Summary Plan Description

Nelnet: Surest Plan

Effective Date: January 1, 2026

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A UnitedHealthcare Company

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1. Quick Reference

This section is a quick reference guide. Please review this entire Summary Plan Description (SPD) for additional details about your coverage.

Website Access to what is covered, how much it costs, and where you can get care.	**Once enrolled:** Benefits.Surest.com
Mobile App Access — from your smartphone - to what is covered, how much it costs, and where you can get care.	**Once enrolled:** Surest mobile app
Phone Numbers Who to contact to help answer any questions.	**Surest Plan Questions:** **Surest Member Services Team** 1-866-683-6440 **Monday – Friday** 6:00 am to 9:00 pm Central **Prescription Drug Benefit Questions:** Capital Rx Customer Service 1-833-554-4709 24-Hours 7 Days a Week See Section 13 (Attachment I - Outpatient Prescription Drugs).
Name of the Plan (referred herein as the "Surest Plan")	Nelnet: Surest Plan
Plan Administrator Who is ultimately responsible for administering the Surest Plan.	Nelnet, Inc.
Claims Administrator Who processes Claims, administers appeals, and runs the Surest Member Services team, Surest mobile app, and Benefits.Surest.com website.	Surest
Medical Claims Mailing Address Where to mail medical Claims and written inquiries.	Surest P.O. Box 211758 Eagan, MN 55121

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2. How Does the Surest Health Plan Work?

The Surest Health Plan ("Surest Plan") design allows each Participant to make informed choices about their health care, cost, and coverage needs – in advance of receiving care. With the Surest mobile app and the Benefits.Surest.com website, Participants can search for available care, cost, and coverage options from any geographic location to choose the best option for them, or Participants can call Surest Member Services for assistance navigating their coverage options. Eligible employees and eligible dependents who properly enrolled in the Surest Plan are referred to as "Participants" in this SPD.

The Surest Plan has features that Participants already know and understand — including, for example: no deductible; simple copayments for Covered Health Services; an annual out-of-pocket maximum; and available comprehensive coverage.

When enrolled in the Surest Plan, coverage automatically includes substantial coverage of Physician and hospital services — including, for example: preventive care, Emergency and urgent care, office visits, inpatient and outpatient hospital visits, and prescription drugs. Coverage also provides substantial coverage for common and/or Medically Necessary services and treatments such as, maternity care, cancer treatment, and physical therapy, all of which are more fully described below.

Participants and the Plan Sponsor share in the cost of the Surest Plan. Your paycheck deductions amount depends on the dependents you choose to enroll.

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3. Am I Eligible and How Do I Enroll?

You are eligible to enroll for the Surest Plan for coverage if you are:

- A regular full-time Employee who is scheduled to work at least 20 hours per week. If you work for the Facts Education Solutions division, you must work 30 hours per week to be eligible. For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. Employees who meet eligibility requirements during a measurement period, as described in the Affordable Care Act (ACA) regulations, will have been deemed to have met the eligibility requirements for the appropriate month (if using a monthly measurement period) or the resulting stability period (if using a look-back period and continuing coverage through the stability period regardless of actual hours worked), as determined by the Plan Sponsor.
- An Strategic Advisor as defined by the Plan Sponsor
- An eligible dependent of the employee such as:
  - A legal spouse or domestic partner.
    - A domestic partner is a person of the same or opposite sex with whom the employee has established a Domestic Partnership. All of the following requirements apply to both persons:
      - They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
      - They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
      - They must be at least 18 years old.
      - They must share the same permanent residence and the common necessities of life.
      - They must be mentally competent to enter into a contract.
      - They must be financially interdependent.
  - The Employee and Domestic Partner must jointly sign an affidavit of domestic partnership provided by the Benefits Department upon your request.
  - You or your spouse's / domestic partner's child who is under the age of 26, including:
    - a natural child.
    - a stepchild.
    - a legally adopted child.
    - a child placed for adoption.
    - a child for whom you or your spouse are the legal guardian.
  - Your unmarried child age 26 or over who is or becomes disabled and dependent upon you (see additional information below).
  - A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO).

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An employee must enroll in the Surest Plan coverage in order to enroll his/her dependents. If both parents are covered as employees, a child may be covered as a dependent of either parent, but not both. Employees and eligible dependents enrolled in the Surest Plan for coverage are referred to as 'Participants' in this SPD.

Coverage for any child who is mentally or physically handicapped, mentally ill, or developmentally disabled, as determined by the Social Security Administration, and incapable of self-sustaining employment may continue to be enrolled in the Plan after they reach the limiting age of 26 if their disability began prior to such age. An illness that does not cause a child to be incapable of self-sustaining employment will not be considered a physical disability. The disabled child must be dependent on you for financial support, as defined by the Internal Revenue Code, and the covered employee must claim the disabled child as a dependent for IRS income tax purposes. The employee must provide proof that the child is incapable of self-sustaining employment within 31 days of the date the child reaches the limiting age of 26. The disabled child must meet the above support requirements and submit proof of disability to the Plan Administrator upon request.

A newly hired employee may also add a disabled child as a dependent under the Surest Plan provided the child is incapable of earning his own living and the disability began prior to reaching the limiting age of 26. The disabled child must be dependent upon you for financial support, as defined by the Internal Revenue Code, and the covered employee must declare the child as an income tax deduction.

The Plan Administrator may require documentation proving financial dependency, including tax records and proof of continuous coverage under any previous plan(s). At the Plan Administrator's discretion, subsequent proof of medical disability and financial dependency may be requested from the employee. The Plan Administrator reserves the right to have such child examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine such incapacity.

To enroll in the Surest Plan for coverage, contact the Plan Administrator within 31 days of the date you first become eligible for the Surest Plan coverage. If you do not enroll within 31 days, you will need to wait until the next Open Enrollment to make your benefit elections.

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child, placement for foster care of a child, or other family status change, you must contact the Plan Administrator within 31 days of the event. Otherwise, you will need to wait until the next Open Enrollment to change your election.

Each year during Open Enrollment, you have the opportunity to review and change your election. Any changes you make during Open Enrollment will become effective the following Plan Year Effective Date.

Special Enrollment Period Due to Status Change

You may make Surest Plan coverage changes during the Plan Year if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your new spouse following your marriage, your new child following

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an adoption, etc.). The following are considered family status changes for purposes of the Surest Plan:

- Your marriage, divorce, legal separation, or annulment.
- Registering a Domestic Partner.
- The birth, legal adoption, placement for adoption, placement for foster care, or legal guardianship of a child.
- A change in your spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.
- Your death or the death of a dependent.
- Your dependent child no longer qualifying as an eligible dependent.
- A change in your or your spouse's position or work schedule that impacts eligibility for health coverage.
- Contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer).
- You or your eligible dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible dependent.
- Benefits are no longer offered by the plan to a class of individuals that include you or your eligible dependent.
- Termination of your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Plan Administrator within 60 days of termination).
- You or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Plan Administrator within 60 days of the date of determination of subsidy eligibility).
- You or your dependent lose eligibility for coverage in the individual market, including coverage purchased through a public exchange or other public market established under the Affordable Care Act (Marketplace) (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact) regardless of whether you or your dependent may enroll in other individual market coverage, through or outside of a Marketplace.
- A strike or lockout involving you or your spouse.
- A court or administrative order.

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Unless otherwise noted above, if you wish to change your elections, you must contact the Plan Administrator within 31 days of the change in family status. Otherwise, you will need to wait until the next Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you or your eligible dependent do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible dependent if COBRA is elected.

Note: Any child under the age of 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Surest Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

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

If an eligible employee and/or his/her eligible dependents are covered under a state Medicaid Plan or a state CHIP (if applicable) and that coverage is terminated as a result of loss of eligibility, then such employee may request enrollment in the Plan on behalf of him/herself and/or eligible dependents. Such request shall be submitted to the Plan Administrator no later than 60 calendar days after the eligible employee's and/or his/her dependent's coverage ends under such state plans.

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

Coverage will be effective on the first day of the first calendar month beginning after the date the Plan Administrator receives the request for special enrollment due to eligibility for Medicaid or CHIP payment assistance, provided the Plan Administrator receives the application for coverage as required.

Unless otherwise noted above, if you wish to change your elections, you must contact the Plan Administrator within 31 days of the change in family status. Otherwise, you will need to wait until the next Open Enrollment.

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4. When Does My Coverage Begin and End?

4.1 Effective Dates

If you enroll yourself in the Surest Plan during Open Enrollment, your coverage is effective on the first day of the Plan Year. For employees who are hired mid-year, coverage will begin on the first day of employment or becoming newly eligible and once the Plan Administrator receives your properly completed enrollment information.

Coverage for eligible dependents that you properly enroll during Open Enrollment is effective on the same day your coverage begins.

Coverage for a dependent spouse or stepchild added through marriage is effective on the date of your marriage, provided you notify the Plan Administrator within 31 days of your marriage.

Coverage for dependent children added through birth, adoption, placement for adoption, or is effective on the date of the family status change, provided you notify the Plan Administrator within 31 days of the birth, adoption, or placement.

Coverage for eligible domestic partners and their children become effective the date of your partnership provided you notify the Benefits Department within 31 days and sign the Plan Sponsor's Affidavit of Domestic Partnership.

Please note:

- For adoption and marriage - coverage will begin on the date of the adoption or marriage.

- For loss of coverage – coverage will begin on the first day of the month following the coverage loss.

Special Rule for Newborn

If you are enrolled in the Surest Plan, your newborn child will be considered enrolled in the applicable Plan for the first 31 days of the newborn's life. To continue coverage for the newborn dependent after this period, you must affirmatively enroll the child in the Plan within 31 days of the date of birth by contacting the Plan Administrator and supplying all required information within 31 days after the child's birth. If you do not affirmatively enroll this child accordingly, the child will be terminated from coverage on the end of the 31st day.

4.2 End Dates

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

- The last day of the month your employment with the Company ends.
- The date the Plan is terminated.
- The last day of the month your eligibility under the Plan ends.

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- When you do not make your required premium contribution for coverage under the Surest Plan, Termination will be retroactive to the last day of the month for which your required premium contribution was timely received.
- The date you, or someone acting on your behalf, performed an act or practice that constitutes fraud or made an intentional misrepresentation (including an omission) of material fact under the terms of the Plan.
- The last day of the month in which the status as domestic partner or dependent children of the domestic partner as attested in the Affidavit of Domestic Partnership and Dependency or Non-dependency of Domestic Partner and Children change results in the domestic partner and/or the dependent children of the domestic partner no longer qualifies for coverage under the Plan.
- The last day of the month in which a covered dependent child turns 26.
- The last day of the month in which a covered disabled dependent child age 26 or over ceases to be disabled.

4.3 Leave of Absence

Please contact your Plan Administrator's representative for details on how your coverage is handled and if/when your coverage ends if you take a leave of absence.

If you are absent from work due to an approved family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), coverage may be continued for the duration of the approved leave of absence as if there was no interruption in employment. You are responsible for all required premium contributions for the Surest Plan while on a leave of absence. Such coverage will continue until the earlier of the expiration of such leave or the date you notify your employer that you do not intend to return to work.

If you do not return after an approved leave of absence, you may be eligible to continue coverage, provided that you elect to continue coverage according to Section 10 (Continuation of Coverage) of this SPD. If the covered employee returns to work immediately following his/her approved FMLA leave, no new waiting periods will apply.

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5. What Are My Benefits?

Claims for Benefits under the Surest Plan are payable only for Covered Health Services that are Medically Necessary.

The total cost of Covered Health Services is shared between you and the Plan Sponsor. Your share consists of paycheck deductions and copayments. The Surest Plan does not have a deductible or coinsurance. Your Surest Plan does have an out-of-pocket maximum which is the maximum amount of copayments you will pay each Plan Year for Covered Health Services. Your paycheck deductions do not count against the Surest Plan's out-of-pocket maximum.

Your premium contributions are on a before-tax basis, or in other words, before federal income and Social Security taxes are withheld, and in most states, before state and local taxes are withheld. This gives your paycheck deductions a special tax advantage. Your paycheck deductions are subject to review, and the Plan Administrator reserves the right to change your paycheck deduction amount from time to time. You can obtain current paycheck deductions by contacting the Plan Administrator.

Surest assigns prices to Covered Health Services. These prices are also referred to as copayments. Your copayments for Covered Health Services are listed in Section 5.1 (Covered Health Services), Section 13 (Outpatient Prescription Drugs) and on the Surest mobile app and Benefits.Surest.com website.

The Surest Plan provides Benefits for the remainder of the amount billed by your in-network Provider for Covered Health Services after any discounts are applied.

Discounts are negotiated with in-network Providers. If you use an in-network Provider, you may be responsible for lower copayments and the Provider may not charge you any additional fees. If you use an out-of-network Provider, you may be responsible for (in addition to your higher out-of-network copayment) all amounts that exceed the usual and customary amount, when applicable. Out-of-network Providers may be permitted to bill you for the difference between what the Plan agreed to pay and the full amount charged for a Covered Health Service. This is called "balance billing."

Once your total copayments reach your applicable out-of-pocket maximum, the Surest Plan provides Benefits at 100% of Eligible Expenses for the remainder of the Plan Year, except for amounts you pay for out-of-network Covered Health Services in excess of the usual and customary amount, when applicable. Amounts in excess of usual and customary charges are not counted towards your out-of-pocket maximums.

In-Network Benefits

As a Participant in the Surest Plan, you may choose any eligible Provider of health services each time you need to receive a Covered Health Service. The choices you make may affect the amount you pay, as well as the level of Benefits you receive. You will receive the highest level of Benefits from the Surest Plan (and in most instances, your out-of-pocket expenses will be far less) when you receive care from in-network Providers. The Surest Plan's credentialing

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process confirms public information about the Providers' licenses and other credentials, but does not assure the quality of their services. The Providers are independent practitioners and entities that are solely responsible for the care they deliver. The Surest Plan features a large network of in-network Providers which can be found in the Surest mobile app or Benefits.Surest.com website or call Surest Member Services for assistance.

These in-network Providers will:

1. File Claims for Benefits for you.
2. Accept payment based on the discounted rate previously negotiated.

In-network Providers are responsible for obtaining Prior Authorization, Pre-Admission Notification, pre-admission certification for planned inpatient admissions, and/or Emergency admission notification requirements for you. Therefore, it is important that you confirm the Provider's status before you receive services as a Provider's network status may change. For current in-network Provider information, refer to the Surest mobile app or Benefits.Surest.com website or call Surest Member Services for assistance.

If you receive health care services from an out-of-network Provider and were informed incorrectly by the Claims Administrator prior to receipt of the Covered Health Service that the Provider was an in-network Provider, either through the Surest Plan database, provider directory, or in the Claims Administrator's response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for the same copayment that would apply if the Covered Health Service had been provided from an in-network Provider.

You must show your member identification "ID" card every time you request health care services from an in-network Provider. Your member ID card can be found on the Surest mobile app; you will also receive an actual member ID card in the mail. If you do not show your member ID card, in-network Providers have no way of knowing that you are enrolled under the Surest Plan. As a result, they may bill you for the entire cost of the services you receive.

We have agreements in place that govern the relationship between us, our Plan Sponsors and in-network Providers, some of which are affiliated Providers. In-network Providers enter into agreements with us to provide Covered Health Services to Participants. Do not assume that an in-network Provider's agreement includes all Covered Health Services. Some in-network Providers contract with Surest to provide only certain Covered Health Services, but not all Covered Health Services. Some in-network Providers choose to be an in-network Provider for only some of our Covered Health Services. Refer to the Surest mobile app or Benefits.Surest.com website or call Surest Member Services for assistance.

For in-network benefits for Covered Health Services provided by an in-network Provider, except for your copayment obligations, you are not responsible for any difference between the Eligible Expense and the amount the Provider bills. Eligible Expenses are based on the following:

- When Covered Health Services are received from an in-network Provider, Eligible Expenses are the Claim Administrator's contracted fee(s) with that Provider.

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- When Covered Health Services are received from an out-of-network Provider as arranged by the Claims Administrator, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable copayment. Surest will not pay excessive charges or amounts you are not legally obligated to pay.

Out-of-Network Benefits

The Surest Plan generally provides Benefits for medical Claims incurred with an out-of-network Provider at a lower level. As a result, if you choose to seek Covered Health Services out-of-network, except as described below, you will be responsible for the difference between the amount billed by the out-of-network Provider or facility and the amount Surest determines to be the Eligible Expense for reimbursement (plus any applicable copayments). The amount in excess of the Eligible Expense could be significant, and this amount will NOT apply to the out-of-network out-of-pocket maximum. You may want to ask the out-of-network Provider about their billing practices before you receive care.

- For Covered Health Services that are ***Ancillary Services received at certain in-network facilities on a non-Emergency basis from out-of-network Providers***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your copayment which is based on the Recognized Amount as defined in Section 12 (Glossary).
- For Covered Health Services that are ***non-Ancillary Services received at certain in-network facilities on a non-Emergency basis from out-of-network Providers who have not satisfied the notice and consent criteria as described below***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your copayment which is based on the Recognized Amount as defined in Section 12 (Glossary).
- For Covered Health Services that are ***Emergency Health Services provided by an out-of-network Provider***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your applicable copayment which is based on the Recognized Amount as defined in Section 12 (Glossary).
- For Covered Health Services that are ***air ambulance services provided by an out-of-network Provider***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your applicable copayment which is based on the rates that would apply if the service was provided by an in-network Provider.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. 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).

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- 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. In-network Providers are reimbursed based on contracted rates. Out-of-network Providers are reimbursed at a percentage of the published rates allowed by CMS for Medicare for the same or similar service within the geographic market.

When Covered Health Services are received from an out-of-network Provider as described below, Eligible Expenses are determined, as follows:

- **For non-Emergency Covered Health Services received at certain in-network facilities from out-of-network Providers** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary, the Eligible Expense is based on either:
  - The reimbursement rate as determined by applicable federal or state law or by an applicable state *All Payer Model Agreement.*
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator or the amount subsequently agreed to by the out-of-network Provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR).*

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

  IMPORTANT NOTICE: For Ancillary Services, and for non-Ancillary Services provided without notice and consent, you are not responsible, and an out-of-network Provider may not bill you, for amounts in excess of your applicable copayment which is based on the Recognized Amount as defined in Section 12 (Glossary).
- **For Emergency health care services provided by an out-of-network Provider**, the Eligible Expense is based on either:
  - The reimbursement rate as determined by applicable federal or state law or by an applicable state *All Payer Model Agreement.*
  - The reimbursement rate as determined by state law.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-network Provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR).*

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IMPORTANT NOTICE: You are not responsible, and an out-of-network Provider may not bill you, for amounts in excess of your applicable copayment which is based on the Recognized Amount as defined in Section 12 (Glossary).

- **For air ambulance transportation provided by an out-of-network Provider**, the Eligible Expense is based on either:
  - The reimbursement rate as determined by applicable federal or state law or by an applicable state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator or the amount subsequently agreed to by the out-of-network Provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR).*

  IMPORTANT NOTICE: You are not responsible, and an out-of-network Provider may not bill you, for amounts in excess of your copayment which is based on the rates that would apply if the service was provided by an in-network Provider which is based on the Recognized Amount as defined in Section 12 (Glossary).
- **For ground ambulance transportation provided by an out-of-network Provider**, the Eligible Expense, which includes mileage, is a rate agreed upon by the out-of-network Provider and the Claims Administrator, or, unless a different amount is required by applicable law, determined based on the median amount negotiated with in-network Providers for the same or similar service.

  IMPORTANT NOTICE: Out-of-network Providers may bill you for any difference between the Provider's billed charges and the Recognized Amount as defined in Section 12 (Glossary).

Out-of-network Benefits apply to Covered Health Services that are provided by an out-of-network Provider, or Covered Health Services that are provided at an out-of-network facility. 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.

If the Claims Administrator confirms that care is not available from an in-network Provider, the Claims Administrator will work with you to coordinate care through an out-of-network Provider as outlined in the written policy established by the Claims Administrator. Covered Health Services rendered by an out-of-network Provider will be processed at the in-network Benefit level when there are no available in-network Providers. Requests for this Benefit should be made by calling Surest Member Services at the number on your member ID card **before** you obtain such services.

Out-of-network Providers are not required to file Claims with Surest. If you get Covered Health Services outside of the Surest network and the Provider and/or facility requires that you remit the full amount, contact Surest Member Services for a Claim form to file a Claim for reimbursement. This may require an itemized bill from the Provider.

When Covered Health Services are received from an out-of-Network provider, except as described above, Eligible Expenses are determined as follows: (i) an amount negotiated

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by the Claims Administrator, **(ii)** a specific amount required by law (when required by law), or **(iii)** an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service or an amount that is greater than such rate when elected or directed by the Plan. The Plan will not pay excessive charges. You are responsible for paying, directly to the out-of-network provider, the applicable Copayment. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Copayment or to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Copayment) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to out-of-network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable Copayment. In addition, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

Copayments

A copayment is the amount you pay each time you receive certain Covered Health Services. The table below describes how your coverage works and includes copayments applicable to the Covered Health Services you choose. Some copayments are listed as a range. Surest assigns Provider copayments within the ranges based on the Surest analysis of treatment outcomes and cost information that identifies Physicians, clinics, and hospitals that provide cost-efficient care.

For current Provider-specific copayment information, Participants should check the Surest mobile app or Benefits.Surest.com website or call Surest Member Services prior to utilizing any services covered under the Surest Plan.

The full range of copayments displayed may not be available in all geographical areas or for all services. You can find Provider-specific copayment amounts by utilizing the 'Search tool' on the Surest mobile app or Benefits.Surest.com website or call Surest Member Services.

You may also be eligible for reduced copayments for certain Benefits and for specific focused programs if you use in-network Providers that Surest has designated as preferred, high-value Providers.

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The following chart shows the deductibles and out-of-pocket maximums for the Surest Plan.

Benefit Features

The Surest Plan	In-Network	Out-of-Network
Deductible	$0	$0
Out-of-Pocket Maximum per Plan Year		
Individual	$4,500	$9,000
Family	$9,000	$18,000

Notes:

- Refer to the Surest mobile app for additional coverage information.
- If you enroll in individual coverage, once you reach the out-of-pocket maximum for a Plan Year, Benefits are payable at 100% of the Eligible Expense during the rest of that Plan Year.
- If you have other family members enrolled (Family coverage) in the Surest Plan, they have to meet their own individual out-of-pocket maximum until the overall family out-of-pocket maximum has been met. Once any enrolled family member has reached the individual out-of-pocket maximum, the Surest Plan will pay 100% of that individual's Eligible Expenses for Covered Health Services for the rest of the Plan Year, even if the family out-of-pocket maximum has not yet been met.
- You must pay any amounts greater than the out-of-pocket maximum if any Benefit, day, or visit maximums are exceeded, and for health care services that are not Covered Health Services. Expenses you pay for any amount in excess of the usual and customary amount will not apply towards satisfaction of the out-of-pocket maximum.
- Your paycheck deductions for coverage will not apply towards satisfaction of the out-of-pocket maximum.
- Except as specifically noted in the schedule of benefits in Section 5.1 (Covered Health Services) below, the amount applied to your in-network out-of-pocket maximum also applies to your out-of-network out-of-pocket maximum. The amount applied to your out-of-network out-of-pocket maximum also applies to your in-network out-of-pocket maximum.

5.1 Covered Health Services

Ambulance Services	In-Network	Out-of-Network
Ambulance Services	$650 copayment / transport	$650 copayment / transport

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Out-of-network Ambulance Services copayment applies to the in-network out-of-pocket maximum.
- 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.
- Non-Emergency ambulance transportation provided by a licensed ambulance service (either ground or air ambulance) between facilities only when the transport meets one of the following:
  - From an out-of-network Hospital to the closest in-network Hospital when Covered Health Services are required.
  - To the closest in-network Hospital that provides the required Covered Health Services that were not available at the original Hospital.
  - From a short-term acute care facility to the closest in-network long-term acute care facility (LTAC), in-network Inpatient Rehabilitation Facility, or other in-network sub-acute care facility where the required Covered Health Services can be delivered.
- For purposes of this Benefit, the following terms have the following meanings:
  - "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.

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  - "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden sickness, injury, or flare-up of a chronic sickness.
  - "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.
- Non-Emergency air ambulance services require Prior Authorization and Medical Necessity review.

Behavioral Health: Mental Health and Substance Use Disorder Services	In-Network	Out-of-Network
Mental Health Office Visit (including Telehealth Visit)	$45 copayment / visit	$215 copayment / visit
Applied Behavioral Analysis (ABA) Therapy	$45 copayment / visit	$215 copayment / visit
Mental Health Habilitative, Cognitive, Occupational Therapy	$20 copayment / visit	$60 copayment / visit
Mental Health Physical Therapy	$20 copayment / visit	$60 copayment / visit
Mental Health Speech Therapy	$20 copayment / visit	$60 copayment / visit
Electroconvulsive Therapy (ECT)	$190 copayment / visit	$570 copayment / visit
Intensive Outpatient Treatment Program (IOP)	$100 copayment / visit	$300 copayment / visit
Outpatient Alcohol and Drug Treatment Program	$190 copayment / visit	$570 copayment / visit
Partial Hospitalization (PHP)/Day Treatment	$190 copayment / day	$570 copayment / day
Substance Use Disorder Medication Therapy	$20 copayment / visit	$60 copayment / visit
Transcranial Magnetic Stimulation (TMS) Therapy	$130 copayment / visit	$305 copayment / visit
Residential Treatment Facility Care	$2,750 copayment / stay	$8,000 copayment / stay
Outpatient Mental Health	$190 copayment / visit	$570 copayment / visit
Inpatient Hospital	$3,500 copayment / stay	$8,000 copayment / stay
Virtual Care	See Virtual Care section for details	Not Applicable

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Benefits include:
  - Diagnostic evaluations, assessment, and treatment planning.
  - Other treatments and/or procedures.
  - Medication management and other associated treatments.
  - Methadone Maintenance.
  - Individual, family, and group therapy.
  - Provider-based case management services.
  - Crisis intervention.
  - Intensive Outpatient Treatment program (IOP) (a structured outpatient mental health or substance use treatment program at a freestanding or hospital-based facility and provides services for at least three hours per day, two or more days per week).
  - Residential treatment.
  - Partial hospitalization (PHP)/Day treatment (a structured ambulatory program that may be freestanding or hospital-based and provides services for at least 20 hours per week).
  - Other Outpatient treatment.
- Returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- Mental Health Office Visit refers to a face-to-face visit with your Provider.
- Mental Health Telehealth Visit refers to a non-face-to-face visit with your Provider.
- Nutritional counseling for mental health or substance use disorder does not have visit limits.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.
- Inpatient residential and partial hospitalization services may require Prior Authorization and Medical Necessity review.
- Refer to the Gender Dysphoria Services section for additional coverage information.

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The Surest Plan provides Benefits for behavioral services for Autism Spectrum Disorder, including Intensive Behavioral Therapies (IBT) such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others, property, or impairment in daily functioning.
- Provided by a Board-Certified Applied Behavior Analyst (BCBA) or other qualified Provider under the appropriate supervision.

- Intensive Behavioral Therapy (IBT) is outpatient behavioral care services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors, and improve the mastery of functional age-appropriate skills in Participants with Autism Spectrum Disorder.
- These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.
- Visit limits do not apply to therapies provided for a mental health condition, such as autism disorders.
- Applied Behavioral Analysis for Autism Spectrum Disorder services may require Prior Authorization and Medical Necessity review.

Colonoscopy - Non-Screening	In-Network	Out-of-Network
Colonoscopy – Non-Screening	$0 to $1,850 copayment / visit	$2,850 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments may vary based on Provider and location.
- Benefits include Physician services and facility charges.
- Coverage is available for a non-screening colonoscopy received on an outpatient basis at a hospital, alternate facility, or in a Physician's office.
- A non-screening colonoscopy is a procedure performed to diagnose disease symptoms.
- Services for preventive screenings are provided under the Preventive Care Services section.

Complex Imaging	In-Network	Out-of-Network
MRI (Magnetic Resonance Imaging)	$250 to $1,200 copayment / visit	$1,500 copayment / visit
CT (Computed Tomography)	$150 to $1,100 copayment / visit	$1,650 copayment / visit
Nuclear Imaging	$250 to $1,200 copayment / visit	$1,500 copayment / visit
PET Scan	$250 to $2,550 copayment / visit	$5,700 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments may vary based on Provider and location.
- Benefits include Physician services and facility charges.
- If imaging occurs on multiple areas of the body, such as the lumbar spine and the cervical spine, on the same date of service, one copayment applies.
- If imaging occurs using different types of imaging machines (e.g., MRI and a CT), on the same date of service, more than one copayment applies.
- If your Physician suggests a low-dose CT Scan (LDCT) for lung cancer screening, refer to Preventive Care Services, in this section, for coverage notes.

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Dental and Oral Services	In-Network	Out-of-Network
• **Orthognathic (Jaw) Surgery**	$3,750 copayment / visit	$8,000 copayment / visit
• **Temporomandibular Joint (TMJ) Dysfunction Surgery**	$800 copayment / visit	$2,400 copayment / visit
Accidental and Medical Dental:		
• **Oral Surgery (removal of impacted teeth)**	$900 copayment / visit	$1,365 copayment / visit
Accidental and Medical Dental - All Other Services:		
• **Office Visit**	$45 to $145 copayment / visit	$215 copayment / visit
• **Outpatient Hospital Visit**	$300 to $1,150 copayment / visit	$3,150 copayment / visit
• **Inpatient Hospital**	$3,500 copayment / stay	$8,000 copayment / stay

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Dental Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from a visit with durable medical equipment, such as an oral appliance, may result in an additional copayment.
- The Surest Plan provides Benefits for dental services to treat and restore damage done to a sound, natural tooth as a result of an accidental injury. Coverage is for external trauma to the face and mouth only. A sound, natural tooth is a tooth, including supporting structures, that is healthy and would be able to continue functioning for at least one year. Primary (baby) teeth must have a life expectancy of one year before loss. Treatment and repair for services required due to an accidental injury must be started within three months and completed within twelve months of the date of the injury.
- Benefits are provided for the following limited oral surgical procedures determined to be Medically Necessary and appropriate:
  - Oral surgery and anesthesia for removal of impacted teeth, removal of a tooth root without removal of the whole tooth, and root canal therapy.
  - Mandibular staple implant provided the procedure is not done to prepare the mouth for dentures.
  - Facility Provider and anesthesia services rendered in a Provider facility setting in conjunction with non-covered dental procedures when determined by the Claims Administrator to be Medically Necessary and appropriate due to your age and/or medical condition.
  - The correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof, and floor of the mouth.
- The Surest Plan also covers dental services, limited to dental services required for treatment of an underlying medical condition such as a cleft palate or other congenital defect, oral reconstruction after invasive oral tumor removal, preparation for or as a result of radiation therapy for oral or facial cancer.
- Eligible Expenses for hospitalizations are those incurred by a Participant who: (1) is a child under age five; (2) is severely disabled; or (3) has a medical condition, unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a Physician, dentist, or dental Specialist.
- Accidental Dental Services may require Prior Authorization and Medical Necessity review.

The Surest Plan provides Benefits for services for orthognathic surgery and the evaluation and treatment of TMJ and associated muscles.

- 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.

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- Returning home from a visit with durable medical equipment, such an oral appliance, may result in an additional copayment.
- Orthognathic surgery and select services for TMJ Disorder may require Prior Authorization and Medical Necessity review.

Dialysis Services	In-Network	Out-of-Network
Dialysis	$150 to $600 copayment / visit	$1,800 copayment / visit
Home Dialysis	$130 copayment / visit	$325 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- The Surest Plan provides Benefits for therapeutic treatments received in an office, home, outpatient hospital, or alternate facility.
- Benefit includes services and supplies for renal dialysis, including both hemodialysis and peritoneal dialysis.
- Benefit also includes training of the patient.
- Dialysis Services may require Prior Authorization and Medical Necessity review.

Durable Medical Equipment (DME) and Supplies	In-Network	Out-of-Network
Purchase:		
Tier 1 to Tier 12	$0 to $1,000 copayment	$20 to $2,000 copayment
Rental:		
Tier 1 to Tier 12	$0 to $100 copayment / month	$2 to $200 copayment / month

Notes:

- Durable Medical Equipment (DME) and supplies are tiered based on average cost and allowed amount. Supplies such as tubing, syringes, and catheters are assigned to a lower tier and will result in a lower copayment. Equipment such as glucose monitors, pumps, and wheelchairs are assigned to a higher tier and will result in a higher copayment.
- Each piece of durable medical equipment and supplies are assigned to a tier, which corresponds to a copayment. A breakdown of the tiers and corresponding copayments can be found on Surest mobile app or Benefits.Surest.com website.
- Returning home from an appointment with a health care Provider or from the hospital with durable medical equipment, such as crutches, may result in an additional copayment. Copayments will be dependent on the tier the item falls into.
- For Enteral Nutrition administered at home, multiple copayments will apply (such as for formula, nursing visit and administration).

The Surest Plan provides the following Benefits for durable medical equipment, prosthetics, orthotics, and supplies (subject to any limitations noted below):

- Refer to the Surest mobile app for additional coverage and copayment information.
- This durable medical equipment and supplies list is subject to periodic review and modification (generally quarterly, but no more than six times per Plan Year).
- You may also view which tier a particular DME item has been assigned to by using the Surest mobile app or Benefits.Surest.com website or calling Surest Member Services for assistance.
- Coverage includes rental or purchase of DME if Medically Necessary, ordered or provided by a Physician for outpatient use primarily in a home setting, serves a medical purpose for the treatment of an illness or injury, and is not of use to a Participant in the absence of a disease or disability. If you need certain durable medical equipment for an extended period of time, there may be an option to rent. Length of rental may vary by DME item. The purchase copayment based on tier may be split over a period of time, at which point the DME may be considered “purchased” or coverage may end. Note that some equipment such as oxygen equipment, will be set to rental for the duration of time the equipment is needed. Surest generally follows Centers for Medicare and Medicaid Services (CMS) guidelines on rental vs purchase. Refer to Surest mobile app or Benefits.Surest.com website for additional information.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors, and masks).

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- Cranial orthoses such as head shaping helmets and head reconstruction are a set of orthotic devices and services to reshape the head. They may be medically indicated for plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape).
- Scalp/cranial hair prostheses (wigs) are a Covered Health Service regardless of the reason for the hair loss and is limited to a maximum Benefit of one wig with a $500 maximum per Plan Year for in-network and out-of-network Providers combined.
- Hearing aids are limited to $5,000 every 36 months for in-network and out-of-network Providers combined.
- Communication aids or devices; equipment to create, replace, or augment communication abilities, including but not limited to communication board or computer or electronic-assisted communication, speech processors, and receivers. Speech generating device, digitized speech, and using pre-recorded messages are eligible.
- Purchase of one standard breast pump, either manual or electric, per pregnancy. Participant may have to pay a surcharge to the Provider if they purchase enhanced models.
- Enteral Nutrition and low protein modified food products administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. The formula or product must be administered under the direction of a Physician or registered dietitian. (Example conditions include, but are not limited to, metabolic disease such as phenylketonuria (PKU) and maple syrup urine disease severe food allergies, and impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.)
- Shoes as prescribed by a Provider for a Participant. Limited to one pair per Plan Year.
- Coverage is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.
- Select Durable Medical Equipment (DME) may require Prior Authorization and Medical Necessity review.

Emergency Room Services	In-Network	Out-of-Network
Emergency Room Visit	$1,000 copayment / visit	$1,000 copayment / visit
Observation Stay	$1,000 copayment / stay	$1,000 copayment / stay

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Out-of-network Emergency Room Visit copayment applies to the in-network out-of-pocket maximum.
- Out-of-network Observation Stay copayment applies to the in-network out-of-pocket maximum.
- Copayment applies to Emergency room facility, professional expenses, and includes related expenses.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Emergency Room visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from an Emergency Room visit or hospital with durable medical equipment, such as crutches, may result in an additional copayment.
- If you are admitted as an inpatient directly from the Emergency room for the same condition, the Emergency room services copayment will be waived, and you will be responsible for Inpatient Hospital Services copayment.
- If you are admitted to observation directly from the Emergency room for the same condition, the Emergency room services copayment will be waived, and you will be responsible for the Observation Stay copayment.
- If the Emergency Room facility is unable to treat you, you may be referred to another Emergency Room facility or other Provider, you will be responsible for both Emergency Room copayments. If you are admitted as an inpatient directly from the second Emergency Room facility or admitted for observation, then the second Emergency room visit copay is waived and you will be responsible for either the Inpatient Hospital or Observation Stay copayment.
- Refer to Hospital Services section for additional coverage notes.

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Fertility Preservation	In-Network	Out-of-Network
Office Visit	$45 to $145 copayment / visit	$215 copayment / visit
Iatrogenic IVF In Vitro Fertilization	$500 copayment / service	Not Covered
Egg Retrieval for Iatrogenic Infertility	$1,500 copayment / service	Not Covered
Cryopreservation for Iatrogenic Infertility	$500 copayment / service	Not Covered
Storage for Iatrogenic Infertility	$100 copayment / year	Not Covered
Genetic Testing (PGT) for Iatrogenic Infertility	$500 copayment / visit	Not Covered

Notes:

- Refer to the Surest mobile app for additional coverage information.
- There is a lifetime maximum of $25,000 per Participant for covered fertility treatments and a lifetime maximum of $10,000 for prescription medications. This lifetime maximum is combined across all health plans sponsored by the Plan Administrator. This limit is combined with Fertility Treatments. This Benefit limit will be same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Participant during the entire period of time they are enrolled for coverage under the Plan.

Fertility Preservation for Iatrogenic Infertility:

- Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:
  - Collection of sperm.
  - Cryo-preservation of sperm.
  - Ovarian stimulation, retrieval of eggs and fertilization.
  - Oocyte cryopreservation.
  - Embryo cryopreservation.
  - Storage up to one year.
- Benefits for medications related to the treatment of fertility preservation are provided as described under your Outpatient Prescription Drug Benefit.
- Benefits are not available for elective fertility preservation.
- Benefits are not available for embryo transfer.
- Benefits are not available for long-term storage costs (greater than one year).

Preimplantation Genetic Testing (PGT) and Related Services:

- Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:
  - PGT must be ordered by a Physician after Genetic Counseling.
  - The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
  - Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
    - Ovulation induction (or controlled ovarian stimulation).
    - Egg retrieval, fertilization and embryo culture.
    - Embryo biopsy.
    - Embryo transfer.
    - Cryo-preservation and short-term embryo storage (less than one year).
- Benefits are not available for long-term storage costs (greater than one year).
- Dependent children are eligible for this coverage; however, dependent children are not eligible for other fertility services.

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Fertility Treatments	In-Network	Out-of-Network
Office Visit	$45 to $145 copayment / visit	$215 copayment / visit
Artificial insemination	$100 copayment / service	$200 copayment / service
Egg Retrieval	$1,500 copayment / service	$3,000 copayment / service
Embryo Transfer	$750 copayment / service	$1,500 copayment / service
Cryopreservation	$500 copayment / service	$1,000 copayment / service
Storage	$100 copayment / year	$200 copayment / year
Thawing	$150 copayment / service	$300 copayment / service
Genetic Testing (PGT)	$500 copayment / visit	$1,000 copayment / visit
Donor Services (Egg)	$1,200 copayment / service	$2,400 copayment / service
Donor Services (Sperm)	$300 copayment / service	$600 copayment / service

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Multiple copayments may apply if more than one service is performed during a visit.
- There is a lifetime maximum of $25,000 per Participant for covered fertility treatments and a lifetime maximum of $10,000 for prescription medications. These lifetime maximums are combined across all health plans sponsored by the Plan Administrator.

The Surest Plan provides Benefits for fertility services and associated expenses for Participants enrolled in the Surest plan including:

- 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 copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Therapeutic services 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: egg/oocyte retrieval, fresh or frozen embryo transfer, intracytoplasmic sperm injection (ICSI), 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 will undergo cancer treatment that is expected to render them infertile.
  - Frozen embryo transfer cycle including the associated cryopreservation and storage of embryos for up to 12 months.
  - Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
  - Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
  - Electroejaculation.
  - Pre-implantation 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 and PGT-SR for structural rearrangements).
- If a Participant is bypassing reversal of sterilization and requesting direct fertility treatment (IVF), the IVF would be covered.
- A cycle is defined as one partial or complete fertilization attempt extending through the transfer phase only.
- 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.
- Please refer to other sections of the SPD for Covered Health Services for diagnosis and treatment of underlying medical condition which may cause infertility such as surgical procedures: laparoscopy, lysis of

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adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty, and ovarian cystectomy. These are described under Laboratory Services, X-Rays, and Diagnostic Test – Outpatient, Office Visit, Diagnostic Visit, and Treatments / Tests / Therapies.

- The medical Plan provides Benefits for certain prescription medications or products, including specialty medications, for the treatment of infertility that are administered by a medical Provider on an outpatient basis in a hospital, alternate facility, physician's office, or in your home.
- Fertility Benefits for prescription medications or products for outpatient use that are filled by a prescription order or refill are described under Outpatient Prescription Drugs.

Donor Coverage:

- The Surest Plan will cover associated donor medical expenses, including collection and preparation of oocyte and/or sperm, and the medications associated with the collection and preparation of oocyte and/or sperm. The Surest Plan will not pay for donor charges associated with compensation, administrative services or any non-medical expenses.

Criteria to be Eligible for Benefits:

- You do not need to have a diagnosis of Infertility in order to be eligible to receive fertility services.
- This benefit is not available to dependent children. Note that other services are available related to planned cancer or other medical treatments that are likely to result in Infertility or sterility for any covered member (including dependent children). Refer to the *Fertility Preservation for Medical Reasons section above* for a description of eligibility and covered services.

Gender Dysphoria Services	In-Network	Out-of-Network
Mental Health Office Visit	$45 copayment / visit	$215 copayment / visit
Gender Dysphoria Surgery	$190 to $3,500 copayment / stay	$570 to $8,000 copayment / stay
Gender Dysphoria Reconstructive Services	$190 copayment / stay	$570 copayment / stay
Gender Dysphoria Voice Therapy	$20 copayment / visit	$60 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information.
- The following are covered for Gender Affirming Services:
  - Psychotherapy for **Gender Dysphoria** and associated co-morbid psychiatric diagnoses.
  - Hormone therapy as appropriate to the patient's gender goals: Hormone therapy administered by a medical Provider (for example during an office visit). Hormone therapy dispensed from a pharmacy is provided as described under Section 13 (Outpatient Prescription Drugs).
  - Laboratory testing to monitor the safety of continuous hormone therapy as appropriate to the patient's gender goals.
  - Permanent hair removal for purposes of genital reconstruction.
  - Voice lessons and voice therapy.
  - Members must be 18 years of age or older for the surgical treatment of Gender Dysphoria.
- Surgery treatment for Gender Dysphoria, includes the surgeries listed below:
  - Genital surgeries:
    - Clitoroplasty (creation of clitoris)
    - Hysterectomy (removal of uterus)
    - Labiaplasty (creation of labia)
    - Metoidioplasty (creation of penis, using clitoris)
    - Orchiectomy (removal of testicles)
    - Penectomy (removal of penis)
    - Penile prosthesis
    - Phalloplasty (creation of penis)
    - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
    - Scrotoplasty (creation of scrotum)
    - Testicular prosthesis
    - Urethroplasty (reconstruction of female urethra)
    - Urethroplasty (reconstruction of male urethra)
    - Vaginectomy (removal of vagina)
    - Vaginoplasty (creation of vagina)

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    - Vulvectomy (removal of vulva)
  - Chest surgeries:
    - Bilateral mastectomy or breast reduction
    - Breast enlargement, including augmentation mammoplasty and breast implants
  - Face and neck surgeries:
    - Thyroid cartilage remodeling / thyroid chondroplasty / tracheal shave (remodeling of the Adam's apple)
    - Voice modification surgery
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Gender Affirming Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.

Select services for the treatment of Gender Dysphoria may require Prior Authorization and Medical Necessity review.

Home Health Services	In-Network	Out-of-Network
Home Health Care Visit	$80 copayment / visit	$240 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Home Health Care Visits are limited to 90 visits per Participant per Plan Year for in-network and out-of-network Providers combined.
- Services received from a Home Health Agency (an organization authorized by law to provide health care services in the home) or independent Provider that are the following:
  - Ordered by a Physician.
  - Provided in your home by a registered nurse or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
  - Provided on a part-time, intermittent care schedule.
  - Provided when skilled care is required.
- For Enteral Nutrition administered at home, multiple copayments will apply (such as for formula and nursing visit).
- Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, billed by the Home Health Agency, will apply to the Home Health Services visit limits.
- Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, not administered by a Home Health Agency will apply to the Rehabilitative/Habilitative Services visit limits.
- Select Home Health Services may require Prior Authorization and Medical Necessity review.

Hospice Care	In-Network	Out-of-Network
Home Hospice Visit	$80 copayment / visit	$240 copayment / visit
Inpatient Hospice Care	$3,500 copayment / stay	$8,000 copayment / stay

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill.
- Hospice care can be provided in the home or an inpatient setting and includes physical, psychological, social, spiritual, and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Participant (terminally ill person) is receiving hospice care.
- Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.
- Inpatient Hospice Care may require Prior Authorization and Medical Necessity review.

Hospital Services - Other	In-Network	Out-of-Network
Outpatient Hospital Visit	$300 to $1,150 copayment / visit	$3,150 copayment / visit
Inpatient Hospital	$3,500 copayment / stay	$8,000 copayment / stay

Notes:

- Other Hospital Services: The above copayments apply for Covered Health Services not specifically listed in this SPD, Surest mobile app or Benefits.Surest.com website. Copayments may vary based in Provider and location.
- Refer to the Surest mobile app for additional coverage information.

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- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Hospital Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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.
  - The Surest Plan will allow the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.
- If you are admitted to inpatient from the Emergency department or from observation, the Emergency room copayment or Observation Stay copayment will be waived, and you will be responsible for the Inpatient Hospital Services copayment.
- Outpatient hospital care includes services such as radiation device placement, outpatient pulmonary function testing, esophageal dilation, and hip dysplasia treatment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as crutches, may result in an additional copayment.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.

Laboratory Services, X-Rays, and Diagnostic Tests - Outpatient	In-Network	Out-of-Network
Non-Routine Tests	$30 to $1,450 copayment / visit	$165 to $2,850 copayment / visit
Routine Diagnostic Laboratory Services / X-Rays / Ultrasounds	$0 copayment / visit	$0 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information and the copayment that has been assigned to your procedure/service.
- Copayments for Non-Routine Tests may vary based on Provider, location, and procedure.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the facility service or surgery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Services for illness and injury-related diagnostic purposes, received on an outpatient basis at a hospital, alternate facility, or in a Physician's office include:
  - Non-routine diagnostic testing including, but not limited to:
    - Angiography (Arteriography).
    - Cardiac Event Monitoring.
    - Coronary Calcium Score (Heart Scan).
    - Cystometrogram (CMG).
    - Diagnostic Hearing Exams and Testing.
    - Echocardiogram Exercise Stress Test.
    - EKG Exercise Stress Test.
    - Electroencephalogram (EEG).
    - Electromyography (EMG) and Nerve Conduction Studies (NCS).
    - Gastrointestinal Motility Testing.
    - Genetic Testing.
    - Home Sleep Test & Unattended Sleep Study.
    - Attended Sleep Study (Polysomnography).
    - Non-cardiac Angiography, Arthrography, and Myelography.
    - Pulmonary Function Tests.
    - Tilt Table Testing.
    - Transthoracic Echocardiogram (TTE).

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  - Routine diagnostic testing such as:
    - Diagnostic labs, pathology tests, and interpretation charges, such as blood tests, analysis of tissues, or liquids from the body.
    - Diagnostic ultrasounds and X-rays, such as fluoroscopic tests and interpretation.
- If more than one type of imaging occurs, such as an x-ray and ultrasound, on the same date of service, more than one copayment may apply.
- If more than one type of diagnostic testing occurs, such as an EKG exercise stress test and an electroencephalogram (EEG), on the same date of service, more than one copayment may apply.
- The following categories of Genetic Testing services are covered:
  - Genetic tests for cancer susceptibility.
  - Genetic tests for hereditary diseases.
  - Unspecified molecular pathology.
  - Fetal aneuploidy testing.
- Select Laboratory services and Diagnostic Testing may require Prior Authorization and Medical Necessity review.

Maternity Care and Delivery	In-Network	Out-of-Network
Routine Prenatal and Postnatal Office Visits, including Labs and Tests	$0 copayment / visit	$215 copayment / visit
Newborn Nursery Care	$0 copayment / test	$0 copayment / test
Amniocentesis	$950 copayment / test	$2,850 copayment / test
Chorionic Villus Sampling (CVS)	$900 copayment / test	$2,700 copayment / test
Inpatient Delivery	$1,500 to $3,500 copayment / stay	$8,000 copayment / stay
Home Birth/Delivery	$1,400 copayment / visit	$4,200 copayment / visit
Medically Necessary Non-Surgical Abortion	$200 copayment / visit	$600 copayment / visit
Medically Necessary Surgical Abortion	$300 copayment / visit	$900 copayment / visit
All Other Outpatient Services	Based on place of services	Based on place of services

Notes:

- Refer to the Surest mobile app for additional coverage information.
- The copayments for inpatient delivery may vary based on Provider and location; this includes a birthing center.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Maternity Care and Delivery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as a fetal monitor, may result in an additional copayment.
- Routine prenatal and postnatal maternity services include evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force and Health Resources and Services Administration.
- Home visit limited to one visit immediately following discharge of mother and newborn.
- Hospital visits or admissions that do not result in delivery including false labor and tests or services not considered “routine” will follow the inpatient or outpatient hospital services Benefit.
- There will be one copayment 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 copayment will apply to the baby’s services. See Hospital Services section for Benefits.
- Home Birth/Delivery copayment includes medical supplies used for a home delivery of an infant. Birthing tubs are not covered.
- Inpatient deliveries do not require Prior Authorization or notification unless the mother is hospitalized more than 48-hours following a normal vaginal delivery and 96-hours following a normal cesarean section delivery. Stays beyond these time periods may require Prior Authorization and Medical Necessity review.

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Medical Infusions, Injectables, and Chemotherapy	In-Network	Out-of-Network
Cancer Chemotherapy	$40 to $540 copayment / visit	$270 to $1,620 copayment / visit
Provider Administered Drugs	$60 to $3,100 copayment / visit	$390 to $8,000 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information and for the copayment assigned to your procedure/service.
- Copayments may vary based on Provider and location.
- Benefits are available for certain medical infusions, and injectables, and cancer chemotherapy administered on an outpatient basis in a hospital facility, alternate facility, in a Physician's office, or in the home. This includes intravenous chemotherapy or other intravenous infusion therapy.
- Covered Health Services include medical education services that are provided in an office, outpatient hospital, or alternate facility by appropriately licensed or registered health care professionals.
- The Medical Infusions and injectables require supervision and follow up with a medical professional. The Provider Administered Drugs will be dispensed and administered by a medical professional. Certain drugs are dispensed by a medical professional and may require special handling and storage. Certain drugs may require special handling and storage and are generally considered Specialty Drugs administered by a medical professional.
- Supportive drugs that are often unplanned for your diagnosis and treatment, such as IV fluids or antibiotic injections, have a $0 copayment.
- Provider Administered Drugs and Cancer Chemotherapy that are typically for planned administration have their own copayments when given in a non-emergent outpatient setting. If a mixture of drugs is needed for a chemotherapy visit, the copayment of the highest cost drug will apply to that visit.
- The copayments apply to specific drugs that must be administered in a medical setting or under medical supervision. Call Surest Member Services to learn which medical drug (e.g., infusions and injections) are subject to these copayments.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Medical Drug copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Select injectable drugs that can be safely self-administered may not be covered under the medical Benefit. These drugs or equivalent drugs are covered under the pharmacy Benefits (see Section 13 [Outpatient Prescription Drugs]).
- Select Medical Infusions, Injectables and Chemotherapy may require Prior Authorization and Medical Necessity review.

Office Visit and Diagnostic Visit	In-Network	Out-of-Network
Office Visit (including Telehealth Visit)	$45 to $145 copayment / visit	$215 copayment / visit
Mental Health Office Visit (including Telehealth Visit)	$45 copayment / visit	$215 copayment / visit
Allergy Injection Visit	$0 copayment / visit	$215 copayment / visit
Allergy Testing and Treatment	$225 copayment / visit	$570 copayment / visit
Convenience Care / Retail Visit	$50 copayment / visit	Not Covered
E-Visit and Telephone Consult with Your Physician	$45 copayment / visit	$215 copayment / visit
Outpatient Anticoagulant Management	$20 copayment / visit	$60 copayment / visit
Virtual Care	See Virtual Care section for virtual visit details	Not Applicable

Notes:

The Surest Plan provides Benefits for services provided in an office for the diagnosis and treatment of an illness or injury.

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.

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- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Office Visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Office Visit refers to face-to-face visit or Telehealth Visit with your Provider.
- Multiple copayments may apply if a treatment or procedure is also performed during a visit.
- Hearing Services – Assessments with your Provider.
- Mental Health Office Visit refers to a face-to-face visit with your Provider.
- Mental Health Telehealth Visit refers to a non-face-to-face visit with your Provider.
- Nutritional counseling that is not for preventive or mental health purposes does not have visit limits.
- Virtual Care refers to a visit with a Designated Virtual Network Provider such as Doctor on Demand. See Virtual Care Section for details.
- Convenience Care/Retail Clinics are walk-in clinics in retail stores, supermarkets, and pharmacies that treat uncomplicated minor illnesses and injuries, and provide preventive care services.
- If your Provider refers you for a test or service within a hospital or other facility, the Outpatient Hospital copayment may apply.
- Returning home from a visit with durable medical equipment, such as crutches, may result in an additional copayment.

Palliative Care	In-Network	Out-of-Network
Office Visit	$45 to $145 copayment / visit	$215 copayment / visit
Home Health Care Visit	$80 copayment / visit	$240 copayment / visit
Outpatient Hospital Visit	$300 to $1,150 copayment / visit	$3,150 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits or outpatient hospital visits may vary based on Provider and location.
- The Surest Plan provides Benefits for palliative care for Participants with a new or established diagnosis of progressive debilitating illness.
- Includes services for pain management received as part of a palliative care treatment plan.
- The services must be within the scope of the Provider's license to be covered.
- Select services performed in the office and outpatient hospital setting may require Prior Authorization and Medical Necessity Review.
- Returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- See Home Health Services notes for services related to Home Health Care.
- See Hospice Care notes for services related to Hospice.

Preventive Care Services	In-Network	Out-of-Network
Preventive Care Services	$0 copayment / visit	$215 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Preventive Care Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Services include evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, Bright Futures, Health Resources and Services Administration, and Advisory Committee on Immunization Practices.
- Examples include:
  - 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. This includes mammography, breast ultrasounds and breast MRIs.
  - Routine screening colonoscopy is covered as preventive with a diagnosis of family history.
  - Routine immunizations. Age limits may apply.

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  - 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.
- For Prescription Drug Coverage see Section 13 (Outpatient Prescription Drugs).
- Low-dose CT Scan (LDCT) for lung cancer screening may require Prior Authorization and Medical Necessity review.

Radiation Therapy and Other High Intensity Therapy	In-Network	Out-of-Network
	$70 to $3,700 copayment / visit	$325 to $8,000 copayment / visit

Notes:
- The Surest Plan provides Benefits for services received on an outpatient basis at a hospital, alternate facility, or in a Physician's office.
- Refer to the Surest mobile app for additional coverage information and the copayment assigned to your procedure/service.
- Copayments for Radiation Therapy and Other High Intensity Therapy may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Radiation Therapy copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Benefits include Physician services and facility charges, and services such as, but not limited to:
  - Actinotherapy.
  - Apheresis.
  - Blood Transfusion.
  - Brachytherapy.
  - Conventional External Beam Radiation Therapy (EBRT).
  - Hyperbaric Oxygen Therapy (HBOT).
  - Non-Oral Radiopharmaceutical Therapy.
  - Oral Radiopharmaceutical Therapy.
  - Proton Therapy.
  - Radiation Therapy Simulation and Planning.
  - Radiopharmaceutical Therapy.
  - Stereotactic Radiation Therapy.
- Select Radiation Therapies may require Prior Authorization and Medical Necessity Review.
- See notes under Hospital Services – Other for services related to Radiation Device Placement.
- See Dialysis Services for services for dialysis and home.

Reconstructive Surgery	In-Network	Out-of-Network
Office Visit	$45 to $145 copayment / visit	$215 copayment / visit
Outpatient Hospital	$300 to $1,150 copayment / visit	$3,150 copayment / visit
Inpatient Hospital	$3,500 copayment / stay	$8,000 copayment / stay

Notes:
- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits or outpatient hospital visits may vary based on Provider and location.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Reconstructive Surgery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as a walker, may result in an additional copayment.
- Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive

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procedures include surgery or other procedures which are associated with an illness, injury, or congenital anomaly. The primary result of the procedure is not a changed or improved physical appearance.
- Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.
- Benefits for Reconstructive procedures include breast reconstruction following a mastectomy and Reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Surest Plan if the initial breast implant followed a mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Services. You can contact Surest Member Services at the number on your member ID card for more information about Benefits for mastectomy-related services.
- There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered Cosmetic procedures. An example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive procedure. In other cases, if improvement in appearance is the primary intended purpose, this would be considered a Cosmetic procedure. The Surest Plan does not provide Benefits for Cosmetic services or procedures.
- The fact that a Participant may suffer psychological consequences or socially avoidant behavior as a result of an illness, injury, or congenital anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as Reconstructive procedures.
- Reconstructive Surgery may require Prior Authorization and Medical Necessity review.

Rehabilitative/Habilitative Services and Other Low Intensity Therapy	In-Network	Out-of-Network
Acupuncture Visit	$70 copayment / visit	$165 copayment / visit
Aural Therapy – Post Cochlear Implant	$45 to $190 copayment / visit	$240 copayment / visit
Cardiac Rehabilitation Therapy	$100 copayment / visit	$300 copayment / visit
Chiropractic Visit	$35 copayment / visit	$75 copayment / visit
Cognitive Therapy	$20 to $130 copayment / visit	$175 copayment / visit
Occupational Therapy	$20 to $130 copayment / visit	$175 copayment / visit
Physical Therapy	$20 to $105 copayment / visit	$220 copayment / visit
Speech Therapy	$20 to $130 copayment / visit	$175 copayment / visit
Pulmonary Rehabilitation Therapy	$120 copayment / visit	$360 copayment / visit
Vision Therapy	$45 copayment / visit	$215 copayment / visit

Notes:
Rehabilitative and habilitative services must be performed by a Physician or by a licensed therapy Provider. Benefits include services provided in a Physician's office or on an outpatient basis at a hospital, or alternate facility. Services provided in your home are provided as described under the Home Health Care section.
- Refer to the Surest mobile app for additional coverage and copayment information.
- The copayments for certain therapies may vary based on Provider and location (e.g., aural, cognitive, occupational, physical, and speech therapy).
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Rehabilitative/Habilitative Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- Acupuncture is limited to 20 visits or services per Participant per Plan Year for in-network and out-of-network Providers combined.
- Aural Therapy does not have visit limits.
- Cardiac Rehabilitation is limited to 36 visits per Participant per Plan Year for in-network and out-of-network Providers combined.

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- Chiropractic Visits are limited to 20 visits or services, per Participant per Plan Year for in-network and out-of-network Providers combined.
  - Chiropractic Services are limited to manipulative services including chiropractic care and osteopathic manipulation rendered to diagnose and treat acute neuromuscular-skeletal conditions.
- Occupational and Cognitive therapy visits are limited to a combined 60 visits per Participant per Plan Year for in-network and out-of-network Providers combined.
  - Cognitive rehabilitation therapy following traumatic brain Injury or cerebral vascular accident is covered when Medically Necessary.
- Physical therapy is limited to 60 visits per Participant per Plan Year for in-network and out-of-network Providers combined.
- Pulmonary Rehabilitation is limited to 20 visits per Participant per Plan Year for in-network and out-of-network Providers combined.
- Speech therapy is limited to 60 visits per Participant per Plan Year for in-network and out-of-network Providers combined.
- Therapies provided in the home will be assigned the home health care visit copayment. See Home Health Services for coverage notes.
- Vision therapy does not have visit limits.
- Note that Occupational Therapy and Physical Therapy are different types of services and the copayment varies based on how the claim is billed.
- Therapies related to the treatment of a mental health condition, such as autism disorder, are provided under Behavioral Health – Mental Health and Substance Use Disorder services section and do not apply to limits in this section.

Skilled Nursing Facility Services	In-Network	Out-of-Network
Skilled Nursing Facility	$2,750 copayment / stay	$8,000 copayment / stay
Inpatient Rehabilitation Facility	$2,750 copayment / stay	$8,000 copayment / stay

Notes:
The Surest Plan provides Benefits for services provided during an inpatient stay in a Skilled Nursing Facility or inpatient rehabilitation facility.

- Refer to the Surest mobile app for additional coverage information.
- Skilled Nursing Facility stays are limited to 60 days per Participant per Plan Year for in-network and out-of-network Providers combined.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Skilled Nursing Facility Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- An Inpatient Rehabilitation Facility, such as a long-term acute rehabilitation center, a hospital, or a special unit of a hospital designated as an inpatient rehabilitation facility, that provides occupational therapy, physical therapy, and/or speech therapy as authorized by law.
- Benefits include:
  - Facility services for an inpatient stay in a Skilled Nursing Facility or inpatient rehabilitation facility.
  - Supplies and non-Physician services received during the inpatient stay.
  - Room and board in a semi-private room (a room with two or more beds).
  - Physician services for anesthesiologists, pathologists, and radiologists.
  - Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or inpatient rehabilitation facility for treatment of an illness or injury that would have otherwise required an inpatient stay in a hospital.
- Benefits are available only if both of the following are true:
  - The initial confinement in a Skilled Nursing Facility or inpatient rehabilitation facility was or will be a cost-effective alternative to an inpatient stay in a hospital.
  - You will receive skilled care services that are not primarily Custodial Care.
- Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:
  - Services must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
  - Services are ordered by a Physician.

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  - Services are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair.
  - Services require clinical training in order to be delivered safely and effectively.
- You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Participants who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.
- The Surest Plan does not provide Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 12 (Glossary).
- Returning home from a Skilled Nursing Facility or Inpatient Rehabilitation Facility stay with durable medical equipment, such as a walker, may result in an additional copayment.
- All Skilled Nursing Facility and Inpatient Rehabilitation Facility admissions require Prior Authorization and Medical Necessity review.
- See Hospital Services for other coverage notes.

Transplant Services	In-Network	Out-of-Network
Bone Marrow and Solid Organ Transplant	$3,750 copayment / visit	Not Covered
Corneal Transplant	$3,250 copayment / visit	Not Covered
CAR T and Non-Genetic Cellular Therapy	$3,750 copayment / visit	Not Covered
Cellular and Gene Therapy	$3,750 copayment / visit	Not Covered

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for outpatient hospital visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Transplant Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Transplants for which Benefits are available include bone marrow (including CAR T-cell therapy for malignancies), heart, heart/lung, lung, kidney, kidney/pancreas, pancreas, liver, liver/intestine, intestine, and cornea.
- Benefits are available for CAR T and non-genetic cellular therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility. Note this Benefit excludes the gene therapies as described in Section 6 (What Is Not Covered). Benefits for CAR T therapy for malignancies are provided as described above.
- Benefits are also available for cellular and gene therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility.
- Surest has identified quality Designated Providers for transplant services (except for corneal transplant) that are accessible through Transplant Resource Services. See Section 5.3 (Clinical Programs and Resources) for additional information. Transplant services (except for corneal transplant) must be rendered at a Designated Provider.
- All Participants undergoing transplant services (except for corneal transplant) must enroll in Transplant Resource Services, which is a care coordination program for patients undergoing transplants.
- Benefits are available to the donor and the recipient when the recipient is covered under the Surest Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage.
- Surest has specific guidelines regarding Benefits for transplant services. Contact Surest Member Services at the number on your member ID card for information about these guidelines.
- The Transplant Resource Services program provides Benefits for travel and lodging expenses. See Complex Medical Conditions Travel and Lodging Assistance Program described in Section 5.3 (Clinical Programs and Resources) for more information.

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Treatment / Tests / Therapies – Go to Surest mobile app or Benefits.Surest.com website for additional information	In-Network	Out-of-Network
• **Level 1:** Generally, minor procedures or treatments that are typically performed in an outpatient office setting (e.g., needle biopsy, pain management procedures, etc.)	$70 to $3,700 copayment / visit	$400 to $8,000 copayment / visit
• **Level 2:** Generally, minor procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting (e.g., bronchoscopy, etc.)	$0 to $4,000 copayment / visit	$600 to $8,000 copayment / visit
• **Level 3:** Generally, major procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting but may be performed in an inpatient hospital setting (e.g., thyroid surgery, prostate surgery, etc.)	$250 to $4,000 copayment / visit / stay	$5,100 to $8,000 copayment / visit / stay
• **Level 4:** Generally, major procedures, surgeries, or treatments that are typically performed in an inpatient hospital but may be performed in an outpatient hospital setting (e.g., colon surgery, small bowel surgery, etc.)	$300 to $4,000 copayment / visit / stay	$5,400 to $8,000 copayment / visit / stay
• **Level 5:** Generally, major procedures, surgeries, or treatments that require intensive monitoring and are performed in an inpatient hospital setting (e.g., bone marrow and solid organ transplant, brain tumor surgery, coronary artery bypass graft surgery, etc.)	$1,700 to $4,000 copayment / visit / stay	$8,000 copayment / visit / stay
Other Treatments/Tests/Therapies: Refer to the Surest mobile app or Benefits.Surest.com website for coverage and copayment information or call Surest Member Services. Copayments may vary based on Provider, location and treatment, test, or therapy.		
• **Office Visits**	$45 to $145 copayment / visit	$215 copayment / visit
• **Outpatient Hospital Visit**	$300 to $1,150 copayment / visit	$3,150 copayment / visit
• **Inpatient Hospital**	$3,500 copayment / stay	$8,000 copayment / stay

Notes:

- Refer to the Surest mobile app for additional coverage information and for the copayment assigned to your procedure/service.
- The copayments above apply unless a Benefit is specified in another section of this SPD, Surest mobile app or Benefits.Surest.com website.
- Copayments for outpatient hospital visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Treatment / Tests / Therapies copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Treatment, tests, and therapies have been tiered based on type and level (minor vs. major) of care. Some minor treatments or procedures are either included in the office visit copayment or may have a specific copayment based on the Provider and location selected. Some surgical procedures also have specific copayments based on the Provider or location selected.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Copayments for Procedures in Level 1 - Level 5 may vary based on Provider and location. Refer to the Surest mobile app or call Surest Member Services to determine the copayment assigned to your procedure/service.
  - Level 1 is a category of minor procedures typically performed in an outpatient office setting.
  - Level 2 is a category of minor surgeries and procedures or services typically performed in an outpatient hospital setting.
  - Level 3 is a category of major surgeries and procedures typically performed in an outpatient hospital setting.
  - Level 4 is a category of major surgeries and procedures typically performed in an inpatient hospital setting.

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  - Level 5 is a category of major surgeries and procedures that require intensive monitoring and typically performed in an inpatient hospital setting. Transplant services must be rendered at a location specified as a Designated Provider.
- Copayments for office visits or outpatient hospital visits may vary based on Provider and location. Refer to the Surest mobile app or call Surest Member Services to determine the copayment assigned to your procedure/service.
- 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.
  - The Surest Plan will allow the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.
- If you are admitted to inpatient from the Emergency department or from observation, the Emergency room copayment or Observation Stay copayment will be waived, and you will be responsible for the Inpatient Hospital Services copayment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as a walker, may result in an additional copayment.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.
- Select office-based and outpatient procedures may require Prior Authorization and Medical Necessity review.

Urgent Care	In-Network	Out-of-Network
Urgent Care Visit	$100 copayment / visit	$200 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Benefits include visits at a walk-in Urgent Care center that treats illnesses and injuries requiring immediate care, but not serious enough to require an Emergency department visit.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Urgent Care Visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- If the Urgent Care facility is unable to treat you, you may be referred to the Emergency Room or other Provider, you will be responsible for both the Urgent Care and Emergency Room Copayments.
- Returning home from a visit with durable medical equipment, such as crutches, may result in an additional copayment.

Virtual Care – Designated Provider	In-Network	Out-of-Network
Virtual Primary and Urgent Care	$0 copayment / visit	Not Covered
Virtual Mental Health and Substance Use Disorder Care	$45 to $100 copayment / visit	Not Covered
Virtual Specialty Care	$0 to $145 copayment / visit	Not Covered

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Please see the Behavioral Health and Office Visit sections for additional information on Telehealth Visits with your Provider.
- Virtual care is for Covered Health Services that include the diagnosis and treatment of medical and mental health conditions for Participants that can be appropriately managed virtually within the scope of practice of the virtual providers, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner. Virtual care provides communication of medical information between the patient and a Provider, through use of interactive audio and video communications equipment or through federally compliant secure messaging applications outside of a medical facility (for example, from home or from work).
- Copayments will vary based on Provider. If you choose a Provider that is not a Designated Virtual Network Provider, see the Office Visit section for additional Telehealth Visit copayment information. Benefits are available only when services are delivered through a Designated Virtual Network Provider that are specified by your Surest Plan.

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- Please visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services to locate a Designated Virtual Network Provider.
- No virtual care coverage for out-of-network Providers.
- Please note that not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which in-person Physician contact is needed.

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Travel and Lodging for Covered Health Services

The Plan provides a Participant with a travel and lodging allowance related to the Covered Health Service that is not available in the Participant's state of residence due to law or regulation when such services are received in another state, as legally permissible.

Travel and Lodging provides support for the Participant under the Plan. The Plan provides an allowance for reasonable travel and lodging expenses for a Participant and travel companion when the Participant must travel at least 200 miles from their address, as reflected in our records, to receive the Covered Health Services.

This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Participant. An allowance of up to $2,000 per Participant per year will be provided for travel and lodging expenses incurred as a part of the Covered Health Service. Lodging expenses are further limited to $50 per day for the Participant, or $100 per day for the Participant with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding Travel and Lodging, see Benefits.Surest.com or contact Surest Member Services.

The Transplant Resource Services program provides Benefits for travel and lodging expenses. See Complex Medical Conditions Travel and Lodging Assistance Program described in Section 5.3 (Clinical Programs and Resources) for more information.

Clinical Trials

Clinical trials are research studies designed to find ways to improve health care or to improve prevention, diagnosis, or treatment of health problems. The purpose of many clinical trials is to find out whether a medicine or treatment is safe and effective for treating a certain condition or disease. Clinical trials compare the effectiveness of medicines or treatments against standard, accepted treatment, or against a placebo if there is no standard treatment.

Participants in clinical trials are typically randomized to different treatment arms and based on that randomization may receive either the study intervention or the control intervention.

Services provided in a clinical trial typically include the interventions being evaluated (study agent and control agent) and other clinical services required to evaluate the effectiveness and safety of the interventions being compared.

In compliance with federal law, your Benefits cover routine health care costs for qualifying individuals participating in an approved clinical trial. For more information call Surest Member Services at the number on your member ID card.

Clinical Trial services may require Prior Authorization and Medical Necessity review.

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5.2 Prior Authorization and Pre-Admission Notification

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. 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). This information can also be found in Section 8 (What Do I Do If My Claim Is Denied).

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.

Prior Authorization may be required for but is not limited to the following services:

- Acute care hospitalizations (planned)
- Acute inpatient rehabilitation
- Applied behavioral analysis
- Non-Emergency air transportation
- Bone growth stimulators
- BRCA testing
- Select cardiovascular procedures
- Select chemotherapy
- Clinical trials
- Cochlear implant surgery
- Potentially Cosmetic and Reconstructive surgery
- Select durable medical equipment, orthotics, and prosthetics
- Gender affirming surgery

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- Select genetic and molecular tests
- Select injectable medications
- Intensity-modulated radiation therapy
- Long-term acute care
- MR-guided focused ultrasound
- Organ transplants
- Orthognathic surgery
- Partial hospitalization
- Proton beam therapy
- Residential treatment facilities
- Skilled Nursing Facilities
- Sleep apnea procedures
- Sleep studies
- Select spinal surgeries
- Vein procedures
- Ventricular assist devices

5.3 Clinical Programs and Resources

Surest Care Management

Surest Care Management offers support to help you use your Benefits, improve your health, and achieve an optimal quality of life.

Surest care managers act as an advocate for you and your family by:

- Assisting you in making important health care decisions.
- Coordinating your care with your health care Providers.
- Helping you develop self-management skills.
- Identifying available treatment options.
- Offering personalized coaching to help you live better with an illness or recover from an acute condition.
- Researching resources, such as Digital Health Solutions (see below), support groups, and financial assistance.

Although your care manager will be your primary program contact, you and your Physician will always make the decisions about your treatment. By working closely with your Physician and using the resources available in your community, this program can help you through a difficult time.

It is your choice to participate in Surest Care Management. There are no extra charges for these services, and you can end your participation at any time, for any reason. Participation in

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this program will not affect your Benefits. Contact Surest Member Services if you think you can use this support.

Surest Digital Health Solutions

Surest Digital Health Solutions are programs offered by Surest to provide health-related services that prevent, treat, or reverse one or more chronic diseases or conditions. Services may include education, decision-support, coaching, nutritional support, caregiver support, meditation, therapeutic movement, and other therapeutic or diagnostic services that would not otherwise be considered Medically Necessary, or may be excluded Benefits, if provided outside of Surest Digital Health Solutions.

Surest may offer additional or varying Digital Health Solutions throughout the year. To find out additional information, visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services.

Maven - Maternity & Family Support Program

Surest offers a maternity and family support program with personalized coaching and digital tools. To find out additional information, visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services.

One Pass

Surest offers an optional subscription for access to fitness partners and grocery delivery. To find out additional information, visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services.

Complex Medical Conditions, Programs and Services

Calm Health

Calm Health provides digital support techniques designed to help you relax, shift perspectives or cope with stressful situations.

Calm Health provides tools and support, such as:

- Mood and health data tracking over time.
- Integrated goal-setting and progress assessments.
- Relaxation techniques.

Calm Health can be accessed through Benefits.Surest.com or the Surest mobile app.

Congenital Heart Disease Resource Services

Because Congenital Heart Disease (CHD) care is complex, covered Surest Participants with CHD have access to a CHD Resources Service that can help you locate CHD Centers of Excellence Providers and best practice CDH programs throughout the U.S. A nurse can work with you to help you:

- Identify the CHD hospital options for you, including Centers of Excellence.
- Evaluate your needs for information and support before and after a CHD treatment.

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- Understand your benefits and provide resources to help you navigate the health system to make sure you and your Participants get the care you need.

Transplant Resource Services

For a solid organ and blood/marrow transplant to be a Covered Health Service, you must be enrolled in Transplant Resource Services and use a designated provider. Most transplants are expensive and complicated. At Surest, we ensure you are going to a reputable facility that has expertise in the specific type of transplant you need. Contact Surest Member Services at the number on your member ID card for more information on Transplant Resource Services and access to designated providers.

Once you are enrolled in Transplant Resource Services, a dedicated nurse case manager who specializes in transplant cases will provide assistance in:

- Selecting the transplant facility.
- Scheduling your evaluation at the transplant facility.
- Following up with you routinely while you are on the transplant list.
- Discharge planning, post-transplant support, and ongoing help with your care needs.

Organs included in the program are heart, heart/lung, lung, kidney, kidney/pancreas, pancreas, liver, liver/intestine, intestine, and bone marrow (blood forming stem cell transplants). While corneal transplant is a solid tissue transplant, it is not considered part of the Transplant Resource Services program.

The Transplant Resource Services provides Benefits for travel and lodging expenses. See Complex Medical Conditions Travel and Lodging Assistance Program described in this section for more information.

Complex Medical Conditions Travel and Lodging Assistance Program

This is the travel and lodging assistance program for the Covered Health Services described below.

The Plan provides you with Travel and Lodging assistance for certain Covered Health Services. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the necessary distance from your home address to the facility is at least 50 miles. Allowed amounts are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call Surest Member Services.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the Participant and a travel companion as follows:

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- Transportation of the Participant and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for care related to one of the programs listed below.
- The eligible expenses for lodging for the Participant (while not a hospital inpatient) and one companion.
- If the Participant is an enrolled dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Participant resides at least 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the Participant and his/her companion(s) may be included in the unearned taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offers a maximum of $10,000 per transplant for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, combined 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.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the in-network Provider or Designated Provider.
- Taxi, Uber/Lyft fares (not including limos or car services / rental cars).
- Economy or coach airfare.
- Parking.
- Trains.

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- Boat.
- Bus.
- Tolls.

Other Condition Focused Programs Made Available by Nelnet, Inc.

Fertility Solutions

Fertility Solutions is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. The Fertility Solutions program provides:

- Specialized clinical consulting services to Participants and enrolled Dependents to educate on fertility treatment options.
- Access to specialized Network facilities and Physicians for fertility services.
- Provides education, specialized clinical counseling, treatment options and access to national Network of premier fertility treatment clinics.

The Plan pays Benefits for the fertility services described above when provided by Designated Providers participating in the Fertility Solutions program.
Participants who do not live within a 60-mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine a Network Provider prior to starting treatment.

For fertility services and supplies to be considered Covered Health Services, you must contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.
For Infertility Services and supplies to be considered Covered Health Services, you must contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.
You or a covered dependent may:

- Be referred to Fertility Solutions by the Claims Administrator.
- Call the telephone number on your ID card.
- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Are Incentives Available to You?

Sometimes the Claims Administrator may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost-effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, you should discuss taking part in such programs with your Physician. Contact the Claims Administrator at Benefits.Surest.com or the telephone number on your ID card if you have any questions.

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5.4 Transition of Care and Continuity of Care

If you are new to the Surest Plan and are actively receiving treatment from a Provider who is not in our network, you may be eligible to receive Transition of Care Benefits. Transition of Care Benefits allow you the option to request coverage from your current out-of-network Provider at in-network copayments for a limited time due to a qualifying medical condition until the safe transfer to an in-network Provider can be arranged. Transition of Care Benefits are managed on a case-by-case basis.

If you are currently covered by the Surest Plan and your health care Provider leaves the network, you can apply for Continuity of Care. If you have medical reasons preventing immediate transfer to a network provider, Continuity of Care Benefits will allow you the option to request extended care from your out-of-network Provider while paying in-network copayments until a safe transition can be made to an in-network Provider. Continuity of Care Benefits are managed on a case-by-case basis.

If you are currently receiving treatment for Covered Health Services from a Provider whose network status changes from in-network to out-of-network during such treatment due to termination (non-renewal or expiration) of the Provider's contract, you may be eligible to request continued care from your current Provider under the same terms and conditions that would have applied prior to termination of the Provider's contract for specified conditions and timeframes. This provision does not apply to Provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, call Surest Member Services for assistance.

The following criteria must be met for your Transition of Care or Continuity of Care application to be considered:

- **Transition of Care**: You are newly eligible for the Surest Plan and currently receiving care for a Covered Health Service by an in-network Provider and your Provider is no longer in-network under the Surest Plan.
- **Continuity of Care**: You are currently enrolled in the Surest Plan and actively receiving care for a Covered Health Services by an in-network Provider, who subsequently leaves the network and becomes an out-of-network Provider.

In addition, you must have at least one of the following:

- **Inpatient and Residential Care:** If you are actively receiving inpatient or residential care at a Provider that was in-network and becomes out-of-network, you may qualify for Transition of Care or Continuity of Care Benefits to cover the duration of the inpatient or residential care stay.
- **Recent Major Surgery:** If you have had a recent surgery or procedure with an in-network provider who becomes out-of- network, are in the acute phase and follow-up period (generally six to eight weeks after surgery) you may qualify for Transition of Care or Continuity of Care.

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- **Scheduled Surgery/Procedure:** If you are scheduled to undergo a nonelective surgery or procedure with an in-network Provider who becomes out-of-network, you may qualify for Transition of Care or Continuity of Care Benefits.
- **Pregnancy:** If you are pregnant and receiving care from a Provider who was in-network and becomes out-of-network, you may qualify for Transition of Care or Continuity of Care Benefits.
- **Serious Chronic Condition:** If you are actively being treated for a serious chronic medical condition which may persist or worsen if care is delayed and are receiving care from a Provider who was in-network and becomes out-of-network, you may qualify for Transition of Care or Continuity of Care Benefits.
- **Terminal Illness:** If you have an incurable or irreversible condition that has a probability of causing death within one year or less and are receiving care from a Provider who was in-network and becomes out-of-network, you may qualify for Transition of Care or Continuity of Care Benefits.
- **Transplant:** If you are a transplant candidate or the recipient of an organ transplant and in need of ongoing care due to complications associated with the transplant and are receiving care from a Provider who was in-network and becomes out-of-network, you may qualify for Transition of Care or Continuity of Care Benefits.

To request an application for Transition of Care (new Participants) or Continuity of Care (existing Participants), call Surest Member Services at the number on your Surest member ID card. Applications are also available on Benefits.Surest.com. The application must be completed and returned within 30 days of the Effective Date of coverage for new Participants or within 30 days of the Provider leaving the network for existing Participants. After receiving your request, Surest will review and evaluate the information provided and send you a letter to let you know if your request was approved or denied. A denial will include information about how to appeal the determination.

- If your request is approved for the medical condition(s) listed on your application(s), you will receive the network level coverage for treatment of the specific condition(s) by the Provider for:
  - Up to 30 days from the effective date of coverage for new members for medical services,
  - Up to 90 days from the effective date of coverage for new members for behavioral health services,
  - Up to 90 days from when your provider leaves your health plan network, or
  - Through completion of the current active course of treatment period, whichever comes first.

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6. What Is Not Covered

The Surest Plan does not provide Benefits for the following services, treatments, or supplies (including items or services that are related to the services, treatments, or supplies listed below, but which are not specifically listed below) even if they are recommended or prescribed by a Provider or are the only available treatment for your condition, unless specifically described or listed in Section 5.1 (Covered Health Services).

Alternative Treatments

1. Aromatherapy.
2. 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.
3. Biofeedback.
4. Health care services ordered or rendered by Providers or para-professionals unlicensed by the appropriate regulatory agency.
5. Holistic medicine and services, including dietary supplements.
6. Homeopathic or naturopathic medicine, including dietary supplements.
7. Hypnotism.
8. Massage therapy that is not physical therapy or prescribed by a licensed Provider as a component of a multi-modality rehabilitation treatment plan.
9. Rolfing.
10. Vocational therapy.

Behavioral Health: Mental Health/Substance Use Disorder

11. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
12. Inpatient or intermediate or outpatient care services that were not pre-authorized.
13. Investigational therapies for treatment of Autism Spectrum Disorders.
14. 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.
15. Outside of an initial 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 Mental Disorders by the American Psychiatric Association*.
16. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, and paraphilic disorders.

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17. Outside of initial 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 Mental Disorders by the American Psychiatric Association*.
18. School-based Intensive Behavioral Therapies (IBT) service or services that are otherwise covered under the Individuals with Disabilities Education Act (IDEA).
19. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association*.
20. Transitional living services.
21. Tuition for 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.
22. Intense Early Intervention Using Behavioral Therapy (IEIBT) and Lovaas. This exclusion does not apply when required for the treatment of Autism Spectrum Disorders.
23. Vagus nerve stimulator treatment for the treatment of depression and quantitative electroencephalogram treatment of behavioral health conditions.
24. Wilderness, adventure, camping, outdoor, or other similar programs.

Dental

25. Dental braces (orthodontics).
26. Dental care (which includes dental x-rays, supplies, and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental and Medical in Section 5.1 (Covered Health Services). This exclusion does not apply to dental care (oral exam, x-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan.
27. 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.
28. Dental implants, bone grafts, and other implant-related procedures.
29. Endodontics, periodontal surgery, and restorative treatments are excluded.
30. Preventive care, diagnosis, and treatment of or related to the teeth, jawbones, or gums.
31. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a congenital anomaly.

Devices, Appliances, Supplies and Prosthetics

32. Birthing tub.

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33. Cranial banding except when Medically Necessary for the treatment of plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape).
34. Devices and computers to assist in communication and speech except as described in Section 5.1 (Covered Health Services) under Durable Medical Equipment (DME) and Supplies. Examples of not covered items include iPads and Android tablets.
35. Devices used specifically as safety items or to affect performance in sports-related activities.
36. Disposable supplies for home use such as, but not limited to Ace-type bandages, antiseptics, bandages, diapers, dressings, incontinence supplies, gauze, and tape.
37. Home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits.
38. Household equipment, household fixtures, and modifications to the structure of the home, escalators or elevators, hot tubs and saunas, ramps, swimming pools, whirlpools, wiring, plumbing, or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, hypo-allergenic pillows, mattresses, water purifiers, or waterbeds.
39. Oral appliances for snoring.
40. Orthotic appliances and devices that straighten or re-shape a body part. Examples of excluded orthotic appliances and devices include but are not limited to some types of braces, and arch supports, and include orthotic braces available over-the-counter.
41. 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.
42. Repairs to prosthetic devices due to misuse, malicious damage, or gross neglect.
43. Replacement of prosthetic devices due to misuse, malicious damage, or gross neglect or to replace lost or stolen items.
44. Shoes. This exclusion does not apply to therapeutic, custom-molded shoes when prescribed by a Physician.
45. Shoe orthotics. This exclusion does not apply to therapeutic shoe orthotics when prescribed by a Physician.
46. Supplies, equipment, and similar incidentals for personal comfort. Examples include air conditioners, air purifiers, exercise equipment, humidifiers, Jacuzzis, recliners, saunas, and vehicle modifications such as van lifts.
47. Vehicle/car or van modifications including, but not limited to, car carriers, handbrakes, and hydraulic lifts.

Drugs (under the medical plan)

48. Charges for giving injections that can be self-administered.
49. Drugs dispensed by a Physician or Physician’s office for outpatient use.
50. Investigational or non-FDA-approved drugs.
51. Non-prescription supplies.

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52. Over-the-counter drugs, except as specified in Section 13 (Outpatient Prescription Drugs).
53. Certain new prescription medications or products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

    This exclusion does not apply if you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening sickness or condition, under such circumstances, Benefits may be available for the new prescription medications or product to the extent provided in Section 5.1 (Covered Health Services).
54. A pharmaceutical product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product. Such determinations may be made up to six times during a calendar year.
55. A pharmaceutical product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product. Such determinations may be made up to six times during a calendar year.
56. A pharmaceutical product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product. For the purpose of this exclusion a "biosimilar" is a biological pharmaceutical product approved based on showing that it is highly similar to a reference product (a biological pharmaceutical product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
57. Certain pharmaceutical products for which there are therapeutically equivalent (having essentially the same efficacy to adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six time during a calendar year.
58. Selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects.
59. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Participants for self-administration.
60. Vitamin or dietary supplements, except as specified in Section 13 (Outpatient Prescription Drugs).

Experimental or Investigational or Unproven Services

61. Intracellular micronutrient testing.

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62. 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

63. Routine foot care. Examples include:
    a) Cutting or removal of corns and calluses.
    b) Nail trimming, nail cutting, or nail debridement.
    c) Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

    This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
64. Treatment of flat feet.
65. Treatment of subluxation of the foot.
66. Shoes. This exclusion does not apply to therapeutic, custom-molded shoes when prescribed by a Physician.
67. Shoe orthotics. This exclusion does not apply to therapeutic shoe orthotics when prescribed by a Physician.
68. Shoe inserts.
69. Arch supports.

Gender Dysphoria Services

70. Cosmetic procedures related to a diagnosis of Gender Dysphoria including:
    a) Abdominoplasty
    b) Blepharoplasty (eyelid)
    c) Body contouring (e.g., fat transfer, lipoplasty, panniculectomy)
    d) Brow lift
    e) Calf implants
    f) Cheek, chin and nose implants
    g) Face/forehead lift and/or neck tightening
    h) Facial bone remodeling for facial feminization
    i) Hair removal
    j) Hair transplantation
    k) Injection of fillers or neurotoxins
    l) Laser or electrolysis hair removal not related to genital reconstruction
    m) Lip augmentation
    n) Lip reduction
    o) Liposuction (suction-assisted lipectomy)
    p) Mastopexy (breast lift)

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q) Pectoral implants for chest masculinization
r) Rhinoplasty
s) Skin resurfacing (e.g., dermabrasion, chemical peels, laser)

Nutrition

71. Enteral feedings and other nutritional and electrolyte formulas, including infant formula, blenderized food, and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under Enteral Nutrition in Section 5.1 (Covered Health Services).
72. 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).
73. Nutritional education that is non-disease specific, such as general good eating habits, calorie control or dietary preferences (e.g., vegetarian, macro-biotic).

Physical Appearance

74. Cosmetic Procedures such as:
    a) Hair removal or replacement by any means.
    b) Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
    c) Pharmacological regimens, nutritional procedures, or treatments.
    d) Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures).
    e) Skin abrasion procedures performed as a treatment for acne.
    f) Treatments for hair loss.
    g) Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
    h) Treatment for spider veins of the lower extremities when it is considered Cosmetic.
    i) Varicose vein treatment of the lower extremities when it is considered Cosmetic.
75. Excision or removal of hanging skin on any part of the body, unless determined to be Medically Necessary. Examples include plastic surgery procedures called abdominoplasty, brachioplasty and panniculectomy.
76. Physical conditioning programs such as athletic training, bodybuilding, diversion or general motivation, exercise, fitness, flexibility, health club memberships and programs, and spa treatments.
77. 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

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reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

78. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic procedure.
79. Treatment of benign gynecomastia (abnormal breast enlargement in males).
80. Weight loss programs, whether or not they are under medical supervision or for medical reasons, even if for morbid obesity, except as described in Section 5.3 (Clinical Programs and Resources).

Procedures and Treatments

81. Abortion, except in situations where the life of the covered Participant (mother) would be endangered if the fetus is carried to full term and/or due to rape or incest.
82. Bariatric Surgery.
83. Chelation therapy, except to treat heavy metal toxicity and overload conditions.
84. Helicobacter pylori (H. pylori) serologic testing.
85. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
86. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.
87. 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.
88. 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.
89. Rehabilitation services for speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, congenital anomaly, or Autism Spectrum Disorder.
90. 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

91. Services ordered or delivered by a Christian Science practitioner.
92. Services performed by a Provider who is a family member by birth or marriage, including your spouse, domestic partner, brother, sister, parent, or child. This includes any service the Provider may perform on himself or herself.
93. Services performed by a Provider with your same legal residence.

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94. Services performed by an unlicensed Provider or a Provider who is operating outside of the scope of his/her license.

Reproduction

95. The fertility treatment-related services, including the following, except as described in Section 5.1 (Covered Health Services):
    a) All charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to, fees for laboratory tests.
    b) All costs associated with surrogate parenting including, but not limited to, donor oocytes (eggs), donor sperm and host uterus.
    c) Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
    d) Cloning.
    e) 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.
    f) Donor services and non-medical costs of oocyte or sperm donation (e.g., donor agency fees).
    g) Embryo or oocyte accumulation, defined as a fresh oocyte (egg) retrieval prior to the depletion of previously banked frozen embryos or oocytes (eggs).
    h) Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma.
    i) Ovulation predictor kits.
    j) Reversal of voluntary sterilization.
    k) Services for partners, spouses, and the maternity expenses of gestational carriers not covered by the Surest Plan.
    l) Treatments considered Experimental by the American Society of Reproductive Medicine.

Services Provided Under Another Plan

96. Services for which coverage is available:
    a) For treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you.
    b) 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.
    c) Under another medical plan, except for Eligible Expenses, or Recognized Amount when applicable, payable as described in this SPD.
    d) Under Workers' Compensation or similar legislation if you could elect it or could have it elected for you.
    e) While on active military duty.

Transplants

97. Health services for transplants involving permanent mechanical or animal organs.

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98. 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

99. Health services provided in a foreign country, unless required as Emergency Health Care Services.
100. Travel or transportation expenses, even if ordered by a Physician, except as identified under Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services described in Travel and Lodging in Section 5.1 (Covered Health Services) and Section 5.3 (Clinical Programs and Resources). Additional travel expenses related to Covered Health Services received from a Designated Provider or other Network Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 5.1 (Covered Health Services).

Types of Care

101. Custodial Care.
102. Domiciliary Care.
103. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
104. Private Duty Nursing.
105. Respite care, except as defined under Hospice Care in Section 5.1 (Covered Health Services).
106. Rest cures.
107. Services of personal care attendants.
108. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision, Hearing and Voice

109. Implantable lenses used only to correct a refractive error such as radial keratotomy or related procedure, and artificial retinal devices or retinal implants.
110. Refractive surgery (e.g., Lasik) for ophthalmic conditions that are correctable by contact lenses or glasses.
111. Routine eye exams (including refractions), Eyeglasses, contact lenses and any fittings associated with them, except as identified in Section 5.1 (Covered Health Services).
112. 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.
113. Over-the-counter hearing aids and related supplies.

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114. Bone-anchored hearing aids except when either of the following applies:
    a) For Participants with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
    b) For Participants with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
115. 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.
116. Any type of communicator, electronic voice producing machine, voice enhancement, voice prosthesis, or any other language assistive devices.

All Other Exclusions

117. Autopsies and other coroner services and transportation services for a corpse.
118. Charges for:
    a) Completion of Claim forms.
    b) Missed appointments.
    c) Record processing.
    d) Room or facility reservations.
119. Charges prohibited by federal anti-kickback or self-referral statutes.
120. Direct-to-consumer retail genetic tests.
121. Expenses for health services and supplies:
    a) 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.
    b) 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.
    c) That are received as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces 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.
    d) That exceed Eligible Expenses, or the Recognized Amount when applicable, or any specified limitation in this SPD.
122. Foreign language and sign language services.
123. Health care services that Surest determines are not Medically Necessary.
124. Long-term (more than 30 days) storage of blood, umbilical cord, or other material (e.g., cryopreservation of tissue, blood, and blood products).
125. 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.

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126. Physical, psychiatric, or psychological exams, testing, and all forms of vaccinations and immunizations, or treatments when:
    a) Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 5.1 (Covered Health Services).
    b) Related to judicial or administrative proceedings or orders, unless determined to be Medically Necessary.
    c) Required solely for purposes of adoption, career or employment, education, insurance, marriage, sports or camp, travel, or as a result of incarceration.
    d) Required to obtain or maintain a license of any type.
127. 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.
128. In the event an out-of-network Provider waives, does not pursue, or fails to collect, copayments or other amount owed for a particular health care service, no Benefits are provided for the health care service when the copayments are waived, not pursued, or not collected.

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7. Claims Procedures

When you receive in-network services, the Provider will generally collect your copayment from you at the time of your treatment and send a medical Claim to the Surest Plan for payment. Sometimes out-of-network Providers will do the same. Other times, out-of-network Providers may bill you for the total cost of your treatment, and you will need to submit the medical Claim to the Surest Plan to be reviewed for Benefits. Whether you pay out-of-pocket, or your Provider bills the Surest Plan directly, you are still entitled to the same Benefits.

If you receive a bill from your Provider (whether in-network or out-of-network) for the Surest Plan's portion of the costs, or you pay for your medical care out-of-pocket and need to be reimbursed, you must submit a medical Claim to the Surest Plan. This section summarizes the procedures you must follow to submit a medical Claim for payment, and the procedures the Surest Plan will use to determine whether and how much to pay for that medical Claim.

If you would like more details about medical Claims procedures and your rights and responsibilities, contact Surest Member Services.

Regular Post-Service Medical Claims

Post-service medical Claims are non-urgent medical Claims processed after you have received treatment. Pre-Service and Urgent Care Request for Benefits are described in Section 8 (What Do I Do If My Claim Is Denied). 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 Surest Plan, you can submit a medical Claim using this procedure.

You can submit a post-service medical Claim by mail to the address on your member ID card. You will need to provide several pieces of information for Surest to be able to process your medical Claim and determine the appropriate Surest Plan Benefits:

- The name and birthdate of the Participant who received the care.
- The Participant ID listed on the Surest member ID card.
- An itemized bill from your Provider, which should include:
  - The Provider's name, address, tax identification number, NPI number, and license number (if available).
  - The date(s) the Participant received care.
  - The diagnosis and procedure codes for each service provided.
  - The charges for each service provided.
- Information about any other health coverage the Participant has.
- Proof of payment may be requested to substantiate your medical Claim but is not required upon initial submission to Surest.

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Regular Post-Service Pharmacy Claims

See Section 13 (Outpatient Prescription Drugs).

Other General Claims Procedures

Your medical Claim must be submitted within one year from the date you received the health care services. If you are not capable of submitting a Claim within one year, you must submit the Claim as soon as reasonably possible. If your Claim relates to an inpatient stay, the date you were discharged counts as the date you received the health care service for Claims purposes.

You will receive a decision within 30 days of submitting your Claim. If we need more information on a Claim, we will reach out to you to request that additional information, but we will still make a decision on your Claim within 30 days. If you submit the requested additional information after a decision has been made, we may adjust our decision and reprocess your Claim accordingly.

Claims for medical (non-pharmacy) Benefits will be reviewed by Surest. If more time is needed to decide your Claim, we may request a one-time extension of not more than 15 days.

If a Claim for a welfare benefit is denied or ignored, in whole or in part, a Participant has a right to know why this was done, to obtain copies of documents (without charge) relating to the decision, and to appeal any denial, all within certain time schedules.

Notice of Adverse Claim Determination

If your medical Claim is denied in whole or in part, you will receive a written notice of denial. The notice will be written in an understandable and, where required by law, in a culturally and linguistically appropriate manner and will include all of the following:

- Information sufficient to identify the medical Claim involved (including the date of service, the health care Provider, and the medical Claim amount [if applicable]); you can also request from the Claims Administrator the diagnosis and treatment codes, and their explanation.
- The specific reason or reasons for the denial, the denial code and its meaning and a description of the Plan standard, if any, that was used in denying the Claim and a discussion of the decision.
- The specific reference to the relevant Plan provision on which the decision is based.
- A description of additional information needed to support your medical Claim and an explanation of why it is needed.
- Information about how to appeal your Claim and any time limits, should you want to pursue it further and your right to bring a civil action under ERISA if your appeal is denied.
- A statement about available external review processes, including information on how to initiate the review.

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- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either a copy of the document or a statement that such a document was relied on and that a copy will be provided (free of charge) upon request.
- Either an explanation of the scientific or clinical judgment for the decision (applying the Plan terms to your medical circumstances) or a statement that such an explanation was relied on and that a copy will be provided (free of charge) upon request, if the decision was based on a limit (for example, a decision that the proposed service is not Medically Necessary).
- A description of the expedited review process in the case of a denial concerning a Claim involving urgent care. If we tell you about our decision orally within the timeframes required, we will follow up within three business days with a written or electronic notice.
- A statement about the availability of contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.
- A description of any voluntary processes the Plan offers.

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8. What Do I Do If My Claim Is Denied?

If your Pharmacy Claim is Denied

See Section 13 (Outpatient Prescription Drugs).

If Your Medical Claim is Denied

If a medical Claim for Benefits is denied in part or in whole, you are encouraged to call Surest Member Services before requesting a formal appeal. If Surest Member Services cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

To submit a medical Claim appeal:

1. Contact Surest Member Services to request a medical Appeal Filing Form or refer to the medical Appeal Filing Form included with your Explanation of Benefits.
2. Complete the medical Appeal Filing Form.
3. Submit the completed medical Appeal Filing Form along with your denial notice and any supporting documentation to:

   Surest
   Consumer Affairs (Member Appeals)
   P.O. Box 31270
   Salt Lake City, UT 84131

Review of a Medical Appeal

Surest will conduct a full and fair review of your medical Claim appeal.

You can send written comments, documents, records, and any other information you think will help decide the medical Claim appeal.

You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Participant's medical Claim for Benefits. "Relates to" means at least one of the following:

- That we used the information to make the Benefit determination.
- The information was submitted, used, or created while making the Benefit determination.
- The information shows that we made the Benefit determination based on your Plan documents and made the same decision for other Plan Participants in the same situation.
- The information is one of our policies or guidance.

When Surest reviews your medical Claim appeal, Surest will take into account all comments, documents, records, and other information you give, even if we did not have that information when we denied the medical Claim.

Surest adheres to the following review practices:

- The appeal will be reviewed by an appropriate individual(s) who did not make the initial Benefit determination and who does not report to the person who did make the initial Benefit determination.

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- If your medical Claim involves medical judgment or whether the medical Claim is about investigational or Experimental services, the appeal will be reviewed by a health care professional with appropriate expertise who was not consulted during the initial Benefit determination process.
- Surest will review all medical Claims in accordance with the rules established by the U.S. Department of Labor and applicable state law.
- Our reviewers avoid conflicts of interest and act independently and impartially. We do not hire, pay, terminate, promote, make decisions, or incentivize medical Claims reviewers to make denials.

Once the review is complete, if Surest upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

If you are not satisfied with the first-level medical Claim appeal decision, you have the right to request a second-level medical Claim appeal within 60 days of receipt of the first-level medical Claim appeal determination.

Access to New or Additional Information

If you ask, we will give you the identification of any medical expert who gave an opinion – whether or not we used that opinion to decide your medical Claim. Any Participant will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required, with: (i) any new or additional evidence considered, relied upon, or generated by the Surest Plan in connection with the medical Claim; and (ii) a reasonable opportunity for any Participant to respond to such new evidence or rationale.

Pre-Service and Urgent Care Request for Benefits

A pre-service request for Benefits is a type of Benefit request that requires Prior Authorization but is not urgent. An urgent care request for Benefits is a special type of Prior Authorization that occurs when a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. Because your Provider is the one who initiates Prior Authorization, it will usually be your Provider who will request expedited processing. An urgent care request for Benefits will be decided as soon as possible, taking into account the medical exigencies, but no more than 72 hours after we receive your request. Urgent care requests for Benefits filed improperly or missing information may be denied.

If your pre-service or urgent care request for Benefits is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request an expedited review).

Timing of Medical Claim Appeals Determinations

Separate schedules apply to the timing of Benefit requests and medical Claim appeals, depending on the type of request. There are four types of requests:

- **Urgent Care Request for Benefits:** A request for Benefits provided in connection with urgent care services.

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- **Concurrent Care Requests:** A request to extend an already approved ongoing course of treatment that was approved for a specific period of time or a specific number of treatments. If the request is urgent, we will follow the urgent care request for Benefits and appeals process. If it is not urgent, it will be treated like a new request for services and will follow the Pre-Service Request for Benefits and Appeal process.
- **Pre-Service Request for Benefits:** A request for Benefits which the Surest Plan must approve or for which you must notify Surest before non-urgent care is provided.
- **Post-Service Medical Claim Request for Benefits:** A medical Claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Surest Plan for the proposed treatment or procedure.

You may have the right to external review through an Independent Review Organization (IRO) upon completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in a decision letter to you from Surest.

The tables below describe the time frames which you and Surest are required to follow.

Urgent Care Request for Medical Benefits and Appeal*

Request for Urgent Care or Concurrent Care Benefits	Claims Timing
If your request for medical Benefits is incomplete, Surest must notify you within:	**24 hours** and advise you what information is needed
You must then provide a completed request for medical Benefits to Surest within:	**48 hours** after receiving notice of additional information required
Surest must notify you of the medical Benefit determination within:	**48 hours** of receiving the needed information
If your request for medical Benefits is complete when it is filed, Surest must notify you within:	**72 hours**
If Surest denies your request for medical Benefits, you must appeal an Adverse Benefit Determination no later than:	**180 days** after receiving the Adverse Benefit Determination
Expedited Appeals (Urgent Care or Concurrent Care)	**Appeals Timing**
Surest must notify you of the medical Claim appeal decision within:	**72 hours** after receiving the medical Claim appeal — if the medical Claim appeal is still urgent. If services have already been provided, we follow the post-service medical Claim appeals process.

*Follow the procedure for an Expedited Appeal provided in your denial of coverage letter.

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Pre-Service Request for Medical Benefits and Appeal*

Request for Pre-Service Benefits	Claims Timing
If your request for medical Benefits is filed improperly, Surest must notify you within:	**5 days**
If your request for medical Benefits is incomplete, Surest must notify you within:	**15 days**
You must then provide a completed request for medical Benefits information to Surest within:	**45 days**
Surest must notify you of the medical Benefit determination:	
• If the initial request for medical Benefits is complete, within:	**15 days**
• After receiving the completed request for medical Benefits (if the initial request for medical Benefits is incomplete), within:	**15 days***
*Surest may require a one-time extension for the request for Pre-Service Benefits, of no more than 15 days only if more time is needed due to circumstances beyond control of the Surest Plan. Surest will notify you if Surest determines that the additional time is needed before the 15 days expires.	
You must appeal an Adverse Benefit Determination no later than:	**180 days** after receiving the Adverse Benefit Determination
Appeals (Pre-Service)	**Appeals Timing**
Surest must notify you of the first-level medical Claim appeal decision within:	**15 days** after receiving a complete first-level medical Claim appeal
You must appeal the first-level medical Claim appeal (file a second-level medical Claim appeal) within:	**60 days** after receiving the first-level medical Claim appeal decision
Surest must notify you of the second-level medical Claim appeal decision within:	**15 days** after receiving a complete second-level medical Claim appeal

Post-Service Medical Claim Request for Benefits and Appeal*

Post-Service Claim	Claims Timing
If your medical Claim is incomplete, Surest must notify you within:	**30 days**
You must then provide completed medical Claim information to Surest within:	**45 days**
Surest must notify you of the Benefit determination:	
• If the initial medical Claim is complete, within:	**30 days**
• After receiving the completed medical Claim (if the initial medical Claim is incomplete), within:	**30 days**
*Surest may require a one-time extension for the initial Post-Service Claim determination, of no more than 15 days only if more time is needed due to circumstances beyond control of the Surest Plan. Surest will notify you if Surest determines that the additional time is needed before the 30 days expires.	
You must appeal an Adverse Benefit Determination no later than:	**180 days** after receiving the Adverse Benefit Determination

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Appeals (Post-Service)	Appeals Timing
Surest must notify you of the first-level medical Claim appeal decision within:	**30 days** after receiving the first-level medical Claim appeal
You must appeal the first-level medical Claim appeal (file a second-level medical Claim appeal) within:	**60 days** after receiving the first-level medical Claim appeal decision
Surest must notify you of the second-level medical Claim appeal decision within:	**30 days** after receiving the second-level medical Claim appeal

Concurrent Care Request for Benefits

In some cases, you may have an ongoing course of treatment approved for a specific period of time or a specific number of treatments, and you may want to extend that course of treatment. This is called a Concurrent Care Claim.

If your extension request is not “urgent” (as defined in the previous section), your request will be considered a new request and will be decided according to the applicable procedures and timeframes. If your request for an extension is urgent you may request expedited processing.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Surest will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If we inform you about our decision orally, we will follow up within three business days with a written or electronic notice.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Please note that the decision is based only on whether or not Benefits are available under the Surest Plan for the proposed treatment or procedure.

If your Concurrent Care Claim is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request expedited review). You may have the right to an external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in decision letter to you from Surest.

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Notice of Claim Denial on Appeal

If your Claim is denied on review, the reviewer will provide you with a notice of the Adverse Benefit Determination that will:

- Be written in a manner designed to be understood by an average individual and, where required by law, in a culturally and linguistically appropriate manner.
- Include information sufficient to identify the Claim involved (including the date of service, the health care Provider, and the Claim amount [if applicable]); you can also request from the reviewer the diagnosis and treatment codes and their explanation.
- Include the specific reasons for the Adverse Benefit Determination (including the denial code and its meaning and a description of the Plan's standard, if any, that was used in denying the Claim and a discussion of the decision).
- Refer to the specific Plan provisions on which the determination was based.
- Inform you that, upon request and free of charge, you are entitled to reasonable access to, and copies of, all documents, records, and other information relevant to the Claim for Benefits.
- Notify you of your right to bring legal action under ERISA.
- Include a copy of any internal rule, protocol or criterion that was relied on in making the determination or indicate that a copy of such material is available (free of charge) upon request.
- Either explain the scientific or clinical judgment made or indicate that such an explanation is available upon request, free of charge, if the determination was based on Medical Necessity or similar exclusion or limit.
- Contain a statement about the availability of contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.
- A statement about any voluntary appeal procedures your Plan may offer.
- Notify you that you can contact the Department of Labor or State Insurance Regulatory Agency to learn about other voluntary alternative dispute resolution options.

The reviewer’s decision on appeal is the final internal Adverse Benefit Determination.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Surest, you may be entitled to request an external review. The process is available at no charge to you.

You can also start the external review process without exhausting the internal appeals if Surest fails to follow the internal appeals process described above (unless it is a minor failure).

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If one of the above conditions is met, you may request an external review of Adverse Benefit Determinations based upon any of the following:

- Medical judgement and/or Clinical reasons — for example Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered Benefit.
- A determination that a treatment, service, drug, or device is an Experimental or Investigational Service(s) or Unproven Service(s).
- Whether a Participant is entitled to a reasonable alternative standard for a reward under a wellness program.
- A determination as to whether a Plan is complying with non-quantitative mental health parity requirements.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, call Surest Member Services or by sending a written request to the address set out in the determination letter. A request must be made within 120 days after the date you received the final internal Adverse Benefit Determination letter from Surest.

An external review request should include all of the following:

- A specific request for an external review.
- The Participant’s name, address, and member ID number.
- Your designated representative’s name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). Surest has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available, and both are free to you.

Standard External Review

A standard external review comprises of all of the following:

- A preliminary review by Surest of the request completed within five business days following Surest’s receipt of the request.
- A referral of the request by Surest to the IRO.
- A decision by the IRO.

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Within the applicable timeframe after receipt of the request, Surest will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following criteria:

- Is or was covered under the Surest Plan at the time the health care service or procedure that is at issue in the request was provided.
- The denial does not relate to your eligibility to participate in the Plan.
- Has exhausted the applicable internal appeals process or is deemed to have exhausted the internal appeals process.
- Has provided all the information and forms required for Surest to process the request.

After completing the preliminary review, Surest will issue a notification in writing to you within one business day. If the request is eligible for external review, Surest will assign an IRO to conduct such review. Surest will assign requests by either rotating assignments among the IROs or by using a random selection process.

If the request is complete but not eligible for external review, Surest will provide notification that includes the reasons for ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete; you will have at least 48 hours (or, if longer, until the end of the four-month filing period) to complete the request.

The IRO will timely notify you in writing whether the request is eligible for external review. Within 10-business days following the date of receipt of the notice, you may submit in writing to the IRO additional information for the IRO to consider in conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after 10-business days.

Surest will provide to the assigned IRO the documents and information considered in making the determination, including:

- All relevant medical records.
- All other documents relied upon by Surest.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and Surest will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the Claim as new and not be bound by any decisions or conclusions reached by Surest. The IRO will provide written notice of its determination (the “Final External Review Decision”) within 45 days after receiving the request for the external review (unless they request additional time, and you agree). The IRO will deliver the notice of Final External Review Decision to you and Surest, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the determination made by Surest, the Surest Plan will immediately provide coverage or payment for the Benefit Claim at issue in

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accordance with the terms and conditions of the Surest Plan, and any applicable law regarding Plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Surest Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The time for completing the review process is much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An Adverse Benefit Determination of a Claim or appeal if the Adverse Benefit Determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure, or product for which the individual received Emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, Surest will determine whether the individual meets both of the following criteria:

- Is or was covered under the Surest Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that Surest may process the request.

After completing the review, Surest will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, Surest will assign an IRO in the same manner Surest utilizes to assign standard external reviews to IROs. Surest will provide all necessary documents and information considered in making the Adverse Benefit Determination or final Adverse Benefit Determination to the assigned IRO electronically, by telephone, facsimile, or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the Claim as new and not be bound by any decisions or conclusions reached by Surest. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the

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initial notice the assigned IRO will provide written confirmation of the decision to you and to Surest.

You may contact Surest Member Services for more information regarding external review rights, or if you are making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against the Plan Administrator or Claim Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your Claim have been completed.

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9. What are My Rights under ERISA?

Statement of ERISA Rights

A Participant under the Surest Plan is entitled to certain rights and protections under ERISA, which provides that all Participants shall be entitled to:

- Receive information about the Surest Plan and Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Surest Plan, including insurance contracts and collective bargaining agreements, if applicable, and a copy of the latest annual report (Form 5500 Series), if required to be filed by the Surest Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Surest Plan, including insurance contracts and collective bargaining agreements, if applicable, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of this Plan's annual financial report if an annual financial report is required. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Surest Plan Coverage

- Continue health care coverage for the employee or dependents if there is a loss of coverage under the Surest Plan as a result of a qualifying event. Participants may have to pay for such coverage. Review Section 10 (Continuation of Coverage) in this document and the Surest Plan rules governing COBRA continuation coverage rights.

Prudent Actions by Surest Plan Fiduciaries

- In addition to creating rights for Surest Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participants.
- No one, including the employer, a union, or any other person, may fire an employee or otherwise discriminate against an employee in any way to prevent him/her from obtaining a welfare benefit or exercising rights under ERISA.

Enforce Rights

- If a Claim for a welfare benefit is denied or ignored, in whole or in part, a Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Section 8 [What Do I Do If My Claim Is Denied]).
- Under ERISA, there are steps Participants can take to enforce the above rights. For instance, if a Participant requests a copy of Surest Plan documents or the latest annual report from this Plan and does not receive them within 30 days, the Participant may file

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suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant up to $110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Participant has a Claim for Benefits that is denied or ignored, in whole or in part, the Participant may file suit in a state or Federal court after exhausting the appeal procedures provided in the Surest Plan (see Section 8 [What Do I Do If My Claim Is Denied]). In addition, if a Participant disagrees with the Surest Plan's decision or lack thereof concerning the qualified status of a medical child support order, the Participant may file suit in Federal court. If it should happen that Plan fiduciaries misuse this Plan's money, or if a Participant is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor or may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person he/she has sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees — for example, if it finds the Claim is frivolous.

- Exhaustion of administrative procedures required. To the fullest extent permitted under applicable law, the right to maintain a court action is subject to the Plan's requirements that administrative procedures be completed first. This is called exhaustion of administrative remedies. Failure to exhaust administrative procedures may preclude you from bringing an action in court.

Assistance with Questions

- For questions about this Plan, contact the Plan Administrator.
- For questions about this statement or about a Participant's rights under ERISA, or if a Participant needs assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.
- A Participant may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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10. Continuation of Coverage

COBRA Continuation Coverage

Under certain circumstances, a Participant may elect to continue coverage under the Surest Plan in accordance with COBRA.

A Participant whose coverage is ending may be able to elect to continue the coverage. Continued coverage shall be provided as required under COBRA. The Plan Sponsor shall, within the parameters of the law, establish uniform policies for the purpose of providing such continuation of coverage.

COBRA requires most employers with 20 or more employees to offer employees and their families the opportunity to pay for a temporary extension of coverage (called “continuation coverage”) at group rates in certain instances where coverage would otherwise end. This information is provided with respect to the Surest Plan.

There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may be required to pay the entire premium for the continuation coverage until the end of the maximum coverage period.

This notice is intended to inform Participants under the Surest Plan, in summary fashion, of their rights and obligations under the continuation coverage provisions of this law. It does not fully describe your continuation coverage rights. For additional information about your rights and obligation under the Surest Plan and under federal law, you should contact the Plan Administrator. It is intended that no greater rights be provided than those required by the law.

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

When Continuation Coverage is Available

Continuation Coverage is available in the following circumstances:

- **Qualifying Event.** A qualifying event is the occurrence of a specified event (described below) that results in a loss of coverage under the terms of the Surest Plan. Upon the occurrence of a “qualifying event,” each person that loses coverage has rights as a “qualified beneficiary.”
- **Qualified Beneficiary.** A qualified beneficiary is the employee and/or the employee’s spouse or dependent children who on the day before the qualifying event were covered under the Surest Plan. In addition, a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is a qualified beneficiary. Furthermore, an individual for whom the employee must provide coverage

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under the Surest Plan pursuant to a Qualified Medical Child Support order (QMCSO) is a qualified beneficiary.

- **Employee Loss of Coverage.** If covered by the Surest Plan, the employee has the right to elect continuation coverage if they lose coverage under the Surest Plan due to termination of employment (other than for gross misconduct) or a reduction in hours of employment.
- **Spouse or Dependent Child's Loss of Coverage.** If covered by the Surest Plan, a spouse or dependent child has the right to elect continuation coverage if they lose coverage under the Surest Plan due to any of the following:
  - The employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment.
  - The employee's death.
  - The employee's entitlement to (actual coverage under) Medicare.
  - The spouse or child ceasing to be a dependent under the terms of the Surest Plan.

Participant's Responsibility to Notify

In certain circumstances, you are required to provide notification to the Plan Administrator to protect your rights under COBRA. These circumstances are:

- **Notice of Qualifying Event.** Under the law, the Participant (or a representative acting on behalf of the Participant) has the responsibility to inform the Plan Administrator of a spouse or child losing dependent status under the Surest Plan within 60 days of the latest of:
  - The date of the qualifying event.
  - The date coverage would be lost because of the qualifying event.
  - The date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so.

  The notice must be provided in writing and be mailed to the Plan Administrator at the address identified below. Oral notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notice must be postmarked no later than the last day of the 60-day notice period described above. The notice must:
  - State the name of the Surest Plan.
  - State the name and address for the employee or former employee who is or was covered under the Surest Plan.
  - State the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the qualifying event.
  - Include a detailed description of the event.
  - Identify the Effective Date of the event.
  - Be accompanied by any documentation providing proof of the event (e.g., a death certificate).

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If the required notification is not received within the required time period, no continuation coverage will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within 30 days. If the missing information is not provided within that time, the notification will be ineffective, and no continuation coverage will be provided.

- **Notice of the Second Qualifying Event.** In addition, the Participant (or a representative acting on behalf of the Participant) must notify the Plan of the death of the employee or a spouse or dependent child ceasing to be eligible for coverage as a dependent under the Surest Plan, if that event occurs within the 18-month continuation period (or an extension of that period for disability or for pre-termination Medicare entitlement). The notification must be provided within 60 days after such a second qualifying event occurs for the qualified beneficiary to be entitled to an extension of the continuation period. The notification must be provided in writing and be mailed to the Plan at the address identified below. Oral notice, including notice by telephone, is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notice must be postmarked no later than the last day of the 60-day notice period described above. The notification must:
  - State the name of the Surest Plan.
  - State the name and address for the employee or former employee who is or was covered under the Surest Plan.
  - State the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the qualifying event and who are receiving COBRA coverage at the time of the notice.
  - Identify the nature and date of the initial qualifying event that entitled the qualified beneficiaries to COBRA coverage.
  - Include a detailed description of the event.
  - Identify the Effective Date of the event.
  - Be accompanied by any documentation providing proof of the event (e.g., divorce decree).

  If the required notification is not received within the required time period, no extension of the continuation coverage will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within 30 days. If the missing information is not provided within that time, the notification will be ineffective, and no extension of the continuation period will be provided.

- **Notice of Disability.** The Participant (or a representative acting on behalf of the Participant) must notify the Plan Administrator when a qualified beneficiary has been determined to be disabled under the Social Security Act within 60 days of the latest of:
  - The date of the disability determination.

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- The date of the qualifying event.
- The date coverage would be lost because of the qualifying event.
- The date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so.

In addition, the notice must be provided before the end of the first 18 months of continuation coverage.

The notice must be provided in writing and be mailed to the Plan Administrator at the address identified below. Oral notice, including notice by telephone, is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notice must be postmarked no later than the last day of the 60-day notice period described above. The notification must:

- State the name of the Surest Plan.
- State the name and address of the Employee or former employee who is or was covered under the Surest Plan.
- State the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice.
- Identify the nature and date of the initial qualifying event that entitled the qualified beneficiaries to COBRA coverage.
- State the name of the disabled qualified beneficiary.
- Identify the date upon which the Social Security Administration made its determination of disability.
- Include a copy of the determination of the Social Security Administration.

If the required notification is not received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the Plan to which it applies, the identity of the Employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within 30 days. If the missing information is not provided within that time, the notification will be ineffective, and no extension of the continuation period will be provided.

If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the Plan Administrator of that determination with 30 days or the later of:

- The date of the termination.
- The date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so.

The notice must be in writing and be mailed to the Plan Administrator at the address identified below. Regardless of when the notification is provided, continuation coverage will terminate retroactively on the first day of the month that begins 30 days after the

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date of the determination, or the end of the initial coverage period, if later. If you do not provide the notification within the required time, the Surest Plan reserves the right to seek reimbursement of any Benefits provided by the Surest Plan between the date coverage terminates and the date the notification is provided.

Failure to provide timely and complete notice ends the right to COBRA continuation coverage.

COBRA Administrator

UnitedHealthcare

Election Rights

When a qualifying event occurs, or when the Plan Administrator is notified that a qualifying event has occurred in the case of those events in which the employee has an obligation to provide notice, the Plan Administrator must notify the qualified beneficiaries of the right to elect continuation coverage. Qualified beneficiaries have 60 days to elect continuation coverage measured from the later of:

- The date coverage would be lost because of a qualifying event.
- The date a notice of election rights is provided.

An election is considered made on the date sent. If continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If continuation coverage is not elected within this period, coverage under the Surest Plan ends.

Each qualified beneficiary has an independent right to elect continuation coverage. Employees may elect continuation coverage on behalf of all qualified beneficiaries, and parents may elect continuation coverage on behalf of their children. Furthermore, other third persons can elect continuation coverage on behalf of a qualified beneficiary.

Qualified beneficiaries are allowed to maintain continuation coverage as follows:

- **18 months.** If the qualifying event is the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment, the continuation period is 18 months measured from the date coverage would otherwise be lost because of the qualifying event.
- **Disability Extension.** For qualified beneficiaries receiving continuation coverage because of the employee's termination or reduction in hours, the continuation period may be extended 11 months, for a total maximum of 29 months, where a qualified beneficiary receives a determination under the Social Security Act that at the time of the employee's termination of employment or reduction of hours, or within 60 days of the start of the 18-month continuation period, the qualified beneficiary was disabled. The extension is available to all qualified beneficiaries in the family group.
- **Pre-Qualifying Event Medicare Extension.** The 18-month continuation period may be extended if the employee became entitled to (actually covered under) Medicare prior to the employee's termination of employment (other than for gross misconduct) or a

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reduction in hours. Qualified beneficiaries other than the employee are entitled to the greater of:

- 18 months measured from the qualifying event.
- 36 months measured from the date of the employee's Medicare entitlement.

- **36 months.** For qualifying events other than termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period is 36 months measured from the date coverage would otherwise be lost because of the qualifying event.
- **Second Qualifying Events.** If during the initial 18-month continuation period (or during an extension of that period for disability or for pre-termination Medicare entitlement) a second qualifying event occurs (e.g., death of employee, loss of dependent status) that would have caused the qualified beneficiary to lose coverage under the Surest Plan had the first qualifying event not occurred, the continuation period for the particular qualified beneficiaries affected by the second qualifying event may be extended to 36 months.

Under no circumstances may the total continuation period be greater than 36 months from the date coverage would otherwise be lost because of the original qualifying event that triggered the continuation coverage.

Type of Coverage

Initially, continuation coverage will be the same coverage as immediately preceding the qualifying event. Thereafter, continuation coverage must be identical to the coverage provided to similarly situated employees and dependents that have not experienced a qualifying event. Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active employees to change their coverage options or to add or eliminate coverage for dependents at Open Enrollment. In addition, Special Enrollment Rights under HIPAA will apply to those who have elected COBRA.

Under the law, a person electing continuation coverage may be required to pay all or part of the cost of continuation coverage. You will receive additional information regarding the cost requirements following the occurrence of a qualifying event. The amount charged cannot exceed 102% of the cost to the plan providing the coverage. The amount charged may be increased to 150% for the months after the 18th month of continuation coverage when the additional months are due to a disability under the Social Security Act. Payment is generally due monthly. Payment is considered "made" on the postmark date.

The law provides that continuation coverage shall automatically end before the end of the maximum continuation period for any of the following reasons:

- The employer no longer provides group health coverage to any of its employees.
- The premium for continuation coverage is not paid on time (including any applicable grace period).
- After electing COBRA, the qualified beneficiary becomes covered under another group plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition of the qualified beneficiary.

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- After electing COBRA coverage, the qualified beneficiary becomes entitled to (actually covered under) Medicare.

The Participant (or a representative acting on behalf of the Participant) must notify the Plan Administrator immediately if any qualified beneficiary actually becomes covered by another group health plan or Medicare. Regardless of when such notification is provided, coverage will terminate on the date of the coverage under the other group health plan or Medicare. If, for whatever reason, a qualified beneficiary receives any Benefits under the Surest Plan after coverage is to cease under these rules, the Surest Plan reserves the right to seek reimbursement from the qualified beneficiary.

Insurability and Conversion. A qualified beneficiary does not have to demonstrate insurability to elect continuation coverage. At the conclusion of the available continuation coverage, the Plan Administrator will provide an opportunity to convert to individual coverage if such coverage is offered under the Surest Plan.

Address Changes. Important information is distributed by mail. To protect your rights and the rights of your family, if a qualified beneficiary's address changes, the qualified beneficiary or someone on his/her behalf should notify the Plan Administrator immediately.

Other Coverage Options. Instead of enrolling in COBRA continuation coverage, there may be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at healthcare.gov.

More Information. You should contact the Plan Administrator with any questions about COBRA continuation coverage. Also, for more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation Rights under Uniformed Services Employment and Reemployment Rights Act (USERRA)

Although USERRA protections look similar to COBRA protections, USERRA rights are separate and independent from COBRA rights.

In addition to COBRA rights, a Participant may be entitled to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). USERRA requires your employer to offer employees and their spouse and/or dependent children the opportunity to pay for a temporary extension of health coverage (called "USERRA continuation coverage") at group rates where health coverage under employer-sponsored group health plan(s) would otherwise end because of the employee's service in the uniformed services (e.g., for service in the military).

This section is intended to inform Participants, in summary fashion, of their rights and obligations under the continuation coverage provision of USERRA. It is intended that no

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greater rights be provided than those required by this law. It does not fully describe your USERRA continuation coverage rights. For additional information about your rights and obligations under the Surest Plan and under federal law, you should contact the Plan Administrator.

Service Leave Event. If covered under the Surest Plan, the employee has the right to elect USERRA continuation coverage for him/herself, his/her spouse, and his/her dependents if they lose coverage under the Surest Plan due to an absence from employment for service in the uniformed services (a “service leave”).

Service in the Uniformed Services. Service in the uniformed services generally means the voluntary or involuntary performance of duties in the uniformed services. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

Election Rights. You have 60 days to elect USERRA continuation coverage, measured from the date your absence from employment for the purpose of performing service begins. An election is considered made on the postmark date. If USERRA continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If USERRA continuation coverage is not elected within this period, coverage under the Surest Plan ends. However, if no election is made in a situation in which you are not required (in accordance with USERRA) to provide advance notice of your service (e.g., because such notice was impossible, unreasonable, or precluded by service necessity), your coverage will be reinstated on a retroactive basis upon your election to continue coverage (regardless of when it is received) and payment of all unpaid amounts due.

Unlike COBRA, USERRA does not give your spouse or dependent child(ren) an independent right to elect USERRA continuation coverage. Their coverage may be continued only if you elect USERRA continuation coverage.

Maximum Continuation Period. The law requires that you generally be allowed to maintain USERRA continuation coverage for a 24-month period beginning on the date of your absence from employment for the purpose of performing service begins.

Type of Coverage. Initially, the coverage will be the same coverage as immediately preceding your service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated employees or dependents that are not on service leave.

Cost. A Participant electing USERRA continuation coverage may be required to pay all or part of the cost of USERRA continuation coverage. If you perform service in the uniformed services for fewer than 31 days, you will pay the same amount for the coverage that you normally pay. If your service exceeds 30 days, the amount charged cannot exceed 102% of the cost to the Plan providing the coverage. Payment is generally due monthly on the first day of the month. Payment is considered made on the postmarked date. You will be given a grace period of 30 days within which to make the payment.

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Termination of the Continuation Coverage. The USERRA continuation coverage may be terminated before the end of the maximum continuation period for any of the following reasons:

- The employer no longer provides group health coverage to any of its employees.
- The premium for USERRA continuation coverage is not paid on time (including the grace period).
- Termination for cause under the generally applicable terms of the Surest Plan (e.g., submission of fraudulent benefit Claims).

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11. What Else Do I Need to Know?

11.1 Important Administrative Information

Name of the Surest Plan	Nelnet: Surest Plan
Coverage Plan Year	1/1/2026 through 12/31/2026
Plan Sponsor	Nelnet, Inc. 121 S 13th St; Ste 201 Lincoln, NE 68508
Plan Sponsor's Employer Identification Number (EIN)	84-0748903
Plan Number (from ERISA 5500 form)	501
Type of Surest Plan	Welfare benefit plan providing group health Benefits.
Funding	The Surest Plan is self-insured, meaning that Benefits are paid from the general assets of the Plan Sponsor and are not guaranteed under a Benefit policy or contract. The Plan Sponsor determines the amount of employee contributions to the Surest Plan, based on estimates of Claims and administrative costs.
Plan Administrator	Nelnet, Inc. 121 S 13th St; Ste 201 Lincoln, NE 68508
Agent for Legal Process	If you wish to file suit, legal papers may be serviced on the Plan Administrator at the address listed below: Nelnet, Inc. 121 S 13th St; Ste 201 Lincoln, NE 68508

11.2 Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Surest Plan will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating Benefits.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

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The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charge (defined below).

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan**. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan**. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

For purposes of this section, terms are defined as follows:

A. **Plan**. A Plan is any of the following that provides Benefits or services for medical, pharmacy, or dental care or treatment. If separate contracts are used to provide coordinated coverage for Participants of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans, or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care Benefits to which the COB provision applies, and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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C. **Order of Benefit Determination Rules**. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its Benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its Benefits after those of another Plan and may reduce the Benefits it pays so that all Plan Benefits do not exceed 100% of the total Allowable Expense.

D. **Allowable Expense.** Allowable Expense is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Participant is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its Benefits.
5. The amount of any benefit reduction by the Primary Plan because a Participant has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, pre-certification of admissions, and preferred Provider arrangements.

E. **Closed Panel Plan.** Closed Panel Plan is a Plan that provides health care benefits to Participants primarily in the form of services through a panel of Providers that have

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contracted with or are employed by the Plan, and that excludes benefits for services provided by other Providers, except in cases of Emergency or referral by a panel member.

F. **Custodial Parent.** Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year, excluding any temporary visitation.

What Are the Rules for Determining the Order of Benefit Payments?

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Employee or Dependent**. The Plan that covers the person as an employee, Participant, policyholder, or subscriber is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as an employee, Participant, policyholder, or subscriber, then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, Participant, policyholder, or subscriber is the Secondary Plan and the other Plan is the Primary Plan.
2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, Plans covering a dependent child shall determine the order of benefits as follows:
    a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

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(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan.

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's Plan is the Primary Plan. This shall not apply with respect to any Plan Year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the custodial parent.

(b) The Plan covering the custodial parent's spouse.

(c) The Plan covering the non-custodial parent.

(d) The Plan covering the non-custodial parent's spouse.

c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' Plans and also has their own coverage as a dependent under a spouse's Plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's Plan began on the same date as the dependent child's coverage under either or both parents' Plans, the order of benefits shall be determined by applying

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the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Laid-off Employee.** The Plan that covers a person as an active employee (i.e., an employee who is neither laid off nor retired), is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 2.d)(i) above can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, Participant, subscriber, or retiree or covering the person as a dependent of an employee, Participant, subscriber, or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 2.d)(i) above can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan, and the Plan that covered the person the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the Secondary Plan will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the Claim do not exceed the total Allowable Expense for that Claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Participant is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

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C. This Plan reduces its Benefits as described below for Participants who are eligible for Medicare when Medicare would be the Primary Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

1. The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
2. The person is enrolled in a Medicare Advantage (Medicare Part C) Plan and receives non-Covered Health Services because the person did not follow all rules of that Plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
3. The person receives services from a Provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the Provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
4. The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or any other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
5. The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you do not enroll and maintain that coverage, and if we are secondary to Medicare, we will pay Benefits under this coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating Provider if either of the following applies:

1. You are eligible for, but not enrolled in, Medicare and this coverage Plan is secondary to Medicare.
2. You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating this coverage Plan's Benefits in these situations for administrative convenience, we may, as we determine, treat the Provider’s billed charges, rather than the Medicare-approved amount or Medicare limiting charge, as the Allowable Expense for both This Plan and Medicare.

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Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under This Plan and other Plans covering the person claiming Benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give us any facts we need to apply those rules and determine Benefits payable. If you do not provide the information Surest needs to apply these rules and determine the Benefits payable, your claim for Benefits may be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Does This Plan Have the Right of Recovery?

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

11.3 Subrogation, Overpayment and Reimbursement

Subrogation and Refund

A Participant may incur medical expenses due to illness or injuries that may be caused by the act or omission of a Third Party. Also, a Third Party (such as an insurance company) may be responsible for payment on account of the actions of another person or entity. In such circumstances, the Participant may have a claim against the Third Party for payment of medical expenses. Accepting Benefits under the Plan/Surest Plan for those incurred medical expenses automatically assigns to the Plan/Surest Plan any rights the Participant may have to Recoveries from any Third Party up to the full amount of such Benefits. This Subrogation right allows the Plan/Surest Plan to pursue any claim that the Participant has against any Third Party, whether or not the Participant chooses to pursue that claim. The Plan/Surest Plan may make a claim directly against the Third Party, but in any event, the Plan/Surest Plan has an

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equitable lien on any amount of the Recovery of the Participant whether or not designated as payment for medical expenses. In addition, each Participant agrees to hold Recoveries in a constructive trust for the benefit of the Plan/Surest Plan. The equitable lien and constructive trust shall remain in effect until the Plan/Surest Plan is repaid in full. In the event that the Participant(s) dies as a result of their injuries and a wrongful death or survivor claim is asserted against a Third Party, the Plan's/Surest Plan's Subrogation and Refund rights shall still apply.

Assignment of Interest and the Plan's/Surest Plan's Recovery Right

The Participant:

- Automatically assigns to the Plan/Surest Plan their rights against any Third Party when this provision applies.
- Must repay to the Plan/Surest Plan the Benefits paid on their behalf out of any Recovery.

Each Participant is individually obligated to comply with the provisions of this section. When a Participant receives or claims Plan/Surest Plan Benefits for an illness or injury caused by another, the Participant agrees to immediately reimburse the Plan/Surest Plan from any Recovery for Benefits paid out by the Plan/Surest Plan.

Make Whole and Common Fund Doctrines Inapplicable

The Plan/Surest Plan expressly disavows and repudiates the make whole doctrine, which, if applicable, would prevent the Plan/Surest Plan from receiving a Recovery unless a Participant has been "made whole" with regard to illness or injury that is the responsibility of a Third Party. The Plan/Surest Plan also expressly disavows and repudiates the common fund doctrine, which, if applicable, would require the Plan/Surest Plan to pay a portion of the attorney fees and costs expended in obtaining a Recovery. These doctrines have no application to the Plan/Surest Plan since the Plan's/Surest Plan's Refund rights apply to the first dollars payable by a Third Party.

Duty to Cooperate

Participants are required to cooperate with the Plan Administrator to effectuate the terms of this section. Specifically, it is the Participant's obligation at all times, both prior to and after payment of medical Benefits by the Plan/Surest Plan:

- To cooperate with the Plan/Surest Plan, or any representatives of the Plan/Surest Plan, in protecting the Plan's/Surest Plan's rights, including discovery, attending depositions, and/or cooperating at trial.
- Provide prompt notice to the Plan/Surest Plan when a claim is made against a party for illness or injury.
- To provide the Plan/Surest Plan with pertinent information regarding the illness, disease, disability, or injury, including accident reports, settlement information, and any other requested additional information.
- To take such action and execute such documents as the Plan/Surest Plan may require to facilitate enforcement of its Subrogation and reimbursement rights.

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- To do nothing to prejudice the Plan's/Surest Plan's rights of Subrogation and Refund.
- To promptly reimburse the Plan/Surest Plan when a Recovery through settlement, judgment, award, or other payment is received.
- To not settle or release, without the prior consent of the Plan/Surest Plan, any claim to the extent that the Participant may have Recovery rights against any Third Party.

If the Participant and/or their attorney fails to reimburse the Plan/Surest Plan for all Benefits paid or to be paid from any Recovery, the Participant will be responsible for any and all expenses (including attorney fees and costs) associated with the Plan's/Surest Plan's attempt to Recover such money from the Participant or a Third Party.

Conditions Precedent to Coverage

The Plan/Surest Plan shall have no obligation whatsoever to pay medical Benefits to a Participant if a Participant refuses to cooperate with the Plan's/Surest Plan's Subrogation and Refund rights or refuses to execute and deliver such papers as the Plan/Surest Plan may require in furtherance of its Subrogation and Refund rights. Further, in the event the Participant is a minor, the Plan/Surest Plan shall have no obligation to pay any medical Benefits incurred on account of illness or injury caused by a Third Party until after the Participant or his or her authorized legal representative obtains valid court recognition and approval of the Plan's/Surest Plan's 100%, first-dollar Subrogation and Refund rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Other Coverage

When medical payments are available under other coverage, the Plan/Surest Plan shall always be considered secondary to such plans and/or policies. Other coverage shall include, but is not limited to:

- Any primary payer besides the Plan/Surest Plan.
- Any other group health plan.
- Any other coverage or policy covering the Participant.
- Any first-party insurance through medical payment coverage, personal injury protection, no-fault auto insurance coverage, uninsured or underinsured motorist coverage.
- Any policy of insurance from any insurance company or guarantor of a responsible party.
- Any policy of insurance from any insurance company or guarantor of a third party.
- Workers' compensation or other liability insurance company.
- Any other source Including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Offset

Failure by a Participant and/or his/her attorney to comply with any of the requirements described in this section may, at the Plan's/Surest Plan's discretion, result in a forfeiture of payment by the Plan/Surest Plan of future medical Benefits, and any funds or Benefits

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otherwise payable under the Plan/Surest Plan to or on behalf of the Participant may be withheld until the Participant satisfies his or her obligation.

Defined Terms

The following terms have special meanings for purposes of this section:

- "Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid by a Third Party to, or on behalf of, a Participant by way of judgment, settlement, or otherwise to compensate for all losses caused by an illness or injury, whether or not said monies are characterized as medical expenses covered by the Plan/Surest Plan. "Recoveries" includes, but is not limited to, Recoveries for medical expenses, attorney's fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages, and any other Recovery of any form of damages or compensation whatsoever.
- "Refund" means repayment to the Plan/Surest Plan for medical Benefits that the Plan/Surest Plan has paid toward care and treatment of an illness or injury suffered by a Participant as the result of acts or omissions of a Third Party. This right of Refund includes Recoveries by a Participant under an uninsured or underinsured motorist insurance policy, homeowner's policy, renter's policy, medical malpractice policy, or any liability insurance policy (each of which will be treated as Third Party coverage under this article).
- "Subrogation" means the Plan's/Surest Plan's right to pursue and place a lien upon the Participant's claims for medical expenses against the other person.
- "Third Party" means any individual or entity (including an insurance company) who is legally obligated to pay a Recovery to, or on behalf of, a Participant.

Erroneous Payments

To the extent payments made by the Plan/Surest Plan with respect to a Participant are in excess of the maximum amount of payment necessary under the terms of the Plan/Surest Plan, the Plan/Surest Plan shall have the right to Recover such payments, to the extent of such excess from any one or more of the following sources, as the Plan/Surest Plan shall determine any person to or with respect to whom such payments are made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan/Surest Plan determines are either responsible for payment or received payment in error, and any future Benefits payable to the Participant.

Excess Insurance

Except as otherwise provided under Section 11.2 (Coordination of Benefits) the following rule applies:

- If there is available, or potentially available, any coverage (including coverage resulting from a judgment at law or settlements), the Benefits under the Plan/Surest Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under Section 11.2 (Coordination of Benefits).
- The Plan's/Surest Plan's Benefits shall be excess to:
  - The responsible party, its insurer, or any other sources on behalf of that party.

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- Any first party insurance through medical payment coverage, personal injury protection, no-fault auto insurance coverage, uninsured or underinsured motorist coverage.
- Any policy of insurance from any insurance company or guarantor of a Third Party.
- Worker's compensation or other liability insurance company.
- Any other source, including crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds

Benefits paid by the Plan/Surest Plan, funds Recovered by the Participant(s), and funds held in trust over which the Plan/Surest Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s) or filing of bankruptcy by the Participant(s), will not affect the Plan's/Surest Plan's equitable lien, the funds over which the Plan/Surest Plan has a lien, or the Plan's/Surest Plan's right to Subrogation and reimbursement.

Severability

In the event that any provision of this section is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this section and the Plan/Surest Plan. The provision shall be fully severable. The Plan/Surest Plan shall be construed, and provisions enforced as if such invalid or illegal provision had never been inserted in the Plan/Surest Plan.

11.4 Plan Administrator's Responsibilities

Nelnet, Inc. is the Plan Sponsor and Plan Administrator of this Benefit Plan.

The Plan Administrator has the authority and discretion to interpret the Plan's terms and Benefits available under the Plan and to make factual and legal decisions about them. The Plan Administrator has powers and duties of the general administration of this Plan, including the following:

- To administer the Plan in accordance with its terms.
- Interpret this SPD.
- Develop policies, practices, and procedures for this Plan.
- Administer the Plan in accordance with those policies, practices, and procedures.

The Plan Administrator will exercise its discretion and fulfill its responsibilities in accordance with the provisions of ERISA. The Plan Administrator may delegate some of its responsibilities to Surest or to the individuals or entities as appropriate. Surest may make fiduciary decisions in its role as Claims Administrator. It may also make ministerial and non-fiduciary decisions to facilitate Plan administration, including but not limited to, developing, interpreting, and relying upon policies, practices, and procedures for the administration of the Surest Plan, but is not financially responsible for Claims.

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The Plan Administrator serves without compensation.

11.5 Other Information About Your Surest Plan

Conformity with Applicable Laws

It is intended that the Plan will conform to the requirements of any applicable federal, state, or local law, regulation, guidance, or the order or judgement of a court of competent jurisdiction, and this Plan will be deemed automatically amended to conform, including without limitation, in the event any law, regulation, guidance, or the order or judgement of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be deemed to be in accordance with the terms of the Plan.

Non-Discrimination Policy

This Plan will not discriminate against any Participant based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This Plan will not establish rules for eligibility based on health status, medical condition, Claims experience, receipt of health care, medical history, evidence of insurability, genetic information, or disability.

This Plan intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986 (Code). If the Plan Administrator determines before or during any Plan Year that this Plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on Benefits provided to highly compensated individuals, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated covered employees, to ensure compliance with such requirements or limitation.

Mental Health Parity

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

Newborns' and Mothers' Health Protection Act (NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the Surest Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Order Procedures

The Surest Plan will provide Benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA Section 609(a) or National Medical Support Notice. If the

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Surest Plan receives a medical child support order for your child that instructs the Surest Plan to cover the child, the Plan Administrator will review it to determine that it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Surest Plan as your dependent, and the Surest Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

Your Surest Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides Benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233) prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information. GINA expands on the provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in a number of ways:

- Group health plans and health insurers cannot base health care premiums for plans or a group of similarly situated individuals on genetic information.
- Plans and insurers are prohibited from requesting or requiring an individual to undergo a genetic test.
- Plans and insurers are prohibited from collecting genetic information (including family history) prior to or in connection with enrollment, or for underwriting purposes.

Patient Protection Notice

Nelnet: Surest Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at Benefits.Surest.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on your ID card.

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12. Glossary

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Surest Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Surest Plan.

Adverse Benefit Determination	An Adverse Benefit Determination is a denial, reduction of or a failure to provide or make payment, in whole or in part, for a Benefit, including those based on a determination of eligibility, application of utilization review, or Medical Necessity.
Ancillary Services	Items and services provided by out-of-network Physicians at a Network facility that are any of the following: • Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; • Provided by assistant surgeons, hospitalists, and intensivists; • Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary; • Provided by such other specialty practitioners as determined by the Secretary; and • Provided by an out-of-network Physician when no other Network Physician is available.
Authorized Representative	A person you appoint to assist you in submitting a Claim or appealing a Claim denial. You will be required to designate your Authorized Representative in writing. This could also be a Provider for urgent care Claims and expedited appeals. The appointment of an Authorized Representative is revocable by you.
Autism Spectrum Disorder	A range of complex neurodevelopmental disorders, characterized by persistent deficits in social communication and interaction across multiple contexts, restricted repetitive patterns of behavior, interests, or activities, symptoms that are present in the early development period that cause clinically significant impairment in social, occupational, or other important areas of functioning and are not better explained by intellectual disability or global developmental delay. Such disorders are determined by criteria set forth in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association*.
Benefits	Plan payments for Covered Health Services, subject to the terms and conditions of the Plan as explained in this SPD and any addendums or amendments.
Claim	A request for Benefits made by a Participant or his/her Authorized Representative in accordance with the procedures described in this SPD. It includes Prior Authorization requests; pre-service request for Benefits and appeals; urgent care request for Benefits and appeals; concurrent care request for Benefits and appeals; and post-services Claims.
Claims Administrator	Provides certain claim administration and other services for the Plan.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 as amended from time to time. A federal law that requires employers to offer continued health insurance coverage to certain Employees/Retirees and their covered dependents whose group health insurance has been terminated.
Continuity of Care	The option for existing Participants to request continued care from their current health care professional if they are no longer working with their health plan and is now considered out-of-network.
Cosmetic	Services, medications, and procedures that improve physical appearance but do not correct or improve a physiological function or are not Medically Necessary.

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Covered Health Service	Health care 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 this SPD. • Not excluded in this SPD.
Custodial Care	Services that are any of the following non-skilled care services: • Non-health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating. • Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.
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 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.
Designated Virtual Network Provider	A provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Services through live audio with video technology or audio only, and/or through federally compliant secure messaging applications.
Domiciliary Care	Living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.
Durable Medical Equipment (DME)	Medical equipment that is all of the following: • Ordered or provided by a Physician for outpatient use primarily in a home setting. • Used for medical purposes. • Not consumable or disposable except as needed for the effective use of covered DME. • Not of use to a person in the absence of a disease or disability. • Serves a medical purpose for the treatment of a sickness or injury. • Primarily used within the home.
Effective Date	The first day of the Plan Year if you have timely completed all applicable enrollment requirements.

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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 a percentage 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.
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: 1) Placing the health of the Participant (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. 2) Serious impairment to bodily functions. 3) Serious dysfunction of any bodily organ or part.

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Emergency Health Care Services	With respect to an Emergency: • An appropriate 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). For purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)). • 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: a) The attending Emergency Physician or treating Provider or facility, determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition. b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law. c) 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. d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law. e) Any other conditions as specified by the Secretary. The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.
ERISA	The Employee Retirement Income Security Act of 1974 as amended from time to time. The federal law that regulates retirement and employee welfare benefit plans maintained by employers.
E-Visit and Telephone Consult with Your Physician	Services provided by a Physician performed without physical face to face interaction, but through electronic (including telephonic) communication through an online portal or telephone. Examples are emails, texts, or patient portal messages.

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Experimental / Investigational Service(s)	A procedure, study, test, drug, equipment, or supply will be considered Experimental and/or Investigational if 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)	The EOB provides details about a Claim and explains what portion was paid to the Provider and what portion (if any) is the Participant's responsibility. The EOB is not a bill, it is a statement provided by the Claims Administrator to you, your Physician, or another health care professional that explains the Benefits provided (if any); the allowable reimbursement amounts; copayments; any other reductions taken; the net amount paid by the Surest Plan; and the reason(s) why the service or supply was not covered by the Surest Plan.
Gender Dysphoria	A disorder characterized by the diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association*.
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

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Medically Necessary / Medical Necessity	Health care services that are all of the following as determined by the Claims Administrator or the Claims Administrator's designee. • 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-related and addictive disorders, disease or its symptoms. • Not mainly for your convenience or that of your doctor or other health care provider. • 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 has the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by the Claims Administrator. 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 the Claims Administrator's determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Participants, Physicians and other health care professionals on Benefits.Surest.com. Participants may also call the telephone number on your ID card.
Network Pharmacy or Network Pharmacies	A retail or mail order pharmacy that has: • Entered into an agreement with an organization contracting on its behalf to dispense prescription drugs to Participants. • Agreed to accept specified reimbursement rates for dispensing prescription drugs. • Been designated by the Plan Administrator as a Network Pharmacy.
Observation Stay	Observation care consists of evaluation, treatment, and monitoring services (beyond the scope of the usual outpatient care episode) that are reasonable and necessary to determine whether the patient will require further treatment as an inpatient or can be discharged from the hospital.
Open Enrollment	A period of time where eligible persons are able to enroll, disenroll, and make Surest Plan changes without a life status change.
Participant	The eligible employee or dependent properly enrolled in the Surest Plan under the eligibility rules and only while such person(s) is enrolled and eligible for Benefits under the Surest Plan.
Pharmacy Benefit Manager (PBM)	A third-party administrator of prescription drug programs for commercial health plans and self-insured employer plans.
Pharmacy Claims Administrator	Also known as the Pharmacy Benefit Manager, or PBM, which provides administrative services for the Plan Administrator in connection with the operation of the pharmacy plan, including processing of Claims, as may be delegated to it.

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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 their license will be considered on the same basis as a Physician. The fact that the Claims Administrator describes a Provider as a Physician does not mean that Benefits for services from that Provider are available to you under the Surest Plan.
Plan	Nelnet: Surest Plan .
Plan Administrator	The person or entity, as defined under Section (3)(16) of ERISA, that has the exclusive, final, and binding discretionary authority to administer the Surest Plan, to make factual determinations, to construe and interpret the terms of the SPD, the Surest Plan, and amendments (including ambiguous terms), and to interpret, review and determine the availability or denial of Benefits. The Plan Administrator may delegate discretionary authority and may employ or contract with individuals or entities to perform day-to-day functions, such as processing Claims and performing other Surest Plan-connected administrative services.
Plan Sponsor	The entity that establishes and maintains the Surest Plan, has the authority to amend and/or terminate the Surest Plan and is responsible for providing funds for the payment of Benefits.
Plan Year	The period following the Effective Date of the Surest Plan and each subsequent period (generally 12 months) the Surest Plan remains in force.
Pre-Admission Notification	Process whereby the Provider or you inform the Surest Plan that you will be admitted to the inpatient hospital, Skilled Nursing Facility, long term acute care facility, inpatient rehabilitation facility, partial hospitalization, or Residential Treatment Facility. This notice is required in advance of being admitted for inpatient care for any type of non-Emergency admission and for partial hospitalization. All contracted facilities are required to provide Pre-Admission Notification to you.
Prior Authorization	Pre-service, urgent care request, concurrent care benefit coverage decision for a service, procedure, or test that has been subject to an evidence-based review resulting in a Medical Necessity determination.
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: • Services exceed the scope of intermittent care in the home. • 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.
Provider	A health care professional, Physician, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide health care services to you. The term “Provider” refers to an in-network Provider unless otherwise specified.

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Recognized Amount	The amount which the copayment is based on for the below Covered Health 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 Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.
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 treatment. The facility must meet all of the following requirements: • It is established and operated in accordance with applicable state law for Residential Treatment programs. • It provides a program of treatment under the active participation and direction of a Physician. • It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services: – 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.

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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.
Secretary	As that term applied in the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)*. This definition encompasses the secretary of HHS, DOL and Treasury.
Skilled Nursing Facility	A hospital or nursing facility that is licensed and operated as required by law. 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	A Physician who has a majority of their practice in areas other than those practicing in the areas of family practice, general medicine, internal medicine, obstetrics/gynecology or general pediatrics.
Specialty Drugs	Infusions, injectables and non-injectable prescription drugs, as determined by the Claim Administrator, which have one or more of the following key characteristics: • Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes. • Intensive patient training and compliance assistance are required to facilitate therapeutic goals. • There is limited or exclusive product availability and/or distribution. • There are specialized product handling and/or administration requirements. • Are produced by living organisms or their products.
Summary Plan Description (SPD)	The document describing, among other things, the Benefits offered under the Nelnet: Surest Plan and your rights and obligations under such benefit option as required by ERISA.
Surest Plan	Refers to the Surest health plan as used in this SPD.
Telehealth Visit	Live interactive audio with visual transmissions, and/or transmissions through federally compliant secure messaging applications of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Participant's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.
Transition of Care	The option for a new Participant to request coverage from your current, out-of-network health care professional at in-network rates for a limited time due to a specific medical condition, until the safe transfer to an in-network health care professional can be arranged.

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Unproven / Unproven Services	Services, including medications and devices regardless of *U.S. Food and Drug Administration (FDA)* approval, 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. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment isreceived.) • Well-conducted cohort studies from more than one institution. (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 sickness 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 sickness or condition. Prior to such a consideration, Surest must first establish that there is sufficient evidence to conclude that, even though Unproven, the service has significant potential as an effective treatment for that sickness or condition.
Usual and Customary	The amount allowed for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service. The usual and customary amount is used to determine the amount that may be charged by a Provider for the Benefits.
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).
Virtual Care	Virtual care is for Covered Health Services that include the diagnosis and treatment of medical and mental health conditions for Participants that can be appropriately managed virtually through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health care Specialist, through use of interactive audio and video communications equipment or through federally compliant secure messaging applications outside of a medical facility (for example, from home or from work).

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13. Outpatient Prescription Drugs

Capital Rx and Archimedes

GETTING FAMILIAR WITH PHARMACY BENEFITS

As a pharmacy benefit manager or PBM, our role is to oversee your prescription benefit plan. We work closely with your employer or health plan to offer the right balance of drug access and cost savings. The plan setup or features of your pharmacy benefit can impact where you can fill your prescriptions and your cost at the pharmacy.

WHAT FEATURES OF YOUR PHARMACY BENEFIT COULD IMPACT YOU?

Pharmacy Network: A pharmacy network is a group of pharmacies that we are contracted with to provide medication at a specific price. For a pharmacy to be part of our network, they must meet specific standards and go through a detailed review process. Each pharmacy in the network is reviewed on a recurring basis to ensure they consistently meet business standards. Different types of pharmacies can be included in a network. They are typically organized into channels called retail, mail order or specialty pharmacy. This part of your pharmacy benefit can affect your cost and drug access.

Copay or Coinsurance: A copay or coinsurance is a form of cost sharing between you and your employer or health plan. Copays are flat costs your pharmacy plan setup may have to determine what you pay for medications. Coinsurance also defines what you pay for medications, but it is calculated as a percentage rather than a flat cost.

Deductible: A deductible is another form of cost sharing but defines the amount you must pay before your plan will pay for covered medications. A deductible can be combined with your medical costs and will count toward one total amount. If a plan setup has a separate prescription deductible, only drug costs will count towards this amount.

Maximum Out-of-Pocket (MOOP): A maximum out-of-pocket (MOOP) is the most you will pay for your covered medications each year. This typically includes your deductible, coinsurance, and copay amounts. How or what costs apply to your MOOP is specific to each plan setup. Please note: Not all plans are set with these features. Please refer to your summary of benefits to review your plan in detail
At Capital Rx, your health is our top priority. We prepare formularies to ensure that you have access to a robust offering that meets your needs and lowers your overall prescription drug cost. Your pharmacy benefit covers many prescription drugs, but some exclusions may apply. If a drug is not covered, an alternative covered drug may be available.

WHAT ARE TERMS COMMONLY USED WHEN TALKING ABOUT FORMULARY?

Tier: Formularies are organized into categories called tiers. Each prescription drug is placed in a tier depending on the type of drug. Formularies are commonly divided into three tiers. Some plans may have more or less than three tiers, but how tiers are managed is the same.

Please note: Drugs that are newly approved by the Food and Drug Administration (FDA) may not be covered until they have been fully evaluated.

Prior Authorization (PA): Approval may be required before your pharmacy benefit plan will cover certain drugs. This process ensures you receive a prescription that is safe and is the most cost effective. Once notified by the pharmacy, your doctor will work with Capital Rx to complete paperwork to submit a prior authorization

Quantity Limit (QL): There is a limit on the maximum dosage or quantity for certain medications that are covered per prescription, or within a specific time frame. If you require a dose or quantity beyond what the limit allows, please work with your doctor to submit a prior authorization for approval.

Step Therapy (ST): You may be required to try another medication (usually a generic) prior to starting the medication your health care provider prescribed (usually a brand). If a medication you are prescribed has a step therapy program in place, please discuss your options with your health care provider.

FORMULARY RESOURCES FOR YOU & YOUR DOCTOR

To review if your medications have prior authorization, step therapy, and/or quantity limit requirements, log into the member portal and use the 'Lookup Formulary' tool.
Your health care provider can work with Capital Rx to complete paperwork needed for prior authorization requests. They can refer to www.cap-rx.com/prescribers#prescriber-forms to download a fillable form and more.
If you are prescribed a 90-day prescription for maintenance medications, you can fill your prescription through mail service.

Getting started with Costco Mail Pharmacy
Please reach out to your prescriber and update your mail order pharmacy provider as Costco.
Before prescriptions can be filled through Costco Pharmacy, you will need to setup an account using one of the following ways.
Online: Go to rx.costco.com and create a patient account.

Phone: Call Customer Care and follow the prompts for 'medications delivered to your home'. Select option 1 for 'assistance setting up an online pharmacy account'.
Please have your patient, prescriber, and payment information readily available.

Managing New Prescriptions and Refill Requests
Choose one of the following options to request refills of current prescriptions or to send new prescriptions to Costco Mail Pharmacy.

Mail: Go to rx.costco.com and access your patient account. Select refill or new prescriptions. follow the prompts to complete the request. Mail your paper prescription to Costco Pharmacy, 6801 Seaway Blvd., Suite A-2, Everett, WA 98203.

Fax: Have your prescriber fax your prescription to 1-877-258-9584. Faxed prescriptions may only be sent by a doctor's office and must include patient information.

E-prescribe: Have your prescriber electronically send your prescription to Costco Pharmacy Mail Order #1748, Zip Code 98203.

Outpatient Prescription Drug Plan Schedule of Benefits Table

The amounts you are required to pay as shown below are based on the Prescription Drug Charge for Network Benefits. Out-of-Network Pharmacy Benefits are not covered.

Retail Copays		
	1-30 Days	31-90 Days
Tier 1 (Generic)	$10	$20
Tier 2 (Preferred Brand)	$90	$180
Tier 3 (Non-Preferred Brands)	$120	$240
Mail Order Copays		
	1-90 Days	
Tier 1 (Generic)	$20	
Tier 2 (Preferred Brand)	$180	
Tier 3 (Non-Preferred Brands)	$240	
Specialty Copays		
	1-30 Days	
Specialty Drugs	$375* *Specialty medications are covered through Archimedes. Please call 888.504.5563, opt.2 for assistance.	
Special Coverage Rules		
• Diabetic medications & supplies have a $0 copay for all plans.		
General Therapeutic Categories		
INCLUSIONS	EXCLUSIONS	
Acne ADHD Anaphylactic Kits Fertility, oral & non-oral Narcolepsy Sexual Dysfunction, oral Spacers Syringe Tobacco Cessation Vaccines Vitamins: Multivitamins (requires a prescription) Vitamins: Prenatal Vitamins (requires a prescription) Weight Loss	Abortifacients Allergen Extracts; oral & non-oral Anabolic Steroids Cosmetic OTC Sexual Dysfunction, non-oral	

The Plan's specialty prescription drug benefits are administered by Archimedes.

Specialty Prescription Drug Covered Expenses

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. The Specialty Drug List can be found by logging into www.archimedesrx.com or by calling Archimedes member services at 888-504-5563 and is updated from time-to-time.

Up to a 30-day supply of specialty drugs will be covered at a time. Specialty drugs are only available through the approved Archimedes specialty pharmacy network.

Not all specialty drugs are covered by the benefit, and some specialty drugs may be covered under the medical benefit. Select specialty medications, typically covered under the medical benefit, may be covered under the pharmacy benefit only. You may be required to obtain select specialty medications that are typically covered under the medical benefit at the most cost-effective site of care. Likewise, select medications that are administered by a health care professional may be required to be obtained through your pharmacy benefit.

Some specific reasons a drug may not be covered are listed below. This list is subject to change.

- Drugs not approved by the U.S. Food and Drug Administration (FDA), which may also include off-label use (meaning drugs that may be prescribed but are not approved for that condition or age group).
- Drugs labeled “Caution: Limited by federal law to investigational use”.
- Any drug being used for cosmetic purposes.
- Medical devices or appliances.
- Prescription drugs not covered by a current prescription order.
- Drugs not listed on the Plan’s Formulary.
- Any compounded drugs that contain products excluded by the Plan.
- Drugs of unproven clinical efficacy and/or value.
- Drugs that have less expensive, but clinically equivalent alternatives.
- Products for nutritional support, unless required for coverage by the Affordable Care Act.
- Products recently approved by the FDA may not be covered upon release to the market.
- Coverage may be changed and/or the amount you pay may vary based on the condition being treated.

If your drug is not covered and you think it should be, you may ask us to make an exception to the drug coverage rules, by having your physician submit a statement that explains the medical reasons for requesting an exception. This letter and request can be faxed to 866-491-6971.

Pharmacy Network
Specialty prescriptions must be obtained through Acaria Health Pharmacy. In rare instances you may be required to use a different specialty pharmacy for medications that are available only

through limited distribution pharmacies. In those cases, you must use a pharmacy in the Archimedes specialty pharmacy network. You will be responsible for 100% of the drug costs if prescriptions are obtained at out-of-network pharmacies. Please contact Archimedes member services at 888-504-5563 for any questions about pharmacy access.

The Amount You Will Pay for Prescription Drug Coverage

Benefits are provided for the payment of the prescription charge, less the amount you pay, according to your benefit design, for each prescription order or refill. You will NEVER pay more than the cost of the drug. The amount you pay for each prescription order or refill will be determined based on the applicable "tier" (or level) of the drug, and the day supply of the drug. Refills of prescriptions are allowed after 75% of the previous prescription has been used (e.g., 23 days in a 30-day supply).

If the drug has copay assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design, $0 or the amount determined by the manufacturer-funded copay assistance program. Once copay assistance is exhausted, the amount you pay will be no more than your benefit design. Dollars used from copay assistance programs will not be considered member out-of-pocket costs and will not count toward your deductible and/or out-of-pocket maximums. If you received financial assistance such as a manufacturer's reimbursement or coupon, you are obligated to report the financial assistance amount including any supporting documentation as may be requested.

If you paid cash for a drug, the amount you paid for drug may count toward the deductible and/or out-of-pocket maximum amounts. For the amounts to be considered, you must submit the receipt using the Prescription Reimbursement Request Form. The form can be found by contacting Archimedes at 888-504-5563.

Non-Essential Health Benefits

Your plan covers select Non-Essential Health Benefits Drugs at the tiers outlined below. For Tier 6 drugs, if the drug has copay assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design, $0 or the amount determined by the manufacturer-funded copay assistance program. Because these medications do not qualify as Essential Health Benefits under the Affordable Care Act the amount you pay for Non-Essential Health Benefits Drugs, whether paid by you or a manufacturer copay assistance program, will NOT count toward your out-of-pocket maximum. A list of non-essential drugs can be found by logging in to www.archimedesrx.com or by contacting Archimedes at 888-504-5563.

Non-Essential Health Benefits Drugs	THE AMOUNT YOU PAY AT AN IN-NETWORK PHARMACY	THE AMOUNT YOU PAY AT AN OUT-OF-NETWORK
Tier 1 drugs	50% coinsurance	100%
Tier 2 drugs	70% coinsurance	100%
Tier 3 drugs	80% coinsurance	100%
Tier 4 drugs	90% coinsurance	100%
Tier 5 drugs	100% coinsurance	100%
Tier 6 drugs	Variable	100%
Maximum Day Supply	30 Days	N/A

Lifetime Maximums

Your plan covers up to $10,000 for medications used to treat infertility during your lifetime. The list of drugs to treat infertility may change from time-to-time and any claims for infertility medications are subject to your copays. If you use more than $10,000 of fertility medications, you will be responsible for any additional drug costs.

Generic and Brand-Name Medications
Prescription drugs are dispensed under three names: the biosimilar name, generic name and the brand name. Biosimilar drugs are alternatives to brand specialty drugs and are almost an identical copy. A generic drug is chemically equivalent to a brand drug for which the patent has expired. By law, biosimilar, generic and brand name medications must meet the same standards for safety, purity, and effectiveness.
If you choose a brand-name drug, when a generic or biosimilar is available, you may have to pay the copayment for the tier the drug is on that you are choosing plus the difference in cost between the brand drug and the generic or biosimilar drug. This cost difference will not apply to your deductible or out of pocket maximums.

Drug Coverage Guidelines - Quality and Utilization Management
To promote safety and clinically appropriate care while controlling costs, prescription drug coverage may be restricted in quantity or require prior authorization and/or step therapy through Drug Coverage Guidelines. These guidelines can be found in the pharmacy section of our website. You may also call the Customer Service Department number on the back of your ID card for more information.

a. Prior Authorization - The Plan requires a review to determine if the drug qualifies for coverage under the benefit. If your physician prescribes a drug that requires a prior authorization, the PBM will work with your prescriber to complete the prior authorization review. Either you or the pharmacy can ask your doctor to call 888-504-5563 to initiate the prior authorization or appeal process. You can also contact us via mail at:

   Archimedes
   Prior Authorizations and Appeals
   5250 Virginia Way, Suite 300
   Brentwood, TN 37027

   Prior Authorization Forms can be found at https://archimedesrx.com/resources. Once your prior authorization is reviewed, a clinician may contact your doctor to discuss your case and potential medication alternatives. Your doctor may change your prescription, when medically appropriate, to a different brand name or generic medication.
b. Quantity Restrictions - For certain drugs, the amount of the drug that will be covered by the plan is limited based on national standards and current scientific literature. These limits ensure the quantity of units supplied for each prescription remain consistent with clinical dosing guidelines and benefit plan design.

c. Step Therapy - In some cases, you are required to first try certain drugs to treat your medical condition before the Plan will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Plan may not cover Drug B unless you try Drug A first.

   Appeals - If you request authorization for a drug that is covered under the Archimedes benefit, and that request is clinically denied, you have the right to appeal that decision. This denial may be appealed twice, and if coverage is still denied, you have the option for your case to be reviewed by an Independent Review Organization (“IRO”) as a final review and coverage determination. Decisions issued by IRO cannot be appealed.

14. Carrum Health Benefit

Participants in the Plan have access to the Carrum Health Benefit, which provides enhanced coverage for certain planned procedures at participating Centers of Excellence. Through the Carrum Health Benefit, participants have access to specialized providers and facilities selected for their expertise in certain high-risk or high-cost procedures, referred to as “Centers of Excellence”.
Subject to limited exceptions described below, the Plan only provides coverage for the following procedures if they are provided by a Center of Excellence through the Carrum Health Benefit:

- Surgery
    - Bariatric (weight loss) surgery (requirement excludes revisions)

Participants may, but are not required to, use the Carrum Health Benefit for the following procedures or conditions:

- Surgery
    - Total, partial, and revision major joint replacement surgery (e.g., knee, hip, shoulder, ankle)
    - Spinal (back and neck) surgery
    - Minor orthopedic procedures (e.g., surgeries of the hand, wrist, elbow, shoulder, ankle, foot) other than major joint replacements*
    - Cardiac (heart) surgery (e.g., bypass, valve repair and replacement)
    - Gynecologic surgery (e.g., hysterectomy)
    - General surgery (e.g., gallbladder removal, hernia repair)*
    - Ear Nose Throat surgery (e.g., tonsillectomy, ear drum repairs, septum repairs)*
    - Urologic surgery (e.g., cystourethroscopy - bladder scope)*
- Non-surgical procedures
    - Pain Management (e.g., major joint steroid injections, spinal injections, ablations)*
    - Gastroenterology (e.g., colonoscopies, upper endoscopies/EGDs)*
- Substance Use Disorder treatment (e.g., alcohol, opioids, stimulants, cannabis, sedatives, hypnotics, and anxiolytics)
    - Detox
    - Residential treatment
    - Partial hospitalization (PHP)
    - Intensive outpatient (IOP)
    - Outpatient including virtual
- Cancer care
    - Advisory Program (virtual second opinions / expert reviews and support)
    - Treatment (e.g., excision surgery, chemotherapy, radiation treatment, supportive care such as psychosocial, nutrition and family support; excludes CAR T-cell therapy for certain hematologic cancers)**

* Only available for participants who reside within 150 miles of the nearest COE
** Some treatment may only be available for participants who reside within 150 miles of the nearest COE; please contact Carrum Health to learn more

This section describes the Carrum Health Benefit, including important conditions and restrictions. The Summary of Benefits Coverage table below summarizes coverage of the medical services available through the Carrum Health Benefit. As shown below, certain eligible services performed through the Carrum Health Benefit are covered at 100%, meaning there is no out-of-pocket spend for the participant such as copays or coinsurance, except that a participant in an HSA-eligible plan must meet their Federal Minimum deductible.

Summary of Benefits Coverage

	Carrum Health Benefit	In-Network	Out-of-Network
SURGERY			
Bariatric surgery (excludes revision)	100% covered; No Deductible*	Not covered**	Not covered**
Major joint replacement	100% covered; No Deductible*	$1,600-$3,500	$8,000
Spine Surgery	100% covered; No Deductible*	$1,900-$4,000	$8,000
Minor orthopedic	100% covered; No Deductible*	$900	$1,365
Cardiac	100% covered; No Deductible*	$1,900-$4,000	$8,000
Gynecologic	100% covered; No Deductible*	$1,800-$3,800	$8,000
General	100% covered; No Deductible*	$250-$4,000	$8,000
Ear Nose Throat	100% covered; No Deductible*	$70-$3,700	$400-8,000
Urologic	100% covered; No Deductible*	$800-$2,500	$3,800
NON-SURGICAL PROCEDURES			
Pain Management	100% covered; No Deductible*	$45-$145	$215
Gastroenterology	100% covered; No Deductible*	$0	$215

Substance Use Disorder	100% covered; No Deductible*	$45-$100	Not covered
Cancer care	100% covered; No Deductible*	$40-$540	$270-$1,620

Note that some procedures are subject to medical necessity and/or prior authorization with UHC.

* Due to federal tax law, participants enrolled in HSA-eligible plans must meet the Federal Minimum deductible before 100% coverage can be provided.

** See the section below titled **Coverage and Exceptions for Bariatric Surgery** for details regarding when coverage under the Plan is available without using the Carrum Health Benefit.

About Carrum Health

Carrum Health provides access to Centers of Excellence for planned medical care and coordinates the delivery of care with travel, communication and other non-medical aspects of the program. Carrum Health itself does not render any medical care or advice and does not recommend any particular medical providers or course of treatment.

To learn more about the Carrum Health Benefit or request a consultation with a Center of Excellence, please contact Carrum Health at 1-888-855-7806, Monday-Friday 9am-8pm EST, or visit carrum.me/nelnet. The ‘Carrum Health’ app is available to download on both iPhone and Android devices.

How It Works

Plan participants can contact Carrum Health at 1-888-855-7806, Monday-Friday 9am-8pm EST, online at carrum.me/nelnet, or by downloading the ‘Carrum Health’ app on iPhone and Android devices to search for and compare participating Centers of Excellence.

After contacting Carrum Health, a participant is assigned a Care Specialist to determine if the participant may be referred to a Center of Excellence and provide non-medical coordination throughout the entire episode of care. Care Specialist services can include assistance with selection of a Center of Excellence, medical records collection, appointment scheduling, and travel reservations and logistics management. The Care Specialist can also assist the participant with registration for the Carrum Health Benefit through the Carrum Health app and completion of required forms.

Participants are required to agree to Carrum Health’s Terms of Service and Member Registration Agreement and must also agree to provide their medical records and any other relevant information to their selected Center of Excellence as needed to schedule a consultation. Medical records and images may be collected on behalf of participants by their assigned Care Specialists. During the consultation, the Center of Excellence will determine if the participant is an appropriate candidate for the requested procedure. Receiving this consultation does not commit a participant to proceed with the procedure or to use the Carrum Health Benefit.

Covered Expenses

Medical

The Carrum Health Benefit covers all medical costs charged by the Center of Excellence that are related to the covered procedure with no Copay, Deductible, or Coinsurance (except those enrolled in an HSA-eligible plan will still be subject to the Federal Minimum Deductible).

Cancer Care

Cancer care covered through the Carrum Health Benefit includes:

- Cancer Advisory Program and ongoing support for all cancer diagnoses
- Treatment for cancer provided by Center of Excellence including:
    - Bone
    - Breast
    - Colorectal
    - Endocrine
    - Esophageal
    - Gynecologic
    - Head & Neck
    - Hematologic
    - Kidney
    - Liver
    - Lung
    - Neurologic
    - Prostate
    - Melanoma (skin)
    - Other cancers
- CAR (chimeric antigen receptor) T-cell therapy for specific hematologic cancers

Travel

The Carrum Health Benefit covers the cost of travel to the Center of Excellence, including transportation, lodging, meals and incidentals, depending on the distance of the participant from the Center of Excellence and the type of procedure requested. Please contact your Care Specialist or Carrum Health at 1-888-855-7806 or via the Carrum Health app for details regarding what travel benefits may be available with respect to your requested treatment.
For transportation and lodging to be covered under the Carrum Health Benefit, it must be booked by Carrum Health's Patient Care Team. Generally, the Patient Care Team will book travel on behalf of the participant for:

- Roundtrip transportation for an in-person consultation with a Center of Excellence, to the extent requested by the Center of Excellence, for the participant only
- Roundtrip transportation and hotel stay to receive the procedure at a Center of Excellence, for the participant and adult travel companion

Any stipend for meals and incidentals is provided via PayPal or prepaid Mastercard.
A participant will receive a Form 1099 reflecting any taxable travel benefits, such as lodging costs over federal tax limits and daily stipends.

Coverage Limitations and Disclosures

- To receive coverage under the Carrum Health Benefit, a Center of Excellence must determine that it will provide the requested procedure to the participant. A Center of Excellence may decline to treat a participant as it determines in its discretion, including, but not limited to, for failure to:
    1. identify a designated adult companion who is willing and able to meet caregiver requirements;
    2. be safe to travel to the Center of Excellence for medical care and not requiring emergency care at the time of travel;
    3. follow preoperative and postoperative instructions;
    4. provide all required medical history, labs, and diagnostic tests;
    5. make lifestyle changes required by the Center of Excellence as a condition of obtaining the covered procedure (e.g., stop smoking or lose weight); or
    6. refrain from committing an act of physical or verbal abuse or other threatening behavior to the staff of the Center of Excellence.
- To receive coverage under the Carrum Health Benefit, services MUST be scheduled and authorized by Carrum Health. If the participant does not use the Carrum Health Benefit, their care will be covered as outlined in the Summary of Benefits Coverage table above under “In-Network” and “Out-of-Network”, as applicable.
- Emergency medical services that are rendered by a Center of Excellence are not covered under the Carrum Health Benefit and are subject to the coverage limits, cost-sharing, and other terms of the Plan.
- Certain examinations, tests, or other medical services may be required before or after the participant visits the Center of Excellence under the Carrum Health Benefit. Any medical services not performed by a participating Center of Excellence facility or physician, including necessary pre-and post-acute care, are not covered under the Carrum Health Benefit and are subject to the coverage limits, cost-sharing, and other terms of the Plan.
- The Carrum Health Benefit applies toward any benefit maximums on the covered procedures under the Plan. Any cost-sharing paid by the participant will count towards the Plan’s annual deductible and out-of-pocket maximum.
- Carrum Health will provide appropriate documentation for any non-medical benefits paid under the program, which may be subject to taxation as income to the participant, such as the allowance paid for meals and incidentals.
- Coverage under the Carrum Health Benefit may be denied by Carrum Health if:
    1. The participant refuses to complete documentation required to participate in the Carrum Health Benefit, including the Terms of Service and Member Registration Agreement;
    2. A participant requests to be referred to another Center of Excellence after the initial Center of Excellence has determined the participant is not an appropriate candidate for the requested treatment. Note this does not apply when the initial referral is to an outpatient facility or ambulatory surgical center (ASC) that cannot treat the participant because their condition is too complex, in which case the participant may be referred to an acute care Center of Excellence. This also does not apply when the consulting COE agrees treatment is necessary, however there are medically related circumstances prohibiting the member from utilizing the initial COE. In this case the participant may be referred to one alternative Center of Excellence;
    3. The treatment is being sought to satisfy a court order;

4. The participant violates the Carrum Health Terms of Service or Member Registration Agreement; or
5. The participant is on probation and does not provide written approval from their probation officer that they are allowed to travel for treatment.

- If the Plan would pay secondary in accordance with its coordination of benefits provisions, such secondary coverage will be determined in accordance with the Plan's standard terms and cost-sharing provisions and not under this Carrum Health Benefit.

Coverage and Exceptions for Bariatric Surgery

- Unless an exception has been approved as described below, the Plan only provides coverage for bariatric surgery if the participant receives such treatment through the Carrum Health Benefit using a Center of Excellence. If treatment is not received through the Carrum Health Benefit and no exception has been approved, the participant will be responsible for the entire cost of their treatment.
- Participants may request an exception to the requirement that they use the Carrum Health Benefit. If an exception is approved, treatment may be covered in accordance with the terms of the Plan, which may include prior authorization requirements, cost-sharing, and other conditions and exclusions.
- An exception will be approved for any of the following reasons:
    - Grace Period: Surgery was secured on or before 03/31/2026.
    - Bariatric Revision Surgery: The participant is seeking a revision from a prior bariatric surgery performed at a provider outside of the Carrum Health Benefit and provides a doctor's note on official letterhead that provides a detailed description of the prior and intended surgery.
    - Urgent Surgery: As stated on a doctor's note on official letterhead, either (i) the participant already received surgery due to a medical emergency, with details of the surgery and the nature of the medical emergency, or (ii) the participant has an urgent need for surgery, detailing the reason for the urgency, and confirmation that the scheduled date of surgery and the actual date of surgery shall occur within a period not to exceed 15 calendar days of one another.
    - Medically Unsafe to Travel: The participant lives more than 60 miles from the nearest Center of Excellence and a doctor's note on official letterhead documents the participant's medical condition and the reason such medical condition makes travel medically unsafe or physically impossible. "Medically unsafe" means travel would result in (i) placing the participant's health in serious jeopardy, (ii) serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) injury, and "physically impossible" means the individual has physical limitations that prevent travel to the nearest Center of Excellence.
    - Surgical Candidacy: As stated on a doctor's note on official letterhead, the reason the participant's doctor disagrees with the Center of Excellence's determination that the participant is not an appropriate candidate for surgery and why the doctor believes that the participant is an appropriate surgical candidate. The Center of Excellence's determination that the participant is not an appropriate surgical candidate may be made (i) after consultation with the participant or (ii) prior to consultation, based on the participant's failure to meet clinical criteria required by the Center of Excellence.
    - Severe Financial Hardship: The participant lives more than 150 miles from the nearest Center of Excellence and provides documentation showing the reason why

having surgery at a Center of Excellence through the Carrum Health Benefit would cause severe financial hardship. Examples of financial hardship include: (i) inability to work or loss of hours due to the condition that the surgery is intended to fix without the ability to receive disability coverage, (ii) loss of insurance prior to earliest possible surgery date, or (iii) disability leave cannot be moved to accommodate a surgery date approved through the Carrum Health Benefit (iv) Existing obligations as a primary caregiver and travel to a Carrum COE would result in unreasonable disruption to caregiver obligations. "Unreasonable disruption" means having to hire a caregiver for 24hrs+ over and above caregiver needs if staying with a local surgeon, resulting in a severe financial hardship.
An example of documentation could include, but is not limited to, providing documentation of disability leave approval, plus documentation (i.e., email communication) showing that such disability leave cannot be moved.

- Inability to Secure Travel Companion (prior to consultation): The participant lives more than 150 miles from the nearest Center of Excellence and provides documentation showing a good faith effort to secure an adult travel companion, including documenting steps taken to find an adult travel companion, describing any roadblocks, and providing supporting materials.
- Non-Required Surgery: The participant is redirected to Carrum Health for a non-required surgery and provides a doctor's note on official letterhead that provides a detailed description of the intended surgery.

- To request an exception, a participant must complete the Exception Initiation Form and send it, along with the required supporting documentation listed in the Exception Initiation Form, to Carrum Health. A participant may request an Exception Initiation Form by contacting Carrum Health at 1-888-855-7806. Please complete the form and submit it via fax to Carrum Health at 650-539-0777, via the Carrum app, or via secure email or U.S. mail. Your Care Specialist, who can be reached at 1-888-855-7806, can walk you through the process of submitting the Exception Initiation Form via the app, secure email, or U.S. mail.
    - Carrum Health will review the Exception Initiation Form to determine whether the submitted information and documentation meets the criteria to approve an exception.
    - Depending on whether the participant has already received treatment when they make their exception request, it will be treated as either a pre-service claim or post-service claim, as described in the Claims and Appeals section of this Summary Plan Description.
    - If the participant's exception request is approved, coverage of the treatment will be subject to the standard Plan terms, including any deductibles, coinsurance, or limitations, and the participant must comply with the Plan's standard protocols for authorizing and receiving care including utilization management. The exception request is not a request for prior authorization for coverage of the treatment under the Plan. The participant may still need to receive prior authorization under the Plan for the desired procedure after their exception is approved. If the exception request is denied, no benefits will be payable for services performed outside the Carrum Health Benefit, as outlined earlier. Participants can file an appeal with Carrum Health if they are denied an exception, as described in the Claims and Appeals section of this Summary Plan Description.