A child is covered at birth as long as the baby meets the child eligibility requirements and is enrolled within 60 days of the birth. Eligibility requirements are described in the *Participating in Healthcare Benefits* section.

The mother and the newborn child are covered for a minimum of 48 hours of care following a vaginal delivery and 96 hours following a Cesarean section. However, the mother's provider may — after consulting with the mother — discharge the mother earlier than 48 hours following a vaginal delivery (96 hours following a Cesarean section).

You must notify the Claims Administrator within 24 hours of a determination to extend the stay.

Does the Plan cover midwife services?

The Plan covers midwives who are in practice with a network group at:

- $275 to $950 copay (based on provider and location) for in-network providers and $2,850 copay for out-of-network providers. There is only one copay for all Covered Health Services related to childbirth/delivery, including the newborn, unless discharged after the mother. If a newborn baby is discharged after the mother, another copay will apply to the baby's services Certified nurse midwives are covered under the childbirth/delivery copay.

What is the wellness program for Maternity?

Surest has a maternity benefit guide located at https://www.surest.com/blog/maternity to help you navigate your maternity journey. Surest also has clinical advocates who can help assess your maternal risk and answer any questions you have about your benefits. If you have issues or risk factors that need special attention, the clinical advocate will put you in touch with a nurse case manager who will work with you to find ways to lower your risks.

If my dependent child has a baby does the Plan cover the newborn child?

Unless the newborn meets the definition of an eligible child and is covered under the Plan, medical care for the newborn, whether in or out of the hospital, is not covered.

Family Planning

Does the Plan cover infertility treatment?

The Plan covers infertility treatments with a benefit cap of $20,000 for medical services, with the following copays:

Fertility Treatments	In-Network	Out-of-Network
Office Visit	$5 to $40 COPAY / visit (based on provider and location)	$120 copay / visit
Artificial insemination	$100 copay / service	$200 copay / service
Egg Retrieval	$1,500 copay / service	$3,000 copay / service
Embryo Transfer	$750 copay / service	$1,500 copay / service
Cryopreservation	$500 copay / service	$1,000 copay / service
Storage	$100 copay / year	$200 copay / year
Thawing	$150 copay / service	$300 copay / service
Genetic Testing (PGT)	$500 copay / visit	$1,000 copay / visit

Benefits for infertility treatment are limited to a medical lifetime maximum of $20,000 per person and a separate pharmacy lifetime maximum of $20,000.

Infertility treatments are covered as follows:

- Diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a PHYSICIAN.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Fertility Treatment copay. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copay.
- Therapeutic services for fertility when provided by or under the direction of a Physician. Benefits under this section are limited to the following procedures:
  - Assisted Reproductive Technologies (ART), including but not limited to, gamete intrafallopian transfer (GIFT), in-vitro fertilization (IVF), pronuclear stage tubal transfer (PROST), tubal embryo transfer (TET), and zygote intrafallopian transfer (ZIFT).
  - Ovulation induction (or controlled ovarian stimulation).
  - Cryopreservation, also known as embryo freezing, and storage (up to 12 months) for embryos produced from one cycle for a PARTICIPANT who is seeking fertility treatment and needs to freeze embryos due to medically necessity reasons. Insemination procedures (artificial insemination [AI] and intrauterine insemination [IUI]).
  - Infertility Genetic Testing (PGT) is a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. (e.g., PGT-M for monogenic disorder [formerly Chromosomal PGD] and PGT-MR for structural rearrangements [formerly chromosomal PGD]).
- The Plan will cover the treatment of the female factor causing infertility and therapeutic donor insemination upon the female Participant. The Plan will also cover reciprocal in-vitro fertilization (Reciprocal IVF or Partner IVF) for persons meeting the definition of infertility. The Plan will cover the Reciprocal IVF or Partner IVF transfer of any resulting embryos to the Participant from whom the oocytes were NOT derived.
- The Plan will cover the diagnosis and treatment of the male factor causing infertility, including collection and preparation of sperm, and the medications associated with the collection and preparation of sperm.
- Multiple copays may apply if more than one service is performed during a visit.

Is there a program for help navigating the fertility process?

The Fertility Solutions program provides tools and information to help members (not a child dependent) navigate the Infertility process by providing:

- Access to dedicated Fertility Solutions Nurses to help provide treatment education and counseling
- Support from the early infertility diagnosis stage to advanced treatment

For more information about the Fertility Solutions program, call +1 866 774 4626.

Are contraceptive devices covered under the Plan?

The Plan covers contraceptive devices under the medical plan at:

- 100% for IN-NETWORK PROVIDERS and $60 copay for OUT-OF-NETWORK PROVIDERS.

Certain contraceptives are covered under the prescription drug plan including oral and injectable contraceptives as well as contraceptive devices. To check drug coverage, visit www.caremark.com.

Does the Plan cover vasectomy?

The Plan covers vasectomies at:

- $30 to $210 copay / visit (based on provider and location) for in-network services and $630 copay / visit for out-of-network services.

You must obtain prior authorization before you are admitted to the hospital.

Vasectomy reversals are not covered under the Plan.

Does the Plan cover tubal ligation?

The Plan covers in-patient and OUTPATIENT tubal ligation at:

- 100% for in-network providers and $0 copay / visit and $60 copay / visit for out-of-network providers.

You must obtain prior authorization before you are admitted to the hospital.

Tubal ligation reversals are not covered.

Gender Affirming Surgery

Does the Plan cover gender affirming surgery?

Gender affirming surgery is covered for persons that meet the diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association.

Prior authorization is required for select services. Contact the Claims Administrator for specific details.

What gender affirming surgery benefits will the Plan pay?

The Plan will provide MEDICALLY NECESSARY benefits in connection with gender affirming surgery.

Refer to the Surest mobile app or Benefits.Surest.com website for coverage and COPAY information or call Surest Member Services at + 1 866 683 6440.

Inpatient Hospital and Physician Services

What will the Plan pay if I have to go to the hospital?

The Plan pays INPATIENT hospital charges at:

- Up to $1,800 COPAY / visit (based on provider and location) for IN-NETWORK PROVIDERS and up to $3,400 copay / visit (based on provider and location)for OUT-OF-NETWORK PROVIDERS per admission.

The Plan will cover the cost of a semi-private room. If you use a private room, the Plan will cover the amount up to the semi-private room rate.

You must obtain prior authorization as soon as possible but at least 14 days before you are admitted for a non-EMERGENCY hospital stay.

What approvals do I need if I am going into the hospital?

All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if an emergency.

Does the Plan cover hospital visits by a physician?

While you are in the hospital, the Plan covers hospital visits by a PHYSICIAN at:

- Up to $1,800 copay / visit (based on provider and location) for in-network providers and up to $3,400 copay / visit (based on provider and location) for out-of-network providers. Inpatient hospitalization/stay. Benefits include:
  - Physician and non-Physician services, supplies, and medications received during an inpatient stay.
  - Facility charges, including room and board in a semi-private room (a room with two or more beds).
  - Physician services for lab tests, anesthesiologists, pathologists, radiologists, and Emergency room Physicians.

Does the Plan cover ambulance charges?

The Plan covers transportation by ambulance as follows:

- $125 copay / transport for in-network providers and $125 copay / transport for out-of-network providers.

- Ground or air ambulance, as the Claims Administrator determines appropriate. Air ambulance is medical transport by helicopter or airplane.
- Emergency ambulance services and transportation provided by a licensed ambulance service (either ground or air ambulance) to the nearest hospital that offers Emergency health services.
- Ambulance service by air is covered in an emergency if ground transportation is impossible or would put your life or health in serious jeopardy. If special circumstances exist, the Claims Administrator may approve Benefits for emergency air transportation to a hospital that is not the closest facility to provide emergency health services.
- Ambulance services for non-emergency: The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as Surest determines appropriate) between facilities when the transport is:
  - From an out-of-network hospital to an in-network hospital.
  - To a hospital that provides the required care that was not available at the original hospital.
  - To a more cost-effective acute care facility.
  - From an acute care facility to a sub-acute care setting.

Non-emergency ground and air ambulance services may require prior authorization and medical necessity review.

Does the Plan cover hospice care?

The Plan covers charges for HOSPICE at:

- $15 copay / visit for in-network Home Hospice Visit and $45 copay / visit for out-of-network Home Hospice Visit.
- $950 copay / visit for in-network Inpatient Hospice Care and $2,850 copay / visit for out-of-network Inpatient Hospice Care.

You must obtain prior authorization before you receive hospice care.

Massage Therapy

Does the Plan cover massage therapy services?

Yes, the Plan covers massage therapy services only as part of a Chiropractic Care or Physical Therapy treatment program.

Mastectomy – Reconstructive Surgery

Does the Plan cover mastectomy-related services?

Yes, the Plan covers mastectomy-related services. Coverage will be provided in a manner determined by the attending PHYSICIAN and the patient. The covered services include:

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

What are the applicable copays for mastectomy-related benefits under the Plan?

Refer to the Surest mobile app or Benefits.Surest.com website for coverage and COPAY information or call Surest Member Services at + 1 866 683 6440.

Musculoskeletal Surgery – Knee, Hip, Spine

The plan covers surgical treatment for knee, hip and spine provided by or under the direction of a PHYSICIAN.

The Medical plan pays benefits for spine and joint surgeries that are ordered by a physician. Spine and joint surgeries are subject to prior authorization. Spine and joint surgical procedures include spine fusion surgery, spine disk surgery, total knee replacement and total hip replacement.

Obesity Surgery

The plan covers surgical treatment of obesity provided by or under the direction of a PHYSICIAN. Coverage is limited to once per person per lifetime.

All services, including surgery, must be obtained from an in-network provider.

Prior authorization under the condition of meeting the medical definition of morbid obesity is required.

Occupational Therapy

The plan covers the treatment to:

- Learn or re-learn daily living skills (e.g., bathing, dressing and eating) or compensatory techniques to improve the level of independence in the activities of daily living
- Provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease.

Coverage includes services, treatment, education testing or training related to developmental delays.

Prior authorization for occupational therapy is recommended. Contact the Claims Administrator for specific details. Ongoing therapy is subject to periodic clinical review to determine medical necessity for continued therapy.

Physical Therapy

The plan covers evaluation and treatment by physical means or modalities that:

- Follows a specific treatment plan prescribed by your PHYSICIAN and is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure
- Includes rehabilitative and HABILITATIVE SERVICES

Coverage includes services related to developmental delays. Ongoing therapy is subject to periodic clinical review to determine medical necessity for continued therapy.

Sword Health Virtual Physical Therapy

The plan covers the virtual treatment of acute, chronic, pre-surgical and post-surgical pain at home combining an exercise program prescribed by licensed physical therapists with motion sensor technology.

- Areas of focus include back, shoulder, neck, knee, elbow, hip, ankle, wrist and pelvic area.
- A physical therapist designs an exercise program based on the specific treatment prescribed by a PHYSICIAN. Sword Health will ship you a tablet and wearable motion sensors which will provide real-time feedback during your exercises. You then complete your exercise sessions at home when it is convenient for you. Your physical therapist is there to support you virtually and is available for chat via the Sword Health mobile app.
- Physical therapy sessions are unlimited per month.
- Virtual physical therapy typically consists of an initial period of 8-12 weeks. Sessions are usually 20-30 minutes and it is recommended that you complete sessions three to five days per week.
- A check-in between a member and a physical therapist is typically twice a week via chat or email. Video calls take place every four weeks. Members can also speak to their physical therapist via phone calls if they choose to exchange personal phone numbers.

Ongoing therapy is subject to periodic clinical review to determine medical necessity for continued therapy.

Sword Health Virtual Physical Therapy includes a Digital Therapist© tablet, motion sensors, straps and support from a licensed physical therapist. Access the Sword Health mobile app is also included which provides for direct chat with the dedicated physical therapist and access to educational articles. The Sword Health mobile app is available in the App Store for iOS devices and on Google Play for Android devices.

You must be 18 years of age or older and enrolled in the Surest COPAY Plan to use Sword Health Virtual Physical Therapy.

The cost to utilize Sword Health Virtual Physical Therapy is subject to a $29 monthly copay. The cost structure for Sword Health Virtual Physical Therapy works differently from the other physical therapy services covered under the plan - services are subject to a monthly cost share. For information on the actual cost for these services, refer to the “Detailed List of Covered Services” on page 43.

For more information and to start virtual physical therapy, go to join.swordhealth .com/mm/.

Note: Sword Health is an available option for physical therapy under the plan. It is not the only option. For an alternative option, see the Physical Therapy section above.

Prescription Drugs

How does the Plan cover prescription drugs?

PRESCRIPTION DRUGS are covered as follows:

Prescription drugs	There is a CVS Caremark® Retail Pharmacy Network for 30-day supply (acute) and CVS Caremark® Retail and CVS Caremark® Mail Order for 90-day supply (maintenance) Prescription drugs.
	Surest Copay Plan[1]
Retail Prescriptions (30-day supply)	
▪ Generic	$10 COPAY
▪ Formulary Brand	$30 copay
▪ Non-Formulary Brand	$60 copay
CVS Caremark® Retail and CVS Caremark® Maintenance Choice Program Mail-order Prescriptions (90-day supply)	
▪ Generic	$25 copay
▪ Formulary Brand	$75 copay
▪ Non-Formulary Brand	$150 copay
Prescription Drug Programs	There are prescription drug programs available as part of the medical plan options. For information on Rx Savings Solutions, PrudentRx, Transform Diabetes® Care, WW Digital Program and Hello Heart, refer to “Prescription Drug Programs” on page 35.

[1] A mandatory program, the PrudentRx prescription drug program, will apply for eligible specialty medications for complex conditions on the PrudentRx Drug List. If you do not speak with PrudentRx, do not enroll in any copay assistance as required by a manufacturer, or do not choose to participate in the PrudentRx program, i.e. opt out, **you’ll be responsible for paying the 30% coinsurance cost for each specialty prescription medication, and the costs will NOT count towards either out-of-pocket maximum.** The PrudentRx Drug List is available at www.caremark.com. For specialty drugs not on the PrudentRx Drug List, standard mail order copays will apply. For more information, refer to “Are there mandatory discount or copay assistance programs applicable for specialty prescription drugs?” on page 31 and “Prescription Drug Programs” on page 35.

Does the Plan cover formulary and non-formulary brand-name prescription drugs?

The Plan covers formulary and non-formulary prescription drugs purchased via the Plan's mail order service or a participating retail pharmacy. The prescription drugs in the formulary may change. Select medications may be excluded from coverage (this list may be updated periodically).

To price medications and check formulary, visit www.caremark.com.

Unless your PHYSICIAN specifically prescribes a brand-name medication without substitution, prescriptions will be filled with the generic equivalent when allowed by state law.

Does the Plan cover generic drugs?

The Plan covers generic prescription drugs purchased via the Plan's mail order service or at a retail pharmacy.

What happens if I buy a brand-name prescription drug when a generic drug is available?

Unless your physician specifically prescribes a brand name medicine without substitution, prescriptions will be filled with the generic equivalent when allowed by state law.

If you or your physician requests the brand-name prescription drug when a generic prescription drug is available and there is no medical reason for the brand-name prescription drug, you pay your share of the cost for the generic drug in addition to the difference between the brand-name prescription drug and generic prescription drug gross cost. The difference in cost between the brand-name prescription drug and generic prescription drug does not accumulate towards your out-of-pocket maximum. If you meet your out-of-pocket maximum, you will continue to pay the difference in cost between the brand-name prescription drug and generic prescription drug.

How does the Plan cover generic and brand-name contraceptive medications with no generic equivalent?

The Plan will cover certain generic and brand-name contraceptive medications **with no generic equivalent** at 100% in-network with no cost sharing as long as a valid prescription is submitted.

What is the Plan coverage for preventive drugs?

Preventive drugs as defined by the Patient Protection Affordable Care Act are covered with no cost sharing (i.e. copay). Certain examples include: aspirin products, fluoride products, folic acid products, immunizations, contraceptive methods, smoking cessation products, bowel preps, primary prevention of breast cancer and statins. The list of preventive medications covered with no cost share, called the CVS Caremark ACA Drug List, is subject to periodic review and may change.

Call CVS Caremark® at +1 844 449 0362 for more information about preventive drugs. You can access the preventive drug listing at www.caremark.com. To obtain information on the cost of preventive drugs, log on to the Drug Cost Tool at www.caremark.com. Follow the provided steps to access the Drug Pricing Tool.

- Go to www.caremark.com.
- Login or create an account.
- Plan & Benefits.
- Check Drug Cost & Coverage.
- Enter drug name & dose and choose a pharmacy

The Pharmacy Benefits Manager provides an online directory of network pharmacies available at www.caremark.com. You may also call the Prescription Drug Benefits Manager.

Is there a mail-order program?

The Plan's mail order service allows participants to order up to a 90-day supply of prescription medication by mail for certain maintenance medications. You may also obtain a 90-day supply of maintenance medications at CVS Caremark® retail pharmacies. Using the CVS Caremark® Maintenance Choice program mail order service or obtaining a 90 day supply of maintenance medications will generally cost you less than using a non-CVS Caremark® retail pharmacy.

If I buy more than three fills of a prescription drug at a retail pharmacy, will I have to pay more?

In addition to mail order, you will be able to fill a 90-day supply of your maintenance medications at a CVS Caremark® retail pharmacy, at the same cost as you would through the mail order program. For all maintenance medications, after the first three fills, you must fill a 90-day supply either at CVS Caremark® Retail or through CVS Caremark® Maintenance Choice Mail Order service. After three fills, the next fill for a 30 day supply or filled at a non-CVS Caremark® Retail pharmacy or not through CVS Caremark® Maintenance Choice Mail Order will be rejected. You will pay 100% of the full cost for all subsequent fills. Amounts you pay for rejected claims will not accumulate towards the out-of-pocket maximum.

If I purchase a specialty medication at retail, will the prescription be covered?

If a specialty medication is filled at non-CVS Caremark® retail pharmacy, the prescription will not be covered and amounts you pay for the non-covered prescription will not accumulate to the out-of-pocket maximum.

Are any prescription drugs or drug supplies subject to limitations?

You may be subject to several different types of drug management programs. These include quantity management, prior authorization and qualification by history or step therapy.

Quantity Management

To ensure safe and effective drug therapy, certain covered medications may have quantity restrictions. These quantity restrictions are based on manufacturer and/or clinically approved guidelines and are **subject to periodic review and change**.

Select examples of drug categories include:

- Antiemetic agents
- Antifungal agents
- Erectile dysfunction agents
- Migraine therapy
- Narcotic analgesics
- Non-narcotic analgesics
- Specialty medications

Prior Authorization

Certain medical treatments and prescription medicines need prior approval (which may include the submission of clinical information by your prescriber) before the Plan will cover them. This requirement is to ensure the treatment or medication is appropriate and effective. If you do not receive approval, you will be responsible for paying the full cost.

Select examples of drug categories include but are not limited to:

- Androgens and anabolic steroids
- Anorexiants
- Antinarcoleptics
- Dermatologicals
- Specialty medications – require prior authorization under the Plan and are subject to quantity limitations as well
  - Examples of drug categories include: Cancer therapies, Growth Hormones, Hepatitis, Immune Globulins, Multiple Sclerosis, Myeloid Stimulants, Psoriasis, Pulmonary Arterial Hypertension (PAH), Rheumatoid Arthritis, RSV agents.

The drugs that require prior authorization may be modified. To obtain prior authorization for coverage, ask your doctor to call CVS Caremark® at +1 800 237 2767. After they receive the necessary information, you and your doctor will be notified confirming whether or not coverage has been approved.

Qualification by History (Step Therapy)

Some medications require the trial of another drug and/or require certain criteria such as age, or condition (determined by previous claims history) to receive coverage. In these cases, a coverage review will be required if certain criteria cannot be determined from past history.

Select examples of drug categories include:

- Cardiovascular agents
- COX-II Inhibitors
- Dermatologicals
- Migraine therapy
- Osteoporosis agents

The drugs that may become subject to qualification by history rules may be modified.

Contact the Prescription Drug Benefits Manager at +1 844 449 0362 for more information about any of these programs.

Are there any limitations on specialty prescription drugs?

Specialty medications may require prior authorization under the Plan and may be subject to quantity limitations and cost caps. These limits are subject to change and are discussed above.

Certain specialty drugs which you can administer to yourself (or a caregiver may administer to you) may not be covered under the medical benefit. These drugs will only be covered through CVS Caremark's Specialty Pharmacy. If these medications are obtained from an OUTPATIENT clinic, a home infusion company, a doctor's office or from another pharmacy, they will not be covered and you will be responsible for the full cost of the medication. This does not apply to medications supplied by an EMERGENCY room or during an INPATIENT hospital stay.

Contact the Pharmacy Benefits Manager at +1 844 449 0362 for more information about any of these programs.

Are there mandatory discount or copay assistance programs applicable for specialty prescription drugs?

PrudentRx is a program that can help you receive eligible specialty medications at no cost for the treatment of complex chronic conditions, including, but not limited to, multiple sclerosis, cancer and rheumatoid arthritis.

Your specialty medication will be filled through CVS Specialty Pharmacy. You can see the prescription drugs in the PrudentRx Program at www.caremark.com. This list is subject to periodic review and change.

You are eligible for the PrudentRx Program if you are currently taking a specialty medication covered under the prescription drug benefit that is on the PrudentRx Drug List (available at www.caremark.com), you receive your prescription drugs benefits through CVS Specialty Pharmacy, and you are enrolled in the Surest Copay Plan.

If you are eligible for the PrudentRx Program and your specialty medication is on the PrudentRx Drug List (available at www.caremark.com), you must participate and enroll in the PrudentRx Program to receive your specialty medication free of charge. If eligible, you'll be enrolled in the PrudentRx program. PrudentRx will reach out to you or your enrolled family members to gather information upon filling a prescription through CVS Specialty Pharmacy. PrudentRx will send a letter followed up by a phone call to provide specific information about the program and gather required information as it relates to your specialty medication, which will be filled through CVS Specialty Pharmacy. To secure your enrollment and participation in the PrudentRx program, you **must speak** with PrudentRx.

You can see the eligible specialty medications included in the PrudentRx Program, (i.e., on the PrudentRx Drug List) at www.caremark.com. The PrudentRx Drug List may be updated periodically.

These specialty medications are considered non-essential health benefits under the program and the cost of such medications will not be applied towards your out-of-pocket maximum as there will be no cost to you.

Participating in the PrudentRx program means that you **must speak with PrudentRx** to verify your enrollment and properly complete any steps required by a manufacturer to obtain copay assistance. If you do not speak with PrudentRx, **you'll be responsible for paying the 30% coinsurance cost for each eligible specialty prescription medication, and the costs will NOT count towards either out-of-pocket maximum.**

If your specialty medication is not on the PrudentRx drug list, your medication cost share follows 90-day supply copays outlined in "How does the Plan cover prescription drugs?" on page 26. If you receive less than a 90-day supply, your copay is prorated based on the day supply of medication you receive.

If You're Currently Enrolled in a Manufacturer Copay Assistance Program:

If you're currently enrolled in a manufacturer copay assistance for a specialty medication and this medication is on the PrudentRx Drug list, you'll need to provide the manufacturer copay enrollment information to PrudentRx in order to pay $0 for this medication. If you do not speak with PrudentRx and provide the manufacturer copay enrollment information to PrudentRx, **you'll be responsible for paying the 30% coinsurance cost for each eligible specialty prescription medication, and the costs will NOT count towards either out-of-pocket maximum.**

If You're Not Currently Enrolled in a Manufacturer Copay Assistance Program:

If you're not currently enrolled in manufacturer copay assistance for a medication on the PrudentRx Drug list and the manufacturer requires enrollment in copay assistance, you'll need to speak with PrudentRx so that PrudentRx can assist with getting you enrolled with the manufacturer copay assistance in order to pay $0 for this medication. PrudentRx will contact you if you're required to enroll in the copay assistance for any medication that you take. PrudentRx will work with you and the drug manufacturer to get copay assistance and will manage enrollment and renewals on your behalf. If you do not enroll in any copay assistance as required by the manufacturer, **you'll be responsible for paying the 30% coinsurance cost for each eligible specialty prescription medication, and the costs will NOT count towards either out-of-pocket maximum.**

If you do not speak with PrudentRx, do not enroll in any copay assistance as required by a manufacturer, or do not choose to participate in the PrudentRx program, i.e. opt out, **you'll be responsible for paying the 30% coinsurance cost for each eligible specialty prescription medication, and the costs will NOT count towards either out-of-pocket maximum.**

If you have any questions, contact PrudentRx at +1 800 578 4403, Monday to Friday, from 9:00 am to 9:30 pm, and Saturday, 9:00 am to 6:00 pm, Eastern Time.

Medical Specialty Drugs Administered by a Medical Provider

Your Plan covers certain Specialty Drugs that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This section applies when a provider orders the drug and a medical provider administers it to you in a medical setting or in your home by a home infusion provider.

The PrudentRx Program does not apply to prescription drugs dispensed through the medical benefit.

Prior Authorization

Prior authorization is required for certain Medically Administered Specialty Drugs to help make sure proper use and guidelines for these drugs are followed. Your provider will submit clinical information which will be reviewed for decision.

For a list of Medically Administered Specialty Drugs that need prior authorization, please contact your Claims Administrator. Drugs requiring prior authorization may be updated from time to time. Your provider may check with the Claims Administrator to verify Specialty Drug coverage, to find out which drugs are covered under this section and if prior authorization is required.

If you are receiving an infused medication, certain medications may require use of the lowest cost site of care.

What prescription drugs and drug supplies are excluded from prescription drug coverage?

The following drugs and drug supplies are excluded from prescription drug coverage:

- Over-the-counter drugs (including topical contraceptives, nicotine products, vitamins and minerals, nutritional products including enteral products and infant formulas, homeopathic products and herbal remedies). Certain drugs will be covered with a prescription under Health Care Reform.
- Medical equipment and devices – insulin pumps
- Home diagnostic kits
- Certain injectables (i.e. IV infused)
- Allergy serums
- Plasma and blood products
- Drugs for cosmetic use
- Investigational drugs, experimental use drugs, non-FDA approved drugs.
- Arestin

Is there a network of pharmacies?

There is a pharmacy network associated with this Plan administered by CVS Caremark®. You may use a pharmacy in the network as well as out-of-network to receive coverage under this Plan.

Note that when you go to a pharmacy that’s out-of-network, you need to submit a claim form for reimbursement. Refer to “How do I file a prescription drug claim form?” on page 63 for more information.

The Pharmacy Benefits Manager provides an online directory of network pharmacies available at www.caremark.com.

To locate an in-network retail pharmacy:

- Go to www.caremark.com.
- Login or create an account.
- Plan & Benefits.
- Pharmacy Locator.

Or call CVS Caremark® at +1 844 449 0362 for more information.

How do I file a claim for benefits for prescription drugs?

All prescriptions filled at a participating retail pharmacy require you to provide an ID card for coverage under the Plan. You are responsible for the applicable copay. Rarely will you need to file a claim with the Prescription Drug Benefits Manager (one example may be a prescription filled at retail before you have received your ID card). To file a claim, contact the Prescription Drug Benefits Manager.

Claim forms are available on the Prescription Drug Benefits Manager's website. Should you need to file a claim, you are responsible for the contracted rate less copay. You have 12 months from the date the expense was incurred to submit a claim.

If you are eligible for the PrudentRx Program and your specialty medication is on the PrudentRx Drug List, refer to "Prescription Drug Programs" on page 35 for information on how the PrudentRx Program works.

Is there a separate ID card for the prescription drug program?

Yes, there is a separate ID card for the prescription drug program. If you are enrolled in medical coverage, you will automatically be sent a prescription drug ID card in addition to your medical plan ID card. You will be sent two prescription ID cards. If you enroll one or more family members, each prescription ID card will list the names of all covered family members.

You may request additional ID cards directly from the Prescription Drug Benefits Manager or by printing online at www.caremark.com.

There is a separate ID card for medical coverage. For information on medical plan ID cards, refer to the ID cards section.

Prescription Drug Programs

Rx Savings Solutions

Rx Savings Solutions is a program and tool to identify cost savings opportunities for prescriptions. Rx Savings Solutions sends proactive, personalized recommendations when an opportunity to save money on a prescription medication is identified. This means that if a lower cost alternative exists for a medication you may be taking (e.g. same medication in a slightly different dose, or a different medication that may work similarly to the one prescribed), Rx Savings Solutions will alert you that another medication option is available. This benefit is available to all members who participate in the Surest COPAY Plan and CVS Caremark® prescription drug plan at no cost to you.

When you receive a recommendation from Rx Savings Solutions, you have the option to talk to your prescriber about changing your prescription, have Rx Savings Solutions assist you by using the Contact Prescriber feature described below, or stay with your initial prescription.

Rx Savings Solutions will send personalized notifications by email (or text message, if you enroll in this service) whenever savings opportunities are found. You may also view savings opportunities from a personal dashboard through the Rx Savings Solutions member portal at https://mmc.rxsavingssolutions.com, as well as those for enrolled family members.

Rx Savings Solutions also offers the following features:

- Medicine Cabinet - a list of medicines a member is taking
- Medication Reminders - reminders for members to take their medication to promote adherence
- Contact Prescriber – members can use the “Contact Prescriber” option to have Rx Savings Solutions call the member’s prescriber to assist the member in getting a new prescription. It automates the process of changing prescriptions when a member decides to take advantage of a savings opportunity (participation is optional).

Call Rx Savings Solutions at +1 800 268 4476, Monday to Friday, 8:00 am to 9:00 pm Eastern Time or visit https://mmc.rxsavingssolutions.com for more information.

PrudentRx Program

PrudentRx is a program that can help you receive, at no cost, eligible specialty medications for the treatment of complex chronic conditions, including, but not limited to, multiple sclerosis, cancer and rheumatoid arthritis.

You are eligible for the PrudentRx Program if you are currently taking a specialty medication covered under the prescription drug benefit that is on the PrudentRx Drug List (available at www.caremark.com), you receive your PRESCRIPTION DRUGS benefits through CVS Specialty Pharmacy, and you are enrolled in the Surest Copay Plan.

If you are eligible for the PrudentRx Program and your specialty medication is on the PrudentRx Drug List (available at www.caremark.com), you must participate and enroll in the PrudentRx Program to receive your specialty medication free of charge. If eligible, you'll be enrolled in the PrudentRx program. PrudentRx will reach out to you or your enrolled family members to gather information upon filling a prescription through CVS Specialty Pharmacy. PrudentRx will send a letter followed up by a phone call to provide specific information about the program and gather required information as it relates to your specialty medication, which will be filled through CVS Specialty Pharmacy. To secure your enrollment and participation in the PrudentRx program, you **must speak** with PrudentRx.

You can see the eligible specialty medications included in the PrudentRx Program, (i.e., on the PrudentRx Drug List) at www.caremark.com. The PrudentRx Drug List may be updated periodically.

These specialty medications are considered non-essential health benefits under the program and the cost of such medications will not be applied towards your out-of-pocket maximum as there will be no cost to you.

Participating in the PrudentRx program means that you **must speak with PrudentRx** to verify your enrollment and properly complete any steps required by a manufacturer to obtain copay assistance. If you do not speak with PrudentRx, **you'll be responsible for paying the 30% coinsurance cost for each eligible specialty prescription medication, and the costs will NOT count towards either out-of-pocket maximum.**

If your specialty medication is not on the PrudentRx drug list, your medication cost share follows 90-day supply copays outlined in "How does the Plan cover prescription drugs?" on page 26. If you receive less than a 90-day supply, your copay is prorated based on the day supply of medication you receive.

If You're Currently Enrolled in a Manufacturer Copay Assistance Program:

If you're currently enrolled in a manufacturer copay assistance for a specialty medication and this medication is on the PrudentRx Drug list, you'll need to provide the manufacturer copay enrollment information to PrudentRx in order to pay $0 for this medication. If you do not speak with PrudentRx and provide the manufacturer copay enrollment information to PrudentRx, **you'll be responsible for paying the 30% coinsurance cost for each eligible specialty prescription medication, and the costs will NOT count towards either out-of-pocket maximum.**

If You're Not Currently Enrolled in a Manufacturer Copay Assistance Program:

If you're not currently enrolled in a manufacturer copay assistance for a medication on the PrudentRx Drug list and the manufacturer requires enrollment in copay assistance, you'll need to speak with PrudentRx so that PrudentRx can assist with getting you enrolled with the manufacturer copay assistance in order to pay $0 for this medication. PrudentRx will contact you if you're required to enroll in the copay assistance for any medication that you take. PrudentRx will work with you and the drug manufacturer to get copay assistance and will manage enrollment and renewals on your behalf. If you do not enroll in any copay assistance as required by the manufacturer, **you'll be responsible for paying the 30% coinsurance cost for each eligible specialty prescription medication, and the costs will NOT count towards either out-of-pocket maximum.**

If you do not speak with PrudentRx, do not enroll in any copay assistance as required by a manufacturer, or do not choose to participate in the PrudentRx program, i.e. opt out, **you'll be responsible for paying the 30% coinsurance cost for each eligible specialty prescription medication, and the costs will NOT count towards either out-of-pocket maximum.**

For additional information, refer to "Are there mandatory discount or copay assistance programs applicable for specialty prescription drugs?" on page 31.

You may contact PrudentRx directly if you missed their outreach or have any questions regarding the PrudentRx program. Specially trained customer care advocates are available at +1 800 578 4403, Monday through Friday, from 9:00 am to 9:30 pm and Saturday, 9:00 am to 6:00 pm, Eastern Time.

Transform Diabetes® Care Program

Transform Diabetes Care offers care for you and your ELIGIBLE FAMILY MEMBERS age 18 years of age and older enrolled in the Surest Copay Plan who've been diagnosed with diabetes. This program is available at no cost to you and your eligible family members. If you're diagnosed with diabetes, you're automatically enrolled. All eligible members will receive communication in the mail with instructions on how to enroll and use the program.

As a part of this program, you and your eligible family members will receive individualized support across five clinical impact areas:

- Glucose and blood pressure monitoring including no cost diabetes test strips (if eligible based on your individual needs and a review from a trained diabetes educator).
- Lifestyle and comorbidity management
- Medication optimization
- Preventative screenings
- Medication adherence

The program provides coaching support from a health coach and a Certified Diabetes Nurse.

Who is Eligible for the Transform Diabetes Care Program?

Members diagnosed with diabetes age 18 years of age and older who are enrolled in the Surest Copay Plan with prescription drug coverage through CVS Caremark®.

If you have any questions about eligibility, you may contact CVS Caremark® at +1 844 449 0362.

Hello Heart Program

Hello Heart provides care and support to you and your eligible family members age 18 years of age and older enrolled in the Surest Copay Plan who've been diagnosed with hypertension. This program is available at no cost to you and your eligible family members. All eligible members will receive communication in the mail with instructions on how to enroll and use the program.

The program provides digital remote blood pressure monitoring. As part of Hello Heart program, you will receive the following:

- Access to the Hello Heart mobile application that includes digital coaching and support aimed at improving heart health
- Hello Heart blood pressure monitor.

If you qualify, you'll receive a blood pressure monitor. You'll have the ability to register for the program via Hello Heart's online portal and download the Hello Heart application to your mobile device, for access to additional tracking tools and resources for heart health.

Who is Eligible for the Hello Heart Program?

Members diagnosed with hypertension who are 18 years of age and older and enrolled in the Surest Copay Plan with prescription drug coverage through CVS Caremark®.

If you have any questions about eligibility, you may contact CVS Caremark® at +1 844 449 0362 or Hello Heart at + 1 800 767 3471.

WW Digital Program

The WW Digital Program provides science-based tools to help you and your eligible family members 18 years of age or older enrolled in the Surest Copay Plan lose weight, eat healthier, move more, and develop a more positive mindset. The program is available at no cost to you and your eligible family members.

WW Digital includes:

- PersonalPoints™ Plan
- Access to a mobile application that includes digital tools:
  - Trackers for food, water, physical activity, sleep and weight

- Recipes
- Meal planning tools
- On-demand workouts
- Support from WW's community of members

Who is Eligible for the WW Digital Program?

Members who are 18 years of age and older and enrolled in the Surest Copay Plan with prescription drug coverage through CVS Caremark®.

If you have any questions about the program, you may contact CVS Caremark® at +1 844 449 0362 or WW Customer Care at +1 866 204 2885. To learn more or enroll, visit WW.com/MarshMcLennan.

Mental Health/Substance Use

Does the Plan cover mental health/substance use services?

The Plan covers MEDICALLY NECESSARY INPATIENT and OUTPATIENT mental health/substance use treatment services, including RESIDENTIAL TREATMENT.

Does the Plan cover services in connection with autism?

The Plan covers medically necessary inpatient and outpatient treatment services for autism, including intensive behavioral therapies such as Applied Behavioral Analysis that are (i) focused on the treatment of core deficits of Autism Spectrum Disorder, (ii) provided by a board certified Applied Behavioral Analyst (BCBA) or other qualified provider under appropriate supervision, and (iii) focused on treating maladaptive/stereotypic behaviors that pose a danger to self, others or property, or that impair daily functioning. Pre-authorization is required for services associated with Applied Behavioral Analysis.

Speech Therapy

The plan covers the treatment of:

- A speech impediment or speech dysfunction that results from injury, stroke or a congenital anomaly
- Delays in speech development.

Prior authorization for speech therapy is recommended. Contact the Claims Administrator for specific details.

Temporomandibular Joint (TMJ) Coverage

The Plan covers services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by and under the direction of a PHYSICIAN. Coverage includes the diagnostic or surgical treatment required as a result of an accident, trauma, congenital defect, developmental defect or pathology.

- Diagnostic coverage includes examination, radiographs and applicable imaging studies, and consultation.
- Includes orthodontic services and supplies, and surgical and non-surgical options for the treatment of TMJ. Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatments have failed.

Travel and Lodging

The Plan covers expenses for travel and lodging for all services, for the patient, provided he or she is not covered by MEDICARE, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The ELIGIBLE EXPENSES for lodging for the patient (while not a Hospital INPATIENT) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 100 miles from the Provider.
- The treatment of covered services offer a lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures and care. This applies when care is not available within 100 miles of your home address. Services must be received either through an in-network provider or at an out-of-network provider. Services must be received at the nearest available provider in order to be eligible.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed after travel has taken place.

What is the Plan's travel expense benefit?

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Provider. Go to www.irs.gov and enter "standard mileage rate" in the "Search" box for more information.
- Taxi, Uber/Lyft fares (not including limos or car services).
- Economy or coach airfare.

- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

What is the Plan's lodging expense benefit?

- A per diem rate, up to $50 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.
- Examples of items that are not covered:
  - Groceries.
  - Alcoholic beverages.
  - Personal or cleaning supplies.
  - Meals.
  - Over-the-counter dressings or medical supplies.
  - Deposits
  - Utilities and furniture rental, when billed separate from the rent payment.
  - Phone calls, newspapers, or movie rentals.

Is there a limit on the travel and lodging expense benefit the Plan will reimburse?

The reimbursement for lodging expenses is limited to $50 per night per person, including lodging expenses of a parent who must go with a child who needs medical care or of a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone. The maximum reimbursement for lodging expenses is $100 per night.

The maximum reimbursement for all travel and lodging expenses combined is $10,000 per episode of care.

How can participants receive reimbursement from the Plan?

Contact the Claims Administrator for information.

Important Information About Your Personal Health Information

- The Company does not collect, maintain, or report on any personal health information pertaining to you or any covered dependents.
- As a PARTICIPANT in our health plan, your personal health information is protected by federal law.
- Our medical THIRD PARTY ADMINISTRATORS (or carriers with respect to the insured programs) are required to protect your personal health information in accordance with federal law and data privacy agreements with the Company and/or plan fiduciaries.
- Please note that states seeking to prohibit or limit certain services under Company-sponsored plans might attempt to challenge your right to privacy under federal law. If a state's legal challenge is successful, there may be legal consequences associated with you procuring a service under a Company-sponsored plan that is or may become prohibited or limited under state law. If you have questions about potential risks, please seek professional legal advice.

Virtual Medicine

What is a Virtual Visit?

The Plan offers access to virtual urgent care, virtual behavioral health visits, and virtual primary care. Virtual visits let you talk to a US board-certified doctor through your mobile device (chat, video, phone) or a computer. The Surest app or member website will show you virtual visit options available for relevant conditions. The doctor can diagnose, recommend treatment, and prescribe medication, when appropriate, for many medical issues. You can use this service for common health concerns like colds, the flu, fevers, rashes, infections, allergies, etc. when you want a convenient way to access a doctor. Virtual visits can also include annual wellness visits or prescription refills using virtual primary care providers. Behavioral health therapy services are also available virtually.

Members can connect with a therapist or psychiatrist using a virtual visit provider.

This service is not the same as telehealth, where you have a regularly scheduled office visit with your treating PHYSICIAN via video. Virtual visit providers have been designated in the Plan and are accessible through the app.

When are virtual visits available?

Doctors are available 24/7, 365 days a year.

How do virtual visits work?

When you need to see a doctor, go to the Surest mobile app or member website. Choose the virtual provider that works for you, download their app, register with your insurance information, and then you can request a virtual visit.

Do doctors have access to my health information?

Doctors can access your health information and review previous treatment recommendations that were obtained through the virtual visit platform used previously. You can request urgent care providers share information with your routine doctor if you supply their contact information. When you use virtual primary care services, they will request you sign a release to gather information from previous providers to populate their medical records. You control who accesses your health information.

How do I access virtual care?

When you need to see a doctor, go to the Surest mobile app or website.

How do I pay for the online doctor's visit?

Virtual visits are covered at 100%, no COPAY. Prescriptions aren't included in the cost of the virtual visit.

Can I get online care from a doctor if I'm traveling or in another state?

Virtual visits are available in all states. If a member is traveling internationally, the board-certified clinician will only be able to provide advice, but no prescriptions will be written. The clinician may advise the member on the medication they should try to obtain, if any is recommended.

Who do I contact for additional information?

You can call Surest Member Services at +1 866 683 6440.

Detailed List of Covered Services

The Plan reimburses MEDICALLY NECESSARY covered services and supplies for the diagnosis and treatment for an illness or injury. The Claims Administrator determines whether the service or supply is covered and determines the amount to be reimbursed.

Most services and supplies are subject to a COPAY.

Your costs for out-of-network services apply toward the in-network out-of-pocket maximum. However, your costs for in-network services do not apply toward the out-of-network out-of-pocket maximum.

	Surest Copay Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**
Alcohol and substance use	***Inpatient and Residential Treatment:*** $950 copay / visit. Prior authorization may be required ***Outpatient:*** $45 copay / visit	***Inpatient and Residential Treatment:*** $2,850 copay / visit. Prior authorization may be required ***Outpatient:*** $135 copay / visit
Allergy testing and treatment	$45 copay / visit (allergy injections covered at 100% when no office visit charged)	$135 copay / visit (allergy injections covered after $60 copay)
Alternative medicine (Acupuncture)	$20 copay / visit	$60 copay / visit
	Coverage limitations: ▪ A form of Alternative Treatment as long as it is rendered by a certified/licensed individual. ▪ Limited to 30 visits per calendar year (combined in-network/out-of-network).	
Ambulance charges	$125 copay / transport Non-EMERGENCY ground and air ambulance services may require prior authorization.	$125 copay / transport Non-Emergency ground and air ambulance services may require prior authorization.
Applied Behavioral Analysis (ABA)	$5 copay / visit. Prior authorization may be required	$60 copay / visit. Prior authorization may be required
Artificial insemination	$100 copay / service. Limited to overall infertility maximum of $20,000 per lifetime. Prior authorization is required.	$200 copay / service. Limited to overall infertility maximum of $20,000 per lifetime. Prior authorization is required.
CT / PET scans	$50 to $310 copay / visit	$930 copay / visit.
Chiropractors	$10 copay / visit. 30 visits per calendar year (combined in-network/out-of-network)	$30 copay / visit. 30 visits per calendar year (combined in-network/out-of-network)
Contraceptive devices (as defined as Preventive Prescriptions)	Covered at 100%	$60 copay
Cosmetic surgery	Not covered	Not covered

	Surest Copay Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**
Dental treatment (covered only for accidental injury to sound teeth within 12 months)	$5 to $40 copay / visit (based on provider and location) for office visit. $50 to $300 copay / visit (based on provider and location) for OUTPATIENT Hospital $950 copay / visit for INPATIENT Hospital Accidental dental services may require prior authorization.	$120 copay / visit for office visit. $900 copay / visit for Outpatient Hospital $2,850 copay / visit for Inpatient Hospital Accidental dental services may require prior authorization.
Doctor delivery charge for newborns	$275 to $950 copay / visit (based on provider and location)	$2,850 copay / visit
Durable medical equipment (DME)	$0 to $500 copay (based on provider and location) for purchase. $0 to $50 copay (based on provider and location) for rental. Select DME may require prior authorization.	$20 to $1,000 copay (based on provider and location) for purchase. $2 to $100 copay (based on provider and location) for rental. Select DME may require prior authorization.
EKG Testing	$10 to $80 copay / visit (based on provider and location). Not considered preventive.	$240 copay / visit. Not considered preventive.
Emergency room	$250 copay / visit for life-threatening injury or illness (See “Life-threatening Illness or Injury in the “Glossary” on page 65).	$250 copay / visit for life-threatening injury or illness (See “Life-threatening Illness or Injury in the “Glossary” on page 65).
Gender Affirming Surgery (and related costs)	$45 copay / visit for Outpatient Hospital. $950 copay / visit for Inpatient Hospital. Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Select services for the treatment of Gender Dysphoria may require prior authorization.	$135 copay / visit for Outpatient Hospital. $2,850 copay / visit for Inpatient Hospital. Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Select services for the treatment of Gender Dysphoria may require prior authorization.

	Surest Copay Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**
Gynecology visits	Covered at 100% (for one routine exam each calendar year)	$60 copay / visit
Hearing care	$0 copay / visit. Hearing and vision screening limited to one exam per Plan Year for children up to age of 21. Covered hearing aids limited to $5,000 per covered person every 3 years (no coverage for hearing aids for degenerative hearing loss).	$60 copay / visit. Covered hearing aids limited to $5,000 per covered person every 3 years (no coverage for hearing aids for degenerative hearing loss).
Home health care	$15 copay / visit for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Prior authorization may be required	$45 copay / visit for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Prior authorization may be required
Hospice care	$15 copay / visit for Home HOSPICE Care. $950 copay / visit for Inpatient Hospice Care. Inpatient Hospice Care may require prior authorization.	$45 copay / visit for Home Hospice Care. $2,850 copay / visit for Inpatient Hospice Care. Inpatient Hospice Care may require prior authorization.
Immunizations (routine)	Covered at 100%	$60 copay
Infertility Services	$5 to $40 copay / visit (based on provider and location) for office visit. $100 to $1,500 copay (based on provider and location) for fertility treatments. Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $20,000 per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis of infertility.	$120 copay / visit for office visit. $200 to $3,000 copay (based on provider and location) for fertility treatments. Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $20,000 per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis of infertility.

	Surest Copay Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**
Inpatient hospital services	$950 copay / stay Prior authorization is required	$2,850 copay / stay Prior authorization is required
▪ Laboratory charges	$0 copay for routine diagnostic laboratory services/x-rays/ultrasounds. $10 to $370 copay / visit (based on provider and location) for non-routine diagnostic. Select laboratory services and diagnostic testing may require prior authorization.	$0 copay for routine diagnostic laboratory services/x-rays/ultrasounds. $210 to $1,110 copay / visit (based on provider and location) for non-routine diagnostic. Select laboratory services and diagnostic testing may require prior authorization.
Magnetic resonance imaging – MRI	$50 to $310 copay / visit (based on provider and location).	$930 copay / visit.
Mammograms, including 3D mammograms (Routine)	Covered at 100%	Covered at 100%
Mastectomy – reconstructive surgery	$225 to $900 copay (based on provider and location) for partial mastectomy $350 to $1,050 copay visit (based on provider and location) for mastectomy	$2,700 copay for partial mastectomy $3,150 copay for mastectomy
Maternity hospital stay	$275 to $950 copay / stay (based on provider and location).	$2,850 copay / stay
Mental health	***Inpatient and Residential Treatment*** $950 copay / visit Subject to prior authorization ***Outpatient:*** $45 copay / visit	***Inpatient and Residential Treatment*** $2,850 copay / visit Subject to prior authorization ***Outpatient:*** $135 copay / visit
Musculoskeletal Surgery	$100 to $1,800 copay (based on provider and location) Prior authorization may be required	$1,800 to $3,400 copay (based on provider and location) Prior authorization may be required
Obesity Surgery	$100 to $700 copay (based on provider and location) Once per lifetime Prior authorization is required	Not covered
Occupational therapy	$5 to $35 copay / visit[1] (based on provider and location) Medical Necessity Required.	$105 copay / visit Medical Necessity Required.

	Surest Copay Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**
Organ transplant	$1,100 copay / visit for bone marrow and solid organ transplants by a DESIGNATED PROVIDER as determined by the Claims Administrator. $1,300 copay / visit for Corneal Transplant Prior authorization may be required	$3,300 copay / visit for bone marrow and solid organ transplants. $3,900 copay / visit for Corneal Transplant Prior authorization may be required
Outpatient physician services	Preventive: 100% Office Visit: $5 to $40 copay / visit (based on provider and location) Mental Health/Substance Use Disorder Medication Therapy: $5 copay / visit Mental Health office visit: $5 copay / visit Outpatient Hospital: $50 to $300 copay / visit (based on provider and location) Outpatient Mental Health: $45 copay / visit	Office Visit: $120 copay / visit Mental Health/Substance Use Disorder Medication Therapy: $15 copay / visit Mental Health office visit: $60 copay / visit Outpatient Hospital: $900 copay / visit Outpatient Mental Health: $135 copay / visit
Physical exams for adults (routine)	Covered at 100% (not subject to copays) for one physical exam each calendar year	$60 copay for one physical exam each calendar year
Physical exams for children (routine)	Covered at 100% (not subject to copays) Subject to Plan limits	$60 copay Subject to Plan limits
Physical therapy	$5 to $30 copay / visit[2] (based on provider and location)	$90 copay / visit
Virtual Physical Therapy (Sword Health)	$29 copay per month for unlimited sessions per month	Not covered – all services must be provided by Sword Health
Pregnancy termination	$50 copay / visit for medical $80 copay / visit for surgical	$150 copay / visit for medical $240 copay / visit for surgical
Prenatal visits	No charge for Routine Prenatal Care; covered at 100%	$60 copay
Prescription drugs[3] (see "Prescription Drugs" on page 26)	There is a pharmacy network for 30-day and 90-day PRESCRIPTION DRUGS.	There is a pharmacy network for 30-day and 90-day prescription drugs.

	Surest Copay Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**
Private Duty Nursing	$15 copay / visit. Maximum of 60 visits per calendar year (Combined in-network/out-of-network) Prior Authorization is required	$45 copay / visit. Maximum of 60 visits per calendar year (Combined in-network/out-of-network) Prior Authorization is required
Prostate specific antigen test–PSA (routine)	Covered at 100%	$60 copay / visit
Skilled nursing facility	$700 copay / stay for up to 120 days per calendar year (combined in-network/out-of-network) Prior Authorization is required	$2,100 copay / stay for up to 120 days per calendar year (combined in-network/out-of-network) Prior Authorization is required
Speech therapy	$5 to $35 copay / visit[4] (based on provider and location)	$105 copay / visit
Surgery	$10 to $1,800 copay / visit (based on provider and location). Select procedures may require prior authorization.	$45 to $3,400 copay / visit (based on provider and location). Select procedures may require prior authorization.
Tubal ligation	Covered at 100%	$60 copay / visit
Urgent Care	$25 copay / visit	$75 copay / visit
Virtual Medicine	$0 copay / visit	Not covered
Vasectomy	$30 to $210 copay / visit (based on provider and location)	$630 copay / visit
Vision care (routine eye exam)	Not covered	Not covered
Vision Therapy/ Orthoptics	Not covered	Not covered
X-rays	Covered at 100%	Covered at 100%

1 $5 for Occupational Therapy when primary diagnosis is autism spectrum disorder (ASD).

2 $5 per visit if primary diagnosis is for Autism Spectrum Disorder (ASD).

3 A mandatory program, the PrudentRx prescription drug program, will apply for eligible specialty medications for complex conditions on the PrudentRx Drug List. If you do not speak with PrudentRx, do not enroll in any copay assistance as required by a manufacturer, or do not choose to participate in the PrudentRx program, i.e. opt out, **you'll be responsible for paying the 30% coinsurance cost for each specialty prescription medication, and the costs will NOT count towards either out-of-pocket maximum.** The PrudentRx Drug List is available at www.caremark.com. For drugs not on the PrudentRx Drug List, standard mail order copays will apply. For more information, refer to "Are there mandatory discount or copay assistance programs applicable for specialty prescription drugs? on page 31 and "Prescription Drug Programs" on page 35.

4 $5 per visit if primary diagnosis is for autism spectrum disorder (ASD).

What's Not Covered

Unless specifically described or listed in Detailed List of Covered Services, the Plan will not pay benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a PHYSICIAN.
- It is the only available treatment for your condition.

The Claims Administrator may modify this list at their discretion, and you will be notified of any such change.

Alternative Treatments

- Aromatherapy.
- Art therapy, dance therapy, horseback therapy, music therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.
- Health care services ordered or rendered by Providers or para-professionals unlicensed by the appropriate regulatory agency.
- Holistic medicine and services, including dietary supplements.
- Homeopathic or naturopathic medicine, including dietary supplements.
- Hypnotism.
- Massage therapy that is not physical therapy or prescribed by a licensed Provider as a component of a multi-modality rehabilitation treatment plan.
- Rolfing.
- Vocational therapy.
- Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.

Comfort or Convenience

- Television
- Telephone
- Beauty/barber service
- Guest service

- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners
  - Air purifiers and filters
  - Batteries and battery chargers
  - Car seats
  - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
  - Dehumidifiers/Humidifiers
  - Devices and computers to assist communication and speech
  - Exercise equipment and treadmills
  - Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools)
  - Hot and cold compresses
  - Hot tubs
  - Jacuzzis
  - Medical alert systems
  - Motorized beds, non-Hospital beds, comfort beds and mattresses
  - Music devices
  - Personal computers
  - Pillows
  - Power-operated vehicles
  - Radios
  - Safety equipment
  - Saunas.
  - Stair lifts and stair glides.
  - Strollers.
  - Treadmills.
  - Vehicle modifications such as van lifts.
  - Video player
  - Whirlpools

Dental

- Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.
- Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
  - Extraction, restoration and replacement of teeth
  - Medical or surgical treatments of dental conditions
  - Services to improve dental clinical outcomes
- Dental implants, bone grafts, and other implant-related procedures
- Dental braces (orthodontics)
- Dental X-rays, supplies and appliances and all associated expenses, including hospitalization and anesthesia. This exclusion does not apply to dental care required for the direct treatment of a medical condition.
- Treatment of congenitally missing, malpositioned or super numerary teeth, even if part of a congenital anomaly.
- Endodontics, periodontal surgery and restorative treatment.

Drugs Administered through Surest (see prescription drugs section for exclusions specific to CVS Caremark®)

- Charges for giving injections that can be self-administered.
- Drugs dispensed by a PHYSICIAN or Physician's office for OUTPATIENT use.
- Investigational or non-FDA-approved drugs.
- Non-prescription supplies.
- Over-the-counter drugs, except as specified in "Prescription Drugs" on page 26.
- Selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects.
- Vitamin or dietary supplements, except as specified in "Prescription Drugs" on page 26.

Experimental or Investigational Services or Unproven Services

- Intracellular micronutrient testing.
- Services that are considered Experimental or Investigational as determined by Surest are excluded. The fact that an Experimental or Investigational treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational in the treatment of that particular condition. To find out additional information, call Surest Member Services.

Foot Care

- Except when needed for severe systemic disease:
  - Routine foot care (including the cutting or removal of corns and calluses)
  - Nail trimming, cutting, or debriding (surgical removal of tissue)
- Hygienic and preventive maintenance foot care. Examples include the following:
  - Cleaning and soaking the feet
  - Applying skin creams in order to maintain skin tone
  - Other services that are performed when there is not a localized illness, injury or symptom involving the foot
- Shoe orthotics unless custom molded shoe inserts prescribed to treat a disease or illness of the foot

Gender Dysphoria

Cosmetic procedures related to a diagnosis of Gender Dysphoria including:

- Buttock lift.
- Calf implants.
- Chemical peels.
- Dermabrasion.
- Ear reduction (Otoplasty).
- Fertility preservation services.
- Laser or electrolysis hair removal not related to genital reconstruction.
- Neurotoxins.
- Piercing.

- Scalp tissue transfer (scalp advancement).
- Treatment for hair growth.
- Treatment received outside the United States.
- Wrinkle removal.

Medical Supplies and Appliances

- Birthing tub.
- Cranial banding except when MEDICALLY NECESSARY for the treatment of plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape).
- Devices and computers to assist in communication and speech except as described in Durable Medical Equipment (DME) and Supplies.
- Devices used specifically as safety items or to affect performance in sports-related activities
- Home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits.
- Oral appliances for snoring.
- Over-the-counter medical equipment or supplies such as saturation monitors, prophylactic knee braces, and bath chairs that can be purchased without a prescription even if a prescription has been ordered.
- Prescribed or non-prescribed medical supplies and some disposable supplies. Examples include:
  - Elastic stockings
  - Ace bandages
  - Gauze and dressings
- Orthotic appliances that straighten or re-shape a body part (including some types of braces)
- Tubings, nasal cannulas, connectors and masks are not covered except when used with durable medical equipment
- Tubings and masks except when used in association with durable medical equipment.
- Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Mental Health/Substance Use

- INPATIENT or intermediate or OUTPATIENT care services that were not pre-authorized.
- Investigational therapies for treatment of autism.
- Non-medical 24-hour withdrawal management which is an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM)* criteria providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.
- School-based Intensive Behavioral Therapies (IBT) service or services that are otherwise covered under the Individuals with Disabilities Education Act (IDEA).
- Intense Early Intervention Using Behavioral Therapy (IEIBT) and Lovaas. This exclusion does not apply when required for the treatment of Autism Spectrum Disorders.
- Vagus nerve stimulator treatment for the treatment of depression and quantitative electroencephalogram treatment of behavioral health conditions.
- Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association.
- Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder and paraphilic disorders.
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
- Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*
- Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Psychosurgery (brain surgery to treat psychiatric symptoms)
- Transitional Living services
- Treatment provided in connection with or to comply with commitments, police detentions and other similar arrangements, unless authorized by the Plan’s prior authorization review

Nutrition

- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).
- Food of any kind. Foods that are not covered include:
  - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, as described under Enteral Formulas and Low Protein Modified Food Products, unless they are the only source of nutrition or they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded.
  - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
  - Oral vitamins and minerals.
  - Meals you can order from a menu, for an additional charge, during an INPATIENT Stay.
  - Other dietary and electrolyte supplements.
- Health education classes unless offered by the Surest COPAY Plan including but not limited to asthma, smoking cessation, and weight control classes.

Physical Appearance

- Breast reduction surgery that is determined to be a Cosmetic procedure, except as required by the Women's Health and Cancer Rights Act of 1998.
- Cosmetic procedures. Examples include:
  - Hair removal or replacement by any means, except as part of a genital reconstruction procedure by a PHYSICIAN for the treatment of gender dysphoria.
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided.
  - Pharmacological regimens, nutritional procedures, or treatments.
  - 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.
  - Treatments for hair loss.

  - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
  - Treatment for spider veins of the lower extremities when it is considered Cosmetic.
  - Varicose vein treatment of the lower extremities when it is considered Cosmetic.

- Excision or removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
- Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. Note: Replacement of an existing breast implant is considered RECONSTRUCTIVE if the initial breast implant followed mastectomy.
- Physical conditioning programs such as athletic training, bodybuilding, diversion or general motivation, exercise, fitness, flexibility, health club memberships and programs, and spa treatments.
- Reconstructive surgery where there is another more appropriate covered surgical procedure or when the proposed Reconstructive surgery offers minimal improvement in your appearance. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
- Wigs (scalp/cranial hair prostheses) except for Participants with scalp/head wound, burns, injuries, alopecia areata, and cancer who are undergoing chemotherapy or radiation therapy.
- Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Skin abrasion procedures performed as a treatment for acne.
- Treatments for hair loss.
- Varicose vein treatment of the lower extremities, when it is considered cosmetic.
- Sclerotherapy treatment of veins.

Procedures and Treatments

- Chelation therapy, except to treat heavy metal toxicity and overload conditions.
- Helicobacter pylori (H. pylori) serologic testing.
- Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
- OUTPATIENT cognitive rehabilitation therapy except as MEDICALLY NECESSARY following traumatic brain Injury or cerebral vascular accident.
- Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- Rehabilitation services and manipulative treatment to improve general physical condition and not therapeutic in nature that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term, or maintenance/preventive treatment.
- Rehabilitation services for speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, or congenital anomaly.
- Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care Providers specializing in smoking cessation and may include a psychologist, social worker, or other licensed or certified professional. The programs usually include behavior modification techniques, intensive psychological support, and medications to control cravings.

Providers

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal residence
- Services ordered or delivered by a Christian Science practitioner.
- Services performed by an unlicensed Provider or a Provider who is operating outside of the scope of his/her license.

Reproduction

The following fertility treatment-related services:

- All charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to, fees for laboratory tests.
- All costs associated with surrogate parenting including, but not limited to, donor oocytes (eggs), donor sperm and host uterus.
- Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
- Cloning.
- Cryopreservation and storage, unless it is embryo freezing and storage (up to 12 months) for embryos produced from one cycle for a PARTICIPANT who will undergo cancer treatment that is expected to render them infertile.
- Donor ovum or oocytes (eggs), embryos, and semen and related costs, including collection, preparation, and storage of.
- Donor services and non-medical costs of oocyte or sperm donation (e.g., donor agency fees).
- Embryo or oocyte accumulation, defined as a fresh oocyte (egg) retrieval prior to the depletion of previously banked frozen embryos or oocytes (eggs).
- Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma.
- Ovulation predictor kits.
- Reversal of voluntary sterilization.
- Services for partners, spouses, and the maternity expenses of gestational carriers not covered by the Surest Plan.
- Treatments considered Experimental by the American Society of Reproductive Medicine.

Services Provided under Another Plan

- Services for which coverage is available:
  - For treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you.
  - Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

- Under another medical plan, except for ELIGIBLE EXPENSES, or RECOGNIZED AMOUNT when applicable, payable as described in this SPD.
- Under Workers' Compensation or similar legislation if you could elect it or could have it elected for you.
- While on active military duty.

Transplants

- Health services for transplants involving permanent mechanical or animal organs.
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's medical coverage.)

Travel

- Health services provided in a foreign country, unless required as EMERGENCY health services
- Except as described in Ambulance or Travel and Lodging section, travel or transportation expenses to and from your home, even if ordered by a PHYSICIAN.

Types of Care

- Custodial Care.
- Domiciliary Care.
- Multi-disciplinary pain management programs provided on an INPATIENT basis for acute pain or for exacerbation of chronic pain.
- Respite care.
- Rest cures.
- Services of personal care attendants.
- Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

- Eye exercise or vision therapy.
- Implantable lenses used only to correct a refractive error such as radial keratotomy or related procedure, and artificial retinal devices or retinal implants.
- Refractive surgery (e.g., Lasik) for ophthalmic conditions that are correctable by contact lenses or glasses.

- Routine eye exams (including refractions), eyeglasses, contact lenses and any fittings associated with them.
- Surgery and other related treatment that is intended to correct farsightedness, nearsightedness, presbyopia, and astigmatism, including but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.
- Bone-anchored hearing aids except when either of the following applies:
- For Participants with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- For Participants with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
- The Surest Plan will not pay for more than one bone-anchored hearing aid per PARTICIPANT who meets the above coverage criteria during the entire period of time the Participant is enrolled in the Surest Plan. In addition, repairs and/or replacement for a bone-anchored hearing aid for Participants who meet the above coverage are not covered, other than for malfunctions.
- Any type of communicator, electronic voice producing machine, voice enhancement, voice prosthesis, or any other language assistive devices.

Work-Related Accident and Illness

The Plan does not cover work-related accidents or illnesses. Work-related accidents and illnesses should be reported as soon as they occur to your Human Resources representative for consideration under the Worker's Compensation program.

All Other Exclusions

- Autopsies and other coroner services and transportation services for a corpse.
- Charges for:
  - Completion of Claim forms.
  - Missed appointments.
  - Record processing.
  - Room or facility reservations.
  - Charges prohibited by federal anti-kickback or self-referral statutes.
- Direct-to-consumer retail genetic tests.

- Expenses for health services and supplies:
  - For which the PARTICIPANT has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Surest Plan.
  - That are received after the date the Participants coverage ends, including health services for medical conditions which began before the date the Participants coverage ends.
  - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Participants who are civilians injured or otherwise affected by war, any act of war, or terrorism in a non-war zone.
  - That exceed ELIGIBLE EXPENSES, or the RECOGNIZED AMOUNT when applicable, or any specified limitation in this SPD.
- Foreign language and sign language services.
- Health care services that Surest determines are not MEDICALLY NECESSARY.
- Long-term (more than 30 days) storage of blood, umbilical cord, or other material (e.g., cryopreservation of tissue, blood, and blood products).
- Over-the-counter self-administered home diagnostic tests (except direct-to-consumer/home-based tests), including but not limited to HIV, ovulation, and pregnancy tests.
- Physical, psychiatric, or psychological exams, testing, and all forms of vaccinations and immunizations, or treatments when:
  - Conducted for purposes of medical research.
  - Related to judicial or administrative proceedings or orders, unless determined to be Medically Necessary.
  - Required solely for purposes of adoption, career or employment, education, insurance, marriage, sports or camp, travel, or as a result of incarceration.
  - Required to obtain or maintain a license of any type.
- Health care services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services that would otherwise be determined to be a Covered Health Service if the service treats complications that arise from the non-Covered Health Service. For the purpose of this exclusion a “complication” is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition.

Filing a Claim

How do I file a claim for medical benefits?

Generally, you do not need to file a medical claim for services from IN-NETWORK PROVIDERS; the provider will handle the filing of the medical claim. For OUT-OF-NETWORK PROVIDERS that do not file medical claims or if you receive EMERGENCY care outside the United States and are seeking reimbursement from the Plan, you can submit a medical claim form to receive benefits.

You can submit a medical claim by mail to the address on your member ID card. You can obtain a Surest COPAY Plan Medical Claim Form from the Claims Administrator.

Read and follow the form's instructions. Be sure to file a separate claim form for each member of your family. Make copies of all itemized bills, and attach the originals to the claim form. You will also need to indicate whether you want the payment to go to the provider or to you.

Mail the completed claim form and all relevant documentation as the form instructs. You may include more than one bill with a claim, even if the bills are for different medical services.

You have 12 months following the date the expense was incurred to file a medical claim.

How long does it normally take to process a claim for medical benefits?

Most claims are normally processed within 30 business days after the claim is received by the Claims Administrator.

You can find out the status of your claims by visiting the Claims Administrator's website.

How do I file a prescription drug claim form?

All prescriptions filled at a participating retail pharmacy require you to provide an ID card for coverage under the Plan. You are responsible for the applicable copay. Rarely will you need to file a claim with the Prescription Drug Benefits Manager (one example may be a prescription filled at retail before you have received your ID card). Should you need to file a claim, contact the Prescription Drug Benefits Manager.

Claim forms are available on the Prescription Drug Benefits Manager's website. Should you need to file a claim you are responsible for the contracted rate less the copay/coinsurance. You have 12 months from the date the expense was incurred to submit a claim.

If you are eligible for the PrudentRx Program and your specialty medication is on the PrudentRx Drug List, refer to "Prescription Drug Programs" on page 35 for information on how the PrudentRx Program works.

How do I file a claim for hospital charges?

Hospitals will submit a claim from your hospital stay directly to the Claims Administrator. After receiving reimbursement from the Claims Administrator, the hospital will then bill you for any amount not eligible for reimbursement.

Be sure to review the hospital bill and to request an explanation of any charges that you question or do not understand. You should let the Claims Administrator know if you have a concern about the charges on your hospital bill.

You have up to 12 months following the date the expense was incurred to file a claim.

Can I be reimbursed for claims incurred outside the United States?

No, you cannot be reimbursed for services incurred outside the US unless they are considered emergency services. If you incur eligible emergency medical or prescription drug expenses while living or traveling outside of the US, you must complete the out-of-network claim form available on Benefits.Surest.com and provide the information requested on the form, including an itemized claim in English.

You have 12 months following the date the expense was incurred to file a claim.

What is an Explanation of Benefits (EOB)?

An Explanation of Benefits statement outlines how the amount of benefit, if any, was calculated. The statement also shows your year-to-date OUT-OF-POCKET EXPENSES. If you are due reimbursement, a check will be mailed to you with an explanation of benefits statement, or to the provider if you assigned payment.

An Explanation of Benefits statement lets you verify that the claim was processed correctly. Always read your statement carefully, checking to make sure that you were billed only for:

- Services you received, on the day(s) you received them, only from the provider of care
- The exact type of services you received (e.g., if you participated in a group therapy session, make sure that you are not billed for individual treatment)
- The amount you were told the treatment would cost
- The type of medication you received (e.g., if you receive generic medication, check that you are not billed for brand name medication).

If your statement lists services you did not receive, please notify the Claims Administrator.

If you authorize that reimbursement be made directly to your provider, both you and the provider will receive an Explanation of Benefits statement, and the provider receives payment.

What happens if I am overpaid for a claim?

If the Plan overpays benefits to you (or a covered family member), you are required to refund any benefit you receive from the Plan that:

- Was for an expense that you (or a covered family member) did not pay or were not legally required to pay;
- Exceeded the benefit payable under the Plan; or
- Is not covered by the Plan.

If a benefit payment is made to you (or a covered family member), which exceeds the benefit amount, this Plan has the right:

- To require the return of the overpayment on request; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of you or a covered family member.

Appealing a Claim

There are special rules, procedures and deadlines that apply to appeals of benefit determinations and denied claims and you have special legal rights under ERISA. Please refer to the *Administrative Information* section for a description of the appeal process.

Glossary

ACTIVELY-AT-WORK

If you are eligible for coverage and enroll as a new hire, you are “Actively-At-Work” on the first day that you begin fulfilling your job responsibilities with the Company at a Company-approved location. If you are absent for any reason on your scheduled first day of work, your coverage will not begin on that date. For example, if you are scheduled to begin work on August 3rd, but are unable to begin work on that day (e.g., because of illness, jury duty, bereavement or otherwise), your coverage will not begin on August 3rd. Thereafter, if you report for your first day of work on August 4th, your coverage will be effective on August 4th.

AFTER-TAX (POST-TAX) CONTRIBUTIONS

Contributions taken from your paycheck after taxes are withheld.

BEFORE-TAX (PRE-TAX) CONTRIBUTIONS

Contributions taken from your paycheck generally before Social Security (FICA and Medicare) and federal unemployment insurance (FUTA) taxes and other applicable federal, state, and other income taxes are withheld.

CLAIMS ADMINISTRATOR/PRESCRIPTION DRUG BENEFITS MANAGER

Vendor that administers the Plan and processes claims; the vendor’s decisions are final and binding.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

A federal law that lets you and your eligible family members covered by a group health plan extend group health coverage temporarily, at their own expense, at group rates plus an administrative fee, in certain circumstances when their coverage would otherwise end due to a "qualifying event", as defined under COBRA.

A "qualifying event" under COBRA includes loss of coverage as a result of your leaving the Company (other than for gross misconduct); a reduction in hours, your death, divorce or legal separation; your eligibility for Medicare, or a dependent child's loss of dependent status; or, if you are a retiree, loss of coverage due to the Company filing for bankruptcy.

Coordination of Benefits

You or a covered family member may be entitled to benefits under another group health plan (such as a plan sponsored by your spouse's employer) that pays part or all of your health treatment costs. If this is the case, benefits from this plan will be "coordinated" with the benefits from the other plan. In addition to having your benefits coordinated with other group health plans, benefits from this plan are coordinated with "no fault" automobile insurance and any payments recoverable under any workers' compensation law, occupational disease law or similar legislation.

Copay

The flat dollar amount you pay for covered services and prescription drugs under the Plan.

Covered Health Service(s)

Covered Health services, including supplies or Pharmaceutical Products, which are determined to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in Summary Plan Description.
- Not excluded in this the Summary Plan Description.

Deductible

The amount of out-of-pocket expenses you must pay for covered services before the plan pays any expenses.

Designated Provider

A provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Care Service for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all network hospitals or network physicians are Designated Providers

DISABILITY

A physical or mental impairment that substantially limits one or more of an individual's major life activities.

ELIGIBLE EXPENSES

Charges for Covered Health Services that are provided while the Surest Plan is in effect and determined by the Claims Administrator.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As indicated in the most recent editions of the *Healthcare Common Procedure Coding System (HCPCS)*, or *Diagnosis-Related Group (DRG) Codes.*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Network Providers are reimbursed based on contracted rates. Out-of-network Providers are reimbursed at 200% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

Note**:** Out-of-network Providers may bill you for any difference between the Provider's billed charges and the Eligible Expense described above, except as required under the No Surprises Act, which is a part of the Consolidated Appropriations Act of 2021.

ELIGIBLE FAMILY MEMBERS

To cover an eligible family member, you will be required to certify in the Mercer Marketplace Benefits Enrollment Website that your eligible family member meets the eligibility criteria as defined below.

Spouse/Domestic Partner means:

Spouse / Domestic Partner

- You have already received a marriage license from a US state or local authority, or registered your domestic partnership with a US state or local authority.

Spouse Only

- Although not registered with a US state or local authority, your relationship constitutes a marriage under US state or local law (e.g. common law marriage or a marriage outside the US that is honored under US state or local law).

Domestic Partner Only

- Although not registered with a US state or local authority, your relationship constitutes an eligible domestic partnership. To establish that your relationship constitutes an eligible domestic partnership you and your domestic partner must:
  - Be at least 18 years old
  - Not be legally married, under federal law, to each other or anyone else or part of another domestic partnership during the previous 12 months
  - Currently be in an exclusive, committed relationship with each other that has existed for at least 12 months and is intended to be permanent
  - Currently reside together, and have resided together for at least the previous 12 months, and intend to do so permanently
  - Have agreed to share responsibility for each other's common welfare and basic financial obligations
  - Not be related by blood to a degree of closeness that would prohibit marriage under applicable state law.

Marsh McLennan reserves the right to require documentary proof of your domestic partnership or marriage at any time, for the purpose of determining benefits eligibility. If requested, you must provide documents verifying the registration of your domestic partnership with a state or local authority, your cohabitation and/or mutual commitment, or a marriage license that has been approved by a state or local government authority.

Child/Dependent Child means:

- Your biological child
- A child for whom you or your spouse are the legally appointed guardian with full financial responsibility
- The child of a domestic partner
- Your stepchild
- Your legally adopted child or a child or child placed with you for adoption.

Note: Any child that meets one of these eligibility requirements and who is incapable of self support by reason of a total physical or mental disability as determined by the Claims Administrator, may be covered beyond the end of the calendar year in which the child attains age 26.

Dependent children are eligible for healthcare coverage until the end of the calendar year in which they attain age 26. This eligibility provision applies even if your child is married, has access to coverage through his or her employer, doesn't attend school full-time or live with you, and is not your tax dependent.

Note: While married children are eligible for healthcare coverage under your plan until the end of the calendar year in which they attain age 26, this provision does not apply to your child's spouse and/or child(ren), unless you or your spouse is the child's legally appointed guardian with full financial responsibility.

The Company has the right to require documentation to verify the relationship (such as a copy of the court order appointing legal guardianship). Company medical coverage does not cover foster children or other children living with you, including your grandchildren, unless you are their legal guardian with full financial responsibility—that is, you or your spouse claims them as a dependent on your annual tax return.

ELIGIBLE RETIREE

An employee is eligible for coverage under this plan if he/she is a US regular employee of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other MMA and any of its subsidiaries) who terminates employment with five or more years of vesting service at age 55 or later, or at age 65 and eligible for active employee medical coverage at retirement or is a current retiree (under or over age 65) enrolled in retiree medical coverage.

When you or a covered family member reach age 65 or is deemed to be eligible for Medicare, the person who is age 65 or is eligible for Medicare is no longer eligible for coverage under the Pre-65 Retiree Medical Plan.

EMERGENCY

The sudden onset or change of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in:

- Placing the Participant's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Care Services

With respect to an Emergency:

- A medical screening exam (as required under section *1867 of the Social Security Act* 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, and
- Such further medical exam 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*, 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).
- Emergency Health Care Services include items and services otherwise covered under the Plan when provided by an out-of-network Provider or facility (regardless of the department of the hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation or an inpatient stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:
  - The Provider or facility, as described above, determines the patient is able to travel using nonmedical transportation or non-EMERGENCY medical transportation.
  - The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
  - The patient is in such a condition to receive information as stated in b above and to provide informed consent in accordance with applicable law.
  - Any other conditions as specified by the Secretary of the *Department of Health and Human Services*

Experimental or Investigational Services

A procedure, study, test, drug, equipment, or supply will be considered Experimental and/or Investigational if it is not covered under Surest Coverage with Evidence Development Policy and any of the following criteria/guidelines is met:

- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose, or effectiveness in comparison to conventional treatments.
- It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
- Other facilities/Providers/etc. studying substantially the same drug, device, medical treatment, or procedure refer to it as Experimental or as a research project, a study, an invention, a test, a trial, or other words of similar effect.
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or Investigational itself pursuant to the above criteria but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).
- It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
- It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
- It is the subject of an ongoing Clinical Trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).
- It is being used for off-label therapies for a non-indicated condition – even if FDA approve for another condition.

Explanation of Benefits (EOB)

A summary of benefits processed by the Claims Administrator.

Global Benefits Department

Refers to the Global Benefits Department, located at 1166 Avenue of the Americas, 31st Floor, New York 10036.

Habilitative Services

Habilitative services help people learn skills and functions for daily living. Habilitative services benefits include the diagnosis categories of autism, pervasive developmental disorder, developmental delay and attention deficit disorder.

Health Insurance Portability and Accountability Act (HIPAA)

A Federal law, HIPAA imposes requirements on employer health plans including concerning the use and disclosure of individual health information.

Hospice

A hospice is an institution that provides counseling and medical services that could include room and board to terminally ill individuals. The hospice must have required state or governmental Certificate of Need approval and must provide 24 hour-a-day service under the direct supervision of a physician. The staff must include a registered nurse, a licensed social service worker and a full-time claims administrator. If state licensing exists, the hospice must be licensed.

Independent Freestanding Emergency Department

A health care facility that:

- Is geographically separate and distinct and licensed separately from a hospital under applicable state law; and
- Provides Emergency Health Care services

In-network Providers

A health care professional, Physician, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide health care services to you. The term “Provider” refers to an in-network Provider unless otherwise specified.

Inpatient

Being treated and admitted at a covered facility for an overnight stay either by a physician or from the emergency room.

Life Threatening Illness or Injury– Emergency Room Coverage

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

Some examples of emergencies include:

- Heart attack, suspected heart attack or stroke
- Suspected overdose of medication
- Poisoning
- Severe burns
- Severe shortness of breath

- High fever (103 degrees or higher), especially in infants
- Uncontrolled or severe bleeding
- Loss of consciousness
- Severe abdominal pain
- Persistent vomiting
- Severe allergic reactions.

The Plan covers emergency services necessary to screen and stabilize a member when:

- A primary care physician or specialist physician directs the member to the emergency room
- A plan representative (employee or contractor) directs the member to the emergency room
- The member acting as a prudent layperson and a reasonable person would reasonably have believed that an emergency condition existed.

Marsh McLennan Medical Plans and Medicare Prescription Drug Coverage for Disabled Employees

Marsh McLennan newsletter that provides an overview of how Medicare Part D could affect your Marsh McLennan prescription drug coverage. It highlights issues you'll want to think about as you consider your prescription drug options.

The US Federal government's health insurance program, administered by the Social Security Administration, that pays certain hospital and medical expenses for those who qualify, primarily those who are over age 65 or under age 65 and are totally and permanently disabled. Medicare coverage is available regardless of income level. The program is government subsidized and operated.

Medically Necessary

Healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your sickness, injury, mental illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician and Health Care Provider Specialty Society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Participants on the Surest mobile app or by calling the number on your ID card, and to Physicians and other health care professionals on Surest Copay Plan site.

MEDICARE

The US Federal government's health insurance program, administered by the Social Security Administration, that pays certain hospital and medical expenses for those who qualify, primarily those who are over age 65 or under age 65 and are totally and permanently disabled. Medicare coverage is available regardless of income level. The program is government subsidized and operated.

NOTICE OF CREDITABLE COVERAGE

The Medicare Modernization Act requires all group health plan sponsors that offer prescription drug coverage to provide notices to covered employees, retirees, and their dependents who are eligible for Medicare's new prescription drug benefit (Part D).

OUT-OF-NETWORK PROVIDERS

Non-preferred health care providers who do not charge reduced fees to members.

OUT-OF-POCKET EXPENSES

Subject to the following, the maximum amount you have to pay (excluding your contributions to participate in the plan) toward the cost of your medical care in the course of one year. There are some services and charges that do not count towards the out-of-pocket maximum, such as amounts exceeding plan limits, amounts exceeding the network negotiated price for prescription drugs, amounts your physician or health care provider may charge above the usual and customary charge.

OUTPATIENT

Treatment/care received at a clinic, emergency room or health facility without being admitted as an overnight patient.

PARTICIPANT

The eligible employee or dependent properly enrolled in the Surest Copay Plan under the eligibility rules and only while such person(s) is enrolled and eligible for Benefits under the Surest Copay Plan.

PHYSICIAN

Any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other Provider who acts within the scope of his or her license will be considered on the same basis as a Physician. 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 Surest Plan.

PRE-EXISTING CONDITION

A health problem you had and received treatment for before your current benefit elections took effect.

PRESCRIPTION DRUGS

- **Formulary/Brand Name (Preferred) Prescription Drugs.** A comprehensive list of preferred brand-name drug products that are covered under the plan. Preferred drugs are selected based on safety, effectiveness, and cost.
- **Generic Prescription Drugs.** Prescription drugs, whether identified by chemicals, proprietary or non-proprietary name, that are accepted by the FDA as therapeutically effective and interchangeable with drugs having an identical amount of the same active ingredient as its brand name equivalent.
- **Non-Formulary (Non-Preferred) Prescription Drugs.** Prescription drugs that do not appear on the formulary list are considered non-formulary or non-preferred; these drugs may either be excluded from coverage or may cost more.

PREVENTIVE/WELLNESS CARE

Annual examinations or routine care covered under the plan; care that prevents or slows the course of an illness or disease or care that maintains good health.

PRIVATE DUTY NURSING

Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an INPATIENT or an office/home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Participant by an independent nurse who is hired directly by the Participant or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

QUALIFIED FAMILY STATUS CHANGE (STATUS CHANGE, QUALIFIED CHANGE IN FAMILY STATUS, LIFE OR FAMILY CHANGE)

An event that changes your benefit eligibility. For example, getting married and having a child or your spouse or dependent lose other coverage. You can make certain changes to your before-tax benefit elections that are due to and consistent with the change in family status.

Qualified Medical Child Support Order (QMCSO)

A court order, judgment or decree that (1) provides for child support relating to health benefits under a plan with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan and is ordered under state domestic relations law or (2) is made pursuant to a state medical child support law enacted under Section 1908 of the Social Security Act. A QMCSO is usually issued requiring you to cover your child under your health care plan when a parent receiving post-divorce custody of the child is not an employee.

Qualifying Event

A “qualifying event” under COBRA includes loss of coverage as a result of your leaving the Company (other than for gross misconduct); a reduction in hours, your death, divorce or legal separation; your eligibility for Medicare, or a dependent child’s loss of dependent status; or, if you are a retiree, loss of coverage due to the Company filing for bankruptcy.

Recognized Amount

The amount which the copay is based on for the below Covered Health Care Services when provided by out-of-network providers:

- Out-of-network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of *section 2799B-2(d) of the Public Service Act*. For the purpose of this provision, “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 described in *section 1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

1. An All Payer Model Agreement if adopted;
2. Applicable State law; or
3. The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Reconstructive

Surgery or procedure to restore or correct:

- A defective body part when such defect is incidental to or follows surgery resulting from illness, injury, or other diseases of the involved body part.
- A congenital disease or anomaly which has resulted in a functional defect as determined by a Physician.
- A physical defect that directly adversely affects the physical health of a body part, and the restoration or correction is determined by the Claim Administrator to be Medically Necessary.

Residential Treatment

Treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Residential Treatment Facility

A facility that is licensed by the appropriate state agency, has, or maintains a written, specific, and detailed treatment program requiring full-time residence and participation, and provides 24-hour-a-day care in a structured setting, supervision, food, lodging, rehabilitation, or treatment for an illness related to mental health and substance use related disorders.

Shared Savings Program

A program in which the network partner may obtain a discount to a non-network Provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-network Provider. When this happens, you may experience lower out-of-pocket amounts. Surest Plan out-of-network copays would still apply to the reduced charge. Sometimes the Surest Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by the network partner, such as:

- 200% of the published rates allowed by the *Centers for Medicare and Medicaid Services* (CMS) for the same or similar service within the geographic market.
- An amount determined based on available data resources of competitive fees in that geographic area.
- A fee schedule established by a third party vendor.
- A negotiated rate with the Provider.

In this case the non-network Provider may bill you for the difference between the billed amount and the rate determined by the network partner. If this happens you should call the number on your medical member ID Card. Shared Savings Program Providers are not network Providers and are not credentialed by the network partner.

Skilled Nursing Facility

A Medicare licensed bed or facility (including an extended care facility, a long-term acute care facility, a hospital swing-bed, and a transitional care unit) that provides skilled care.

Specialist

Providers other than those practicing in the areas of family practice, general medicine, internal medicine, obstetrics/gynecology or general pediatrics.

Third Party Administrator

Each self-insured medical plan has a third party administrator (TPA) that sets the provider network for that medical plan.

The TPA also provides administrative services for that medical plan including record-keeping, enrollment and claims and appeals adjudication, and serves as the sole “Claims Administrator” for that plan. The TPA’s decisions as claims administrator are final and binding.

Unproven / Unproven Services

Health services, including medications that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Surest has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time Surest issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can contact Surest Member Services for additional information.

Please note: If you have a life-threatening illness or condition (one that is likely to cause death within one year of the request for treatment), Surest may, at its discretion, consider an otherwise Unproven service to be a Covered Health Service for that illness or condition. Prior to such a consideration, Surest must first establish that there is sufficient evidence to conclude that, albeit Unproven, the service has significant potential as an effective treatment for that illness or condition.

Utilization Management

Utilization Management processes are conducted by Surest to ensure that certain services are Medically Necessary. Utilization Management processes include clinical, medical, pre-service review (e.g., Prior Authorization), concurrent review (e.g., during a hospital stay), and post-service review (review of Claims to ensure services were Medically Necessary).

Waiting Period/Elimination Period

The amount of time you must wait before being able to participate in a plan.