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***Retiree Medical Plan for Eligible Former
Employees of Schlage Lock Company LLC***

Summary Plan Description

Effective January 2021

For Salaried and Non-Union Hourly Retirees

This document constitutes the Summary Plan Description (SPD) for the Retiree Medical Plan for Eligible Former Employees of Schlage Lock Company LLC for those Schlage retirees eligible for retiree medical coverage.

This SPD summarizes the enrollment and eligibility requirements for the Schlage Lock Company LLC (“The Schlage Lock Company”) Retiree Medical Plan for Eligible Former Employees of Schlage Lock Company LLC. (the “Plan”). Please read this document carefully. It explains eligibility requirements for you and your dependents.. If there are any inconsistencies between this document and the formal Plan documents (including any applicable insurance and administrative contracts), the formal Plan documents will prevail and control in all cases.

References to “the Company” and “Schlage” throughout this document mean Schlage Lock Company LLC and its participating affiliates as applicable. The Company reserves the right to amend or terminate the Plan at any time and for any reason. The benefits offered under the Plan are not vested.

Effective January 1, 2021, the Company only provides subsidized pre-65 retiree medical coverage to eligible retirees and their dependents.

You are encouraged to learn more about the Plan so you understand the value of the benefits it provides and your rights under the Plan. If you have any questions about your benefits, please contact the Benefits Department at (844) 623-9008 or atwork.USBenefits@allegion.com.

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INTRODUCTION

This section of the Summary Plan Description (“SPD”) provides you with eligibility and enrollment information for the Schlage Lock Company LLC Pre-65 Retiree Health and Welfare Plan (the “Plan”).

When Schlage Lock Company LLC became a stand-alone public company on December 1, 2013 (the “Spin-Off”), the retiree medical benefit program for Schlage Lock Company LLC retirees and their dependents transitioned from Ingersoll-Rand to Schlage Lock Company LLC (the “Company”). The benefits earned under the Retiree Medical Plan for Eligible Former Employees of Ingersoll-Rand Company and Participating Affiliates (the “Ingersoll-Rand Plan”) were transferred to the Plan for retirees and their dependents whose employment or retiree medical benefits transferred to the Company in conjunction with the Spin-off.

We encourage you to read this Eligibility and Enrollment information section carefully.

ELIGIBILITY

For You

You are eligible to participate in the Plan if (i) retired from the Company and meet the requirements for subsidized coverage, or (ii) you qualified for retiree medical benefits under the Ingersoll-Rand Plan and your benefits transferred in conjunction with the Spin-Off.

The Company will subsidize a portion of the cost of your coverage if you meet **all of the following**:

- Transferred to Schlage Lock Company, LLC when the Company became a stand-alone public company on December 1, 2013
- Were actively employed by Ingersoll-Rand or an affiliate (including being on an approved leave of absence, receiving short or long term disability benefits or on layoff) on January 1, 2003, and were working for a Schlage or LCN business that offered subsidized retiree medical coverage on that date
- Met the Rule of 50 age and service requirements as of January 1, 2003 (i.e. age and service, as defined below, equal at least 50)
- Are at least age 55 with 15 or more years of service when you retire from the Company and you are not a member of an Ineligible Class of Employees as defined on page 2.

For Your Dependents

You may enroll your dependents who are under age 65 in retiree medical coverage if they meet the eligibility definition as outlined below **at the time you terminate employment**. Dependents acquired after you retire or terminate employment are not eligible dependents. Additionally, only those dependents who you covered under the Company’s active medical coverage at the time you terminated employment are eligible dependents for purposes of retiree medical coverage.

Your eligible dependents include:

- Legal spouse. Your spouse is a person to whom you are legally married at the time you retire.
- Your or your legal spouse’s unmarried biological or adopted (or placed for adoption) children who are primarily dependent on you or your legal spouse for support in accordance with Internal Revenue Service (“IRS”) guidelines. For more information on the IRS guidelines, please go to www.irs.gov or contact the Allegion Benefits Department.
- A child you or your legal spouse is required to cover because of a divorce decree or qualified medical child support order (QMCSO) – (see the **Plan Administration** section for more information on qualified medical child support orders).
- You or your legal spouse’s unmarried eligible dependent child of any age if, as of the date his or her coverage would have otherwise ended, the covered dependent child is mentally or physically

incapable of self-support and primarily dependent upon you or your legal spouse for financial support. To continue covering a disabled child because of mental or physical disability beyond age 19, you must provide satisfactory proof of the incapacity and notify the Company within 30 days of the child's loss of eligibility due to the limiting age.

Please keep the following in mind when enrolling dependents in the Plan:

- If both you and your spouse are retired from the Company, either you or your spouse may enroll as a dependent, or you may each enroll as a retiree, but you may not be covered both as a retiree and as a dependent.
- No person may be covered as a dependent of more than one eligible retiree.
- Your child(ren) may be covered as an eligible dependent of you or your spouse, but not both.
- If your child is an eligible employee, he or she cannot be covered as a dependent under this Plan.

Dependent children are eligible for coverage under this Plan until the last day of the month in which they attain age 26. Michelle's Law extends medical coverage for dependent college students who take a medically necessary leave of absence from school for a period of up to one (1) year, however, coverage may end sooner if the dependent loses eligibility under the Plan for another reason. Certification of medical necessity from the treating physician must be provided to the Plan.

The Company reserves the right to periodically validate your dependents' eligibility. Failure to provide proof may result in termination of coverage (including retroactive termination) and repayment of any erroneously paid claims (in accordance with the Plan's right of recovery provisions).

SPECIAL ELIGIBILITY RULES

Ineligible Classes of Employees/Retirees

You are not eligible under the Plan if:

- You were not enrolled in a Company-sponsored medical plan for active employees immediately prior to the date you retired, or
- You and your eligible dependents are age 65 or over (if either you or your eligible dependent(s) are under age 65, such individual(s) may be eligible).

What Happens if You are Rehired While Receiving Retiree Medical Coverage

If you are rehired by the Company or an affiliate while you are enrolled in retiree medical coverage, you and your eligible dependents will not be eligible to participate in this Plan during the period that you are re-employed by the Company or an affiliate.

If You Terminate Employment and are Rehired

Prior service will count toward the age and service requirements if the following are satisfied:

- Are rehired as a full-time non-union employee within 12 months of the date of your termination, and
- Meet the age and service requirements when you subsequently terminate employment with the Company.

YEARS OF SERVICE

Unless provided otherwise in this SPD, "Years of Service," for purposes of eligibility and the Rule of 50, is defined under the Schlage Lock Company LLC Pension Plan as "Years of Vesting Service." Generally, you earn a year of service for each year you are employed by the Company or an affiliate. You earn 1/12 of a

year of service for each month where you work at least one day. Service also includes any periods of absence of less than one year. Your age and years of service while disabled and receiving Company provided long-term disability benefits also count towards eligibility for retiree medical, provided your long-term disability payments started prior to January 1, 2004.

HOW YOU AND THE COMPANY SHARE IN YOUR BENEFIT COST

The Company may subsidize the cost of your retiree medical coverage as described in the Eligibility section above. The Company limits the annual maximum dollar amount that the Company will pay towards your retiree medical coverage to \$6,650 for pre-65 retiree coverage. This is referred to as the "Company cap". You are responsible for all costs above the Company cap.

ENROLLING FOR COVERAGE

Newly Eligible Retirees

If you are an eligible retiree under the Plan, your retiree medical coverage for you and your eligible dependents begins on the first day of the month coinciding with or immediately following the date you retire, provided you enroll within 31 days of the coverage effective date.

Enrollment cannot be deferred until a later date. You must elect coverage when first eligible or forfeit eligibility for pre-65 retiree coverage under the Plan. You cannot continue coverage through COBRA under the plan for active employees and elect to participate in this retiree plan at a later date.

Annual Enrollment Period

The Plan conducts an annual enrollment period during which you may change your retiree medical election for the next calendar year. Annual enrollment is usually held in the fall and your election is effective the next January 1 through December 31. If you do not change your elections during the open enrollment period, your elections from the prior year will remain in place. Your cost of coverage may change from year to year.

Before the annual enrollment period begins, you will receive detailed information, including enrollment instructions and any changes to the Plan benefits.

Enrollment Changes

Once you make your benefit elections during the annual enrollment period, your elections cannot be changed until the next annual enrollment period, except for certain exceptions. You can change your benefit elections during the following circumstances:

- You can discontinue coverage for yourself or your dependents at any time. However, you cannot subsequently reenroll for coverage.
- You can change your medical option within 30 days of the date you or an eligible dependent becomes Medicare-eligible (i.e. Medicare disabled) or you move into, or out of, a PPO option's service area.

If you have questions on how to make enrollment changes, please consult your latest annual enrollment material or call the Benefits Department.

The Enrollment Process

When you enroll, you choose among the benefits that are available under the Plan and your coverage level and, in some cases, the eligible dependents you want to cover. Before enrollment, you will receive enrollment information.

Please refer to the following chart for specific enrollment details.

	New Retirees	Current Retirees
How to enroll	Please contact the Allegion Benefits Department for enrollment information at (844) 623-9008 or email to atwork.USBenefits@allegion.com .	
When to enroll	You have 31 days from the date you retire to enroll for benefit coverage. Your elections remain in effect until the end of the calendar year; unless you make a change that is allowed mid-year (see "Enrollment Changes" above for more information).	You may enroll or change your benefit elections each year during annual enrollment. Once the calendar year, to which your open enrollment elections apply begins, your elections remain in effect until the end of that calendar year; unless you make a change that is allowed mid-year (see "Enrollment Changes" above for more information).
If you do not enroll	If you don't enroll by the 30-day deadline, you forfeit eligibility for coverage under the Plan.	If you do not enroll by the annual enrollment deadline, your current elections will carry over the following year, at the following year's contributions rates.

Covering Dependents When You Waive Coverage

If you waive coverage for yourself, you may not elect coverage for your eligible dependents, unless you are Medicare-eligible (i.e., Medicare disabled).

When you become Medicare-eligible, you can continue to cover your non-Medicare-eligible dependents until they become Medicare-eligible. Effective January 1, 2014, there is no post-65 coverage under the Plan for retirees or eligible dependents.

Covering Dependents Upon Your Death

Your eligible dependents are eligible for subsidized retiree medical coverage in the event of your death, if:

- You die as an active employee, provided you met the age and service requirements for subsidized retiree medical coverage at the time of your death
- You die as a retiree and you were enrolled in retiree medical coverage, your eligible dependents can continue coverage (i.e., your dependents must be enrolled at the time of your death)

HOW YOU PAY FOR BENEFITS

Contributions you make for retiree medical coverage are made on an after-tax basis. Please consult your latest annual enrollment material or call the Allegion Benefits Department for payment options.

YOUR RETIREE MEDICAL OPTIONS

The medical options available to you at retirement depend on your age and Medicare eligibility. If you have both Medicare-disabled eligible covered dependents and non-Medicare-disabled eligible covered dependents, then your coverage, and your cost for such coverage, will be split so that each family member has the appropriate coverage.

Medical Coverage Before Age 65

You can elect coverage under options similar to those offered to active employees until you reach age 65. These options are subject to change.

Medical Coverage if Medicare-disabled

If you or your spouse become Medicare-disabled and are not yet 65 years old, you or your spouse are eligible for the options offered to active employees.]

HOW MEDICARE WORKS

Generally, you and your dependent become eligible for Medicare coverage at age 65 if you have worked the required number of years to qualify for Social Security benefits. Medicare coverage generally begins on the first day of the month in which you or your dependent reaches age 65. Coverage under this Plan will cease for you or your dependents on the last day of the month preceding the month in which they turn 65. You and your dependent may also be eligible for Medicare if you have been Medicare-disabled for 29 months.

- **Medicare Part A (basic hospital insurance).** You or a covered dependent are automatically covered for Medicare Part A if you are age 65 or older and have applied for Social Security retirement income benefits or after you have been Medicare-disabled for 29 months. Under Part A, once you pay the annual deductible, and most hospital costs are covered for the first 60 days of a hospital confinement. If you are hospitalized for more than 60 days, Medicare will pay reduced benefits. In addition, Medicare Part A may pay benefits for extended care after you leave the hospital, both in a qualified nursing facility and in your own home.
- **Medicare Part B (supplementary medical insurance).** You may enroll for Medicare Part B, which is voluntary*, supplemental Medicare. You can enroll in Medicare Part B up to three months before your 65th birthday or after you have been Medicare-disabled for 29 months. You contribute to the cost of this insurance through deductions from your monthly Social Security check. Once you satisfy an annual deductible, Medicare Part B generally pays 80% of the negotiated fees for eligible services.
- **Medicare Part C (Medicare Advantage plans).** This option provides Part A and Part B (and sometimes Part D) through private insurers. Medicare Advantage plans are health plans approved by Medicare and run by private insurance companies. When you join one of these plans, you are still in Medicare. Medicare Advantage plans provide all of your Part A (basic hospital) and Part B (supplementary medical) coverage under one plan and cover medically necessary services. They may also offer other extra benefits over and above Medicare.
- **Medicare Part D (prescription drug coverage).** You may enroll for Medicare Part D, which is voluntary, provided you are enrolled in Medicare Part B. Medicare Part D is a prescription drug coverage offered by private insurers to Medicare-eligible beneficiaries. You contribute to the cost of this insurance through deductions from your monthly Social Security check.

This information provides only a general summary of the Medicare programs. For more information on Medicare, including information on enrollment, contact your local Social Security office or visit Medicare's Web site at www.medicare.gov.

* Please note that if you do not enroll in Medicare Part B when you first become eligible, the premium may be higher if you decide to enroll later. This also may apply to Medicare Part D coverage. You will receive more information about creditable coverage and Medicare Part D when you retire or become Medicare-eligible.

MEDICARE COORDINATION WITH THE COMPANY'S MEDICAL PLAN

If you or a dependent are eligible for Medicare (i.e. Medicare-disabled), you must enroll in both Medicare Part A and Part B in order to receive the maximum benefit under both Medicare and the Plan. **Even if you do not enroll in Medicare Part A and Part B, the Plan will reduce benefits to reflect whatever Medicare would have paid had the Medicare-primary retiree or dependent elected the full Medicare Parts A and B coverage.**

Since the Plan is secondary to Medicare, it pays benefits after Medicare has made payment on your claim. As the secondary plan, the Plan may pay all or part of the allowable expenses that are not paid by Medicare. That is, the Plan pays as if it was the primary plan, reduced by the allowable expenses paid by Medicare. You will never receive more than 100% of your allowable expenses under Medicare and the Plan combined, and the Plan will never pay for a service or supply that is not covered by the Plan.

Always submit your claims to Medicare first. Be sure to include any explanation of benefits from Medicare and itemized bills when you submit your claims to the Plan's Claims Administrator.

Please refer to the Plan Administration section of your SPD for more information on how to submit a claim under the Plan.

WHEN COVERAGE ENDS

Generally, your coverage under the Plan ends on the earliest of the following dates:

- Your date of death.
- The last day of the month for which you made your final payment for coverage.
- The day you are reemployed by the Company or an affiliate.
- The last day of the month in which benefits are terminated for eligible retirees.
- The day you become covered under a Medicare Part D plan.
- Coverage ends the last day of the month preceding the month in which you become eligible for Medicare as a result of attaining age 65.
- The day the Plan is terminated, or otherwise amended to discontinue coverage. Coverage for your eligible dependents ends on the earliest of the following dates:
 - The date your coverage ends (unless (i) they are eligible to continue coverage as described under "Covering Dependents If You Waive Coverage" (ii) your coverage ends due to your death or (ii) your coverage ends because you turn age 65 and your eligible dependents are not yet 65).
 - The last day of the month for which you make final payment for dependent coverage.
 - The last day of the month your dependents no longer meet the definition of eligible dependent.
 - The date a dependent enters the armed forces of any country or organization.
 - The day you are reemployed by the Company or an affiliate.
 - The last day of the month preceding the month in which your dependent becomes eligible for Medicare as a result of attainment of age 65.
 - The day the plan is terminated, or otherwise amended to discontinue coverage.

Note that committing or attempting to commit fraud against the Plan may also result in the termination of benefits.

IMPORTANT INFORMATION AFFECTING COVERAGE

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Coverage for dependents may be continued through COBRA if they experience certain “qualifying events”. For information on your rights and benefits under COBRA, please refer to the Plan Administration section of your SPD.

Qualified Medical Child Support Order

If your dependent is covered by the Plan under the terms of a Qualified Medical Support Order, coverage also may end when the order expires or when your enrollment under comparable medical coverage ends. For more information regarding Qualified Medical Child Support Orders (QMCSO), please refer to the **Plan Administration** section of your SPD.

Introduction to the HSP, PPO, HPN HSP and HPN PPO Plans

The Health Savings Plan (HSP) and the Preferred Provider Organization (PPO) plan provide you and your family with comprehensive health care coverage. When you enroll, you and your covered family members receive coverage for medical care (including mental health, chemical dependency and prescription drug coverage).

In addition to the HSP and PPO, the Plan also offers a High-Performance Network Health Savings Plan (“HPN HSP”) and a High-Performance Network PPO (“HPN PPO”). The HPN HSP and the HPN PPO offer substantially the same coverage as the HSP and the PPO, though the HPN HSP and the HPN PPO offer no Out-of-Network benefits.

This SPD provides a detailed description of the HSP, PPO, HPN HSP, and HPN PPO information on how the plans work, how to find a network Provider and a description of Covered Services. In addition, it provides you with guidance and contact information should you have additional questions.

. Wellness care services, such as routine physicals and well child care Visits, are not subject to the Deductible.

Certain terms used in this SPD have special meanings when applied to the Plan. For your convenience, those terms are capitalized when used and defined in the “Important Terms to Know” section of this document.

How the HSP, PPO, HPN HSP, and HPN PPO Work

The HSP and PPO give you the freedom to choose any Provider. You can choose health care Providers who are part of the HSP’s or PPO’s network or you can choose to go outside the network for your health care. Your choice of Provider determines how the HSP and PPO plan pay benefits. The network for both plans is the same.

If you choose health care Providers who participate In-Network, your share of the cost for a covered service is less. When you use an In-Network Provider, you will pay 20% of the cost for most Covered Services after you meet the In-Network Deductible. In-Network Providers do not charge more than the HSP’s and PPO’s Allowance (the maximum reimbursable charge) for a service. Also, when you use In-Network Providers you do not have to file claims.

If you use Out-of-Network Providers, you will pay more out-of-pocket for Covered Services. Generally, you can expect to pay 40% or more, after you meet your Out-of-Network Deductible. And, if your Out-of-Network

Provider charges more than the HSP or PPO Allowance, you are responsible for paying the entire difference. You generally will need to file claims to receive reimbursement for Out-of-Network Benefits.

The HPN HSP and the HPN PPO have a two tiered In-Network system. When you use a Tier 1 In-Network provider you will pay 20% of the cost for most Covered Services after you meet the In-Network Deductible, and 30% of the cost for most Covered Services for Tier 2. The HPN HSP and the HPN PPO **do not offer Out-of-Network benefits.**

Your out-of-pocket expenses are limited by an annual Out-of-Pocket Maximum. However, the Out-of-Network maximum is higher than the In-Network maximum. Once your accumulated Deductibles and Coinsurance costs reach your Out-of-Pocket Maximum (combined for In-Network and Out-of-Network costs), the HSP, PPO, HPN HSP and HPN PPO pay 100% of your covered health care costs for the rest of the Calendar year.

Payment of Benefits

The HSP, PPO, HPN HSP and HPN PPO pay benefits based on the Allowance for the service provided. The HSP, PPO, HPN HSP and HPN PPO determine the Allowance based on the Provider, the type of service and the geographic area where the service is provided. For In-Network services and supplies, the HSP, PPO, and HPN HSP have negotiated rates with In-Network Providers. These negotiated rates are often discounted. In-Network Providers accept the discounted rate, subject to the HSP, PPO, HPN HSP and HPN PPO's Deductibles and Coinsurance, which are your responsibility. This means when you use In-Network services, you generally pay a percentage of the discounted rate. Please note that the negotiated rates apply only to services covered by the HSP, PPO, HPN HSP and HPN PPO and according to the contract agreed to by the Provider.

The Allowance for Out-of-Network services and supplies is generally based on the reasonable and customary charge for care in the geographic area. Generally, you are responsible for paying 100% of any charges above the reasonable and customary level. The reasonable and customary charge for Out-of-Network emergency care is the greatest of (i) the amount negotiated for In-Network Providers, (ii) the amount calculated by the Plan as reasonable and customary, and (iii) the amount Medicare would cover for the services. The HPN HSP does not off Out-of-Network benefits.

Deductible

A Deductible is the amount you or you and your covered Dependent must pay each Calendar Year for most Covered Services before the HSP and the HPN HSP begins paying benefits. For the PPO and the HPN PPO there are co-pays for certain services, and the deductible applies to certain other services. There are different Deductible amounts for employee only and employee plus dependents coverage under the HSP & HPN HSP and PPO & HPN PPO. If you are enrolled in employee plus spouse, employee plus child(ren) or family coverage, the full family Deductible must be met before the HSP begins paying benefits for most Covered Services. Under the HSP, the In-Network Deductible for employee only coverage is \$1,500 and the In-Network Deductible for employee plus dependents coverage is \$4,000. The Out-of-Network Deductible is \$3,000 for employee only coverage and \$8,000 for family coverage. The family Deductible can be met by any combination of eligible medical and pharmacy charges incurred by you and your covered Dependent. The Deductible must be met in full before the plan begins to reimburse at the HSP Coinsurance amount for most covered services. Non-preventive Prescription Drugs are subject to the Deductible.

For example, if you enroll in family coverage and have eligible personal expenses of \$3,000, and a Dependent incurs \$1,000 of eligible expenses, you have met the full family annual In-Network Deductible. All eligible expenses will apply toward meeting the family Deductible.

Eligible medical expenses, as well as eligible prescription drug expenses, count toward meeting the Deductible. Expenses related to preventive care services are covered at 100%, so do not count toward the deductible.

Once you have met the Deductible, the HSP will cover any additional eligible charges you may incur during the remainder of the Calendar Year according to the HSP Coinsurance amount.

Under the PPO, the In-Network Deductible for retiree only coverage is \$750 and the In-Network Deductible for retiree plus dependents coverage is \$1,500. The Out-of-Network Deductible is \$1,500 for retiree only coverage and \$3,000 for family coverage. Each individual on the plan must meet their own individual Deductible until the total amount of Deductible expenses paid by all family members meets the overall family Deductible. Medical charges, excluding office visit and emergency room copays and pharmacy charges, contribute to the Deductible. Expenses related to preventive care services are covered at 100% so do not count toward the Deductible.

Once you have met the Deductible, the PPO will cover any additional eligible charges you may incur during the remainder of the Calendar Year according to the PPO Coinsurance amount.

Coinsurance

Coinsurance is your share of medical costs under the HSP, PPO, HPN HSP and HPN PPO. It is the percentage of eligible expenses you pay under the HSP and PPO after the Deductible is met. For example, the HSP and PPO pay 80% of covered In-Network and 60% of Out-of-Network expenses after meeting the Deductible. You would pay 20% Coinsurance (In-Network) or 40% Coinsurance (Out-of-Network).

Refer to the "Schedule of Covered Services and Supplies" section for specific Coinsurance amounts.

Out-of-Pocket Maximums

The annual Out-of-Pocket Maximum is the most you or your covered Dependents must pay in Deductible and Coinsurance amounts for Covered Services in a Calendar Year. Once the Deductible and Coinsurance amounts you have paid during the year equals the individual Out-of-Pocket Maximum amount, the HSP, PPO, HPN HSP and HPN PPO pay 100% of any additional Covered Charges.

If you have retiree plus spouse, retiree plus child(ren) or family coverage, the full family Out-of-Pocket Maximum must be met by any one or more family members before the Plan begins paying 100% of Covered Charges. Deductible and Coinsurance amounts Incurred by all family members combined count toward the family Out-of-Pocket Maximum. After the family Out-of-Pocket Maximum is met, the HSP, PPO, HPN HSP and HPN PPO pay 100% of any additional Covered Charges for all family members for the remainder of the Calendar Year. Prescription drug costs count toward the medical Out-of-Pocket Maximum.

The following do not count toward the Out-of-Pocket Maximum:

- Non-Covered Charges
- Payments to an Out-of-Network Provider above the reasonable and customary Allowance
- Payments made due to noncompliance with precertification requirements or non-emergency use of an emergency room, and
- Charges for services that exceed any separate Plan maximums.

Refer to the "Schedule of Covered Services and Supplies" section for specific Out-of-Pocket Maximum amounts under the HSP, PPO, HPN HSP and HPN PPO plans.

There may be times when you use both In-Network and Out-of-Network Providers. The amounts you pay toward meeting the In-Network Out-of-Pocket Maximum do count toward meeting the Out-of-Network Out-of-Pocket Maximum, and vice-versa.

HSP At-A-Glance		
Benefits	In-Network	Out-of-Network
Benefit Period	Calendar Year	
Lifetime Maximum	Unlimited	
Coinsurance Levels	20%	40%
Calendar Year Deductible		
Individual*	\$1,500	\$3,000
Family (aggregate)**	\$4,000	\$8,000
Annual Out-of-Pocket (OOP) Maximum***		
Individual	\$3,000	\$6,000
Family (aggregate)*	\$7,350	\$12,000
<p>* Applies if you have single coverage. The Deductible must be met before the Plan begins paying benefits for most Covered Services.</p> <p>** Applies if you have retiree plus spouse, retiree plus child(ren) or retiree plus family coverage. The family Deductible must be met before the Plan begins paying benefits for most Covered Services. The family Deductible may be met individually or by any combination of covered persons, together or separately.</p> <p>*** Includes Deductible, Coinsurance and prescription drug copays and Coinsurance.</p> <p>Note: Non-preventive Prescription Drugs are subject to the Deductible. Visit Express Scripts online at www.express-scripts.com to get information on what Prescription Drugs are considered preventive and not subject to the Deductible.</p>		

PPO At-A-Glance		
Benefits	In-Network	Out-of-Network
Benefit Period	Calendar Year	
Lifetime Maximum	Unlimited	
Coinsurance Levels	20%	40%
Calendar Year Deductible		
Individual*	\$500	\$1,000
Family (aggregate)**	\$1,000	\$2,000
Copays*		
Office Visit – Primary Care	\$25	40% Coinsurance
Office Visit - Specialist	\$40	40% Coinsurance
Emergency Room	\$150	40% Coinsurance
Annual Out-of-Pocket (OOP) Maximum***		
Individual	\$2,500	\$5,000
Family (aggregate)*	\$5,000	\$10,000
<p>* If more than one family member is on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p> <p>** Copays apply to Out-Of-Pocket Maximum but not to Deductible.</p> <p>*** Includes Deductible, Copays, Coinsurance and prescription drug costs.</p> <p>Note: Office visit and emergency room copays DO NOT contribute toward the deductible but do contribute to the Out-of-Pocket Maximum. Non-preventive Prescription Drugs are subject to the Out-of-Pocket Maximum and DO NOT contribute to the deductible but do contribute to the Out-of-Pocket Maximum. Visit Express Scripts online at www.express-scripts.com to get information on what Prescription Drugs are considered preventive and not subject to the Deductible.</p>		

HPN HSP & HPN PPO At-A-Glance		
Benefits	HPN HSP In-Network	HPN PPO In-Network
Benefit Period	Calendar Year	
Lifetime Maximum	Unlimited	
Coinsurance Levels	20%	20%
Calendar Year Deductible		
Individual*	\$1,500	\$750
Family (aggregate)**	\$4,000	\$1,500
Annual Out-of-Pocket (OOP) Maximum***		
Individual	\$3,000	\$3,000
Family (aggregate)*	\$7,350	\$6,000
<p>* If you are enrolled in family coverage there is no individual deductible. The family deductible can be met by one family member or a combination of family members.</p> <p>** Each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p> <p>*** Includes Deductible, Coinsurance and prescription drug copays and Coinsurance.</p> <p>NOTE: there are no out of network benefits under the HPN HSP or the HPN PPO.</p> <p>Note: Non-preventive Prescription Drugs are subject to the Deductible. Visit Express Scripts online at www.express-scripts.com to get information on what Prescription Drugs are considered preventive and not subject to the Deductible.</p>		

Preventive Care

Keeping and maintaining good health is important. The HSP, PPO, HPN HSP and HPN PPO cover Preventive Care services— such as annual physicals, mammograms, PAP smears, prostate cancer screenings and immunizations— to keep you healthy with no Deductible. In-Network Preventive Care services are covered at 100% with no Deductible; Out-of-Network Preventive Care services are covered at 60% with no Deductible. For additional information on Preventive Care coverage, refer to the “Schedule of Covered Services and Supplies” section or visit www.mymobilewalletcard.com/allegion for the preventive guidelines for your age and gender. The guidelines are based on recommendations of the U.S. Preventive Services Task Force and other health organizations. Use this information to talk to your doctor about the services that may be right for you.

In-Network vs. Out-of-Network Providers

Under the HSP and PPO, you can use In-Network or Out-of-Network Providers for your health care needs. When you use a Provider who participates In-Network, you will receive:

- **A higher level of coverage.** When you Visit an In-Network Provider, payments by the HSP and PPO for many medical services are paid at a higher percentage.
- **Lower out-of-pocket expenses.** The amount you pay out of your own pocket for medical care through the Deductible and Coinsurance is lower.
- **Help with pre-certification.** Your In-Network Provider will work with the utilization review organization to start the pre-certification process for certain treatments. If you use an Out-of-Network Provider, you may need to call the utilization review organization yourself at the telephone number shown on your Anthem medical ID card to start the pre-certification process.
- **Expenses that fall within the HSP’s or PPO’s In-Network charge.** Payments made by the HSP and PPO are always based on the negotiated charge. When you use Out-of-Network Providers, the payments made by the HSP or PPO are based on the Out-of-Network reasonable and customary Allowance for the charge and you will be responsible for the entire amount in excess of

the reasonable and customary Allowance. This means you may be required to pay a greater share of the charges.

- **Claims filing services.** In-Network Providers will file claims for you. When using Out-of-Network Providers you may be required to submit a claim form to be reimbursed for the charge.

HSP, PPO, HPN HSP and HPN PPO Providers

Anthem offers a broad network of doctors, Hospitals and other Facilities. In-Network Providers must meet certain standards for education, experience and credentials. They are also reviewed for patient satisfaction and overall delivery of care. The HSP, PPO, HPN HSP and HPN PPO also give you access to the Anthem national network of Providers.

For a current list of Providers, call (844) 963-0445, log onto www.anthem.com.

Unlimited Lifetime Maximum Benefit Amount

There is an unlimited lifetime maximum per covered person for Covered Charges under the HSP, PPO, HPN HSP and HPN PPO plans.

Payment Limits

The HSP, PPO, HPN HSP and HPN PPO plans limit what it will pay for certain types of services and only covers services that are Medically Necessary and Appropriate. See the “Schedule of Covered Services and Supplies” section for information on these limits.

Utilization Review

The HSP, PPO, HPN HSP and HPN PPO require that certain services must be reviewed in advance by the HSP, PPO, HPN HSP or HPN PPO’s utilization review program to determine if they are Medically Necessary and covered under the Plan. If your physician recommends any of the following services or procedures, you or your health care Provider must contact the utilization review organization to find out if the service or procedure is covered:

- For all elective Inpatient admissions except maternity admissions
- For an extended length of stay at a Hospital or other health care Facility, and
- To obtain a service or supply that requires Prior Authorization (see “Services That Require Prior Authorization”).

If you, your covered Dependent or Provider do not comply with the utilization review, requirements for pre-admission review, continued stay review or Prior Authorization, your benefits for Covered Services will be reduced by \$500.

Pre-Admission Review

All elective Hospital admissions except maternity admissions must be reviewed by Anthem. This is called Pre-Admission Review (PAR), which refers to the process used to certify the Medical Necessity and length of a Hospital confinement when you or your covered Dependent requires treatment in a Hospital. If treatment is from an In-Network Provider, the Provider will usually make all needed arrangements for pre-admission certification. However, if you use an Out-of-Network Provider, you or your Provider must advise Anthem of the admission.

All medical non-emergency Hospital and other Facility admissions through an In-Network or Out-of-Network Provider must be reviewed by Anthem in advance. You or your Provider must notify Anthem and request a PAR by phone, fax or through email. The Plan must receive notice and your request at least five business days (or as soon as reasonably possible) before the admission is scheduled to occur.

Once Anthem receives your notice and request, it will determine:

- The Medical Necessity and Appropriateness of the admission
- The anticipated length of stay, and
- The appropriateness of health care alternatives—like Home Health Care or other Outpatient or Out-of-Hospital care.

You or your Provider will receive notification of the review outcome by phone, fax, mail or electronically. If the review results in a denial, Anthem will confirm the outcome in writing.

Pre-admission review is not required for Hospital admittance for childbirth that does not exceed 48 hours following a normal (vaginal) delivery or 96 hours following a Caesarean section. For more information, see the “Newborns’ and Mothers’ Health Protection Act” section.

If your admission or treatment is approved, the authorization is valid for:

- The specified Provider
- The named attending Practitioner
- The specified admission date
- The authorized length of stay, and
- The diagnosis and treatment plan.

You must receive Prior Authorization again (the previous authorization becomes invalid) if the following occurs:

- You (or your covered Dependent) enter a Facility other than the specified Facility for treatment of the condition for which PAR was obtained
- You (or your covered Dependent) change attending Practitioners, or
- There is an alteration in the condition, treatment plan or length of stay.

Continued Stay Review

Anthem has the right to conduct a Continued Stay Review (CSR) of any Inpatient Hospital admission. Anthem may contact your (or your covered Dependent’s) Practitioner or Facility by phone or in writing.

You (or your covered Dependent) must ask for a CSR whenever it is Medically Necessary and Appropriate to increase the authorized length of an Inpatient Hospital stay. You must request the CSR before the end of the previously authorized length of stay.

The CSR will determine:

- The Medical Necessity and Appropriateness of the extended stay
- The anticipated length of stay and extended length of stay, and
- The appropriateness of health care alternatives.

Anthem will notify your Practitioner or Facility by phone or fax of the review outcome. This notice will include any newly authorized length of stay. Any review outcome that results in a denial will be confirmed in writing by Anthem.

Prior Authorization

You or your covered Dependent must obtain Prior Authorization for certain Covered Services and Supplies, which are listed under “Services That Require Prior Authorization” below. If you (or your covered

Dependent) or health care Provider do not comply, your benefits for Covered Services will be reduced by \$500.

You (or your covered Dependent) or health care Provider must request a review from Anthem at least five business days before the Covered Inpatient Service or Supply is scheduled to be furnished, or as soon as reasonably possible. If the treatment or procedure is being performed as an Inpatient, the procedure and site of service for Inpatient services is authorized through one authorization. If Prior Authorization is required, the request must be made before the supply is obtained. For In-Network services or supplies, the Provider will generally take care of obtaining the Prior Authorization. For any Outpatient service requiring Prior Authorization, Prior Authorization must be obtained before the service is provided.

Once Anthem receives your request, it will determine the Medical Necessity and Appropriateness of the treatment, procedure or supply. Anthem will either approve or deny the request based on Medical Appropriateness or request for additional information.

Anthem will notify you (or your covered Dependent) or your health care Provider by phone of the review outcome. Anthem will also confirm the review outcome in writing.

The following is a summary of services requiring Prior Authorization under the HSP, PPO, HPN HSP and HPN PPO plans.

Services That Require Prior Authorization

- All elective Inpatient admissions except maternity
- Skilled nursing services or Skilled Nursing Facility or other alternative or extended care Facilities
- Organ transplants
- Home Health Care Services
- Potentially Experimental and cosmetic procedures (i.e., rhinoplasty, septoplasty, endoscopic sinus Surgery)
- Bariatric procedures (for morbid obesity defined as having a BMI>40)
- Home IV infusion (not applicable to Chemotherapy treatments and IV antibiotic services) such as:
 - Vivaglobin, IVIG (for various immune conditions)
 - Antibiotics for Lyme disease, and
 - Remicade (rheumatoid arthritis).

Penalties for Non-Compliance

If Pre-Admission Review (PAR), Continued Stay Review (CSR) or Prior Authorization is not obtained when required, the HSP or PPO reduces what it would otherwise pay for Covered Services and Supplies by \$500. Penalties cannot be used to meet the Deductible or Out-of-Pocket Maximum under the Plan.

Penalties for non-compliance may be incurred for the following situations:

- You, your covered Dependent or Provider do not request and receive a PAR or Prior Authorization when required
- You, your covered Dependent or Provider do not request a PAR five business days or as soon as reasonably possible before the admission is scheduled to occur
- Authorization from Anthem becomes invalid and you (or your covered Dependent) or Provider do not obtain a new one
- You, your covered Dependent or Provider do not request a Continued Stay Review when necessary, or
- You, your covered Dependent or Provider do not receive an authorization for such continued stay

Alternate Treatment/Individual Case Management Plan

The HSP, PPO, HPN HSP and HPN PPO have a case management program administered by Anthem. Under the program, a case manager will review your or your covered Dependent's medical needs in the case of a Catastrophic Illness or Injury to determine whether Alternative Treatment may be available and appropriate. The case coordinator will evaluate the appropriateness of the level of patient care given to you or your covered Dependent as well as the setting in which it is received. To maintain or enhance the quality of patient care for you and your covered Dependent, Anthem may develop an Alternate Treatment/individual case management plan.

Important note: Neither you nor your covered Dependents are required, in any way, to accept an Alternate Treatment/individual case management plan recommended by Anthem.

An Alternative Treatment/individual case management plan is a specific written document developed by Anthem through a discussion with:

- You, your Dependent or his/her legal guardian, if necessary
- You or your Dependent's attending Practitioner, and
- Anthem or its designee.

The Alternate Treatment/individual case management plan includes:

- Treatment plan objectives
- A course of treatment to accomplish those objectives
- The responsibility of you, your covered Dependent, your family members (if any), Anthem and the attending Practitioner in carrying out this treatment plan, and
- The estimated cost of the treatment plan and savings.

If Anthem, the attending Practitioner and you or your covered Dependent agrees in writing to an Alternative Treatment/individual case management plan, the services and supplies provided as part of the Alternative Treatment/individual case management plan will be covered under this Plan.

Benefits payable under the Alternative Treatment/individual case management plan will be counted toward any benefit maximum that applies to you or your covered Dependent.

Important note: Alternative Treatment/individual case management does not include services and supplies that the HSP PPO, HPN HSP or HPN PPO determines to be Experimental or Investigational.

Complex Case Management Program

The HSP, PPO, HPN HSP and HPN PPO also offer complex case management services administered by Anthem.

Under the complex case management program, Anthem contacts potential members identified as having the greatest potential for benefit from the complex case management program. A verbal or written consent is obtained indicating your willingness to enroll in the complex case management program. The program benefits include:

- Development of an individual care plan.
- Physician engagement, when necessary. Anthem will contact your primary physician(s) in an effort to seek physicians' cooperation in, and support of, your participation in the program.

- Ongoing case management. Anthem Nurses will perform ongoing case management activities, following the individual care plan, and shall provide services until all health issues have been successfully addressed or resolved.
- Member survey. Anthem will contract with a third party to conduct a telephonic satisfaction survey when your case is closed. The satisfaction survey consists of a series of questions designed to assess your overall satisfaction with the program.

Anthem will immediately un-enroll you if you are no longer eligible for benefits under the HSP, PPO, HPN HSP or upon receipt, verbal or written, that you no longer want to participate in the complex case management program.

Cost of Coverage

You and the Company share the cost of your medical coverage. See the Eligibility and Enrollment section of the Retiree Medical Plan for Eligible Former Employees of Schlage Lock Company LLC SPD for more information.

Please refer to the following schedule for specific information on In-Network and Out-of-Network services and supplies covered under the HSP and PPO.

Schedule of Covered Services and Supplies		
	In-Network	Out-of-Network
Preventive Care: Coverage includes, for example, office Visits, exams, labs, immunizations, routine mammograms and PAP smears, occult blood test, hearing exams, prostate exam, sigmoidoscopies and colonoscopies based on nationally recommended standards.	Plan pays 100% (No Deductible)	Plan pays 60% (No Deductible)
Well child: Coverage includes office Visits, exams, labs, X-rays, immunizations and diagnostics up to age 18.	Plan pays 100% (No Deductible)	Plan pays 60% (No Deductible)
Emergency Care Sickness/Accident: Refers to services provided for a sudden unexpected medical condition so severe it could cause serious or permanent medical consequences if not treated <i>A \$75 penalty applies for non-emergency use of an emergency room, after which the Deductible and Coinsurance applies (does not apply to out-of-pocket max).</i>	Emergency Care: HSP pays 80% after Deductible PPO - \$150 copay Urgent Care: HSP: pays 80% after deductible PPO: \$40 copay	Covered as a network benefit: HSP pays 80% after Deductible PPO - \$150 copay for emergency care, \$40 copay for urgent care
Outpatient Surgery (Physician charges): Performed in a Physician's office, Hospital or at a freestanding Facility.	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Diagnostic Tests (Non Routine)	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Inpatient Behavioral Health and Substance Abuse*	Plan pays 80% after Deductible	Plan pays 60% after Deductible

Schedule of Covered Services and Supplies		
	In-Network	Out-of-Network
Outpatient Behavioral Health and Substance Abuse: Structured Outpatient (care that is part of a program) and general Outpatient	HSP: Plan pays 80% after deductible PPO: \$25 copay	Plan pays 60% after Deductible
Medical/Surgical Care	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Coordinated Home Care (Home Health Care)*	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Extended Care Facility (Skilled Nursing Facility)*	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Private Duty Nursing*	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Hospice	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Chiropractic Care: Combined maximum 30 Visits per year, network and non-network	HSP: Plan pays 80% after Deductible PPO: \$40 copay	Plan pays 60% after Deductible
Hearing care: Hearing exam and hearing aids covered up to \$2,000 every 36 months	HSP: Plan pays 80% after Deductible PPO: \$40 copay for exam	Plan pays 60% after Deductible
Outpatient Therapies – Physical, Occupational and Speech (limited to 90 total visits per Calendar Year)	HSP: Plan pays 80% after Deductible PPO: \$40 copay	Plan pays 60% after Deductible
Other Outpatient Therapy Services: For example: Chemotherapy, Radiation, respiratory, cognitive and Dialysis treatment	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Podiatry: Care and orthotics for diabetes, peripheral vascular, neuropathic conditions and post-Surgery trauma	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Other Covered Medical Services: Blood and blood components, Ambulance services, oxygen and its administration, Surgical dressings, casts and splints, Durable Medical Equipment, prosthetic devices and leg, arm and neck braces	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Prescription Drugs: Administered by Express Scripts	See more information beginning on page 32.	
* Pre-authorization required; \$500 penalty for non-compliance.		

Please refer to the following schedule for specific information on In-Network services and supplies covered under the HPN HSP and HPN PPO. There are no out-of-network benefits under these plans. If you obtain services or supplies from an out-of-network provider you will be responsible for the entire cost.

Schedule of Covered Services and Supplies		
	HPN HSP In-Network	HPN PPO In-Network
Preventive Care: Coverage includes, for example, office Visits, exams, labs, immunizations, routine mammograms and PAP smears, occult blood test, hearing exams, prostate exam, sigmoidoscopies and colonoscopies based on nationally recommended standards.	Plan pays 100% (No Deductible)	Plan pays 100% (No Deductible)
Well child: Coverage includes office Visits, exams, labs, X-rays, immunizations and diagnostics up to age 18.	Plan pays 100% (No Deductible)	Plan pays 100% (No Deductible)
Emergency Care Sickness/Accident: Refers to services provided for a sudden unexpected medical condition so severe it could cause serious or permanent medical consequences if not treated <i>A \$75 penalty applies for non-emergency use of an emergency room, after which the Deductible and Coinsurance applies (does not apply to out-of-pocket max).</i>	Emergency Care: Plan pays 80% after Deductible Urgent Care: Plan pays 80% after deductible	Covered as a network benefit: HPN HSP & HPN PPO pay 80% after Deductible <i>unless</i> for non-emergency medical condition
Outpatient Surgery (Physician charges): Performed in a Physician's office, Hospital or at a freestanding Facility.	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Diagnostic Tests (Non Routine)	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Inpatient Behavioral Health and Substance Abuse*	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Outpatient Behavioral Health and Substance Abuse: Structured Outpatient (care that is part of a program) and general Outpatient	Plan pays 80% after deductible	Plan pays 80% after Deductible
Medical/Surgical Care	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Coordinated Home Care (Home Health Care)*	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Extended Care Facility (Skilled Nursing Facility)*	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Private Duty Nursing* <i>Limit of 120 visits per year</i>	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Hospice	Plan pays 80% after Deductible	Plan pays 80% after Deductible

Schedule of Covered Services and Supplies		
	HPN HSP In-Network	HPN PPO In-Network
Chiropractic Care: Combined maximum 30 Visits per year	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Hearing care: Hearing exam and hearing aids covered up to \$2,000 every 36 months	HSP: Plan pays 80% after Deductible	Plan pays 80% after Deductible
Outpatient Therapies – Physical, Occupational and Speech (limited to 90 total visits per Calendar Year)	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Other Outpatient Therapy Services: For example: Chemotherapy, Radiation, respiratory, cognitive and Dialysis treatment	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Podiatry: Care and orthotics for diabetes, peripheral vascular, neuropathic conditions and post-Surgery trauma	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Other Covered Medical Services: Blood and blood components, Ambulance services, oxygen and its administration, Surgical dressings, casts and splints, Durable Medical Equipment, prosthetic devices and leg, arm and neck braces	Plan pays 80% after Deductible	Plan pays 800% after Deductible
Prescription Drugs: Administered by Express Scripts	Not Covered under the medical plan	
* Pre-authorization required; \$500 penalty for non-compliance.		

Covered and Non-Covered Services and Supplies

Covered Services and Supplies

The HSP, PPO, d HPN HSP and HPN PPO cover the following Medically Necessary services and supplies:

Abortions - Abortions are covered when Medically Necessary. An abortion is considered Medically Necessary when:

- The mother’s life is in jeopardy
- The pregnancy is due to rape or incest, or
- Due to circumstances dealing with severe medical conditions of the fetus.

Acupuncture - Acupuncture services and supplies are covered when:

- The acupuncture is performed for anesthetic or pain management purposes by a Practitioner, and
- The services are Medically Necessary and Appropriate.

Allergy Testing and Treatment - Allergy testing and treatment, including routine allergy injections.

Ambulance Services - Charges for transporting you or a covered Dependent to:

- A local Hospital, if it can provide the needed care and treatment;
- The nearest Hospital that can furnish the needed care and treatment, if
 - A local Hospital cannot provide it, and

- The person is admitted as an Inpatient; or
- Another Inpatient Facility when Medically Necessary and Appropriate if the first Hospital does not have the required services and/or facilities to treat you or a covered Dependent. The service can be by professional ground or air Ambulance when medically necessary. The HSP, PPO, and HPN HSP do not cover chartered air flights. The HSP, PPO, and HPN HSP will not cover other travel or communication expenses of patients, Practitioners, Nurses or family members.

Ambulatory Surgery - Ambulatory Surgery performed in a Hospital Outpatient department or Out-of-Hospital, a Practitioner's office or an Ambulatory Surgical Center in connection with covered Surgery.

Anesthesia - Anesthetics and their administration.

Audiology Services - Audiology services rendered by a physician or licensed audiologist or licensed speech-language pathologist. The services must be:

- Determined to be Medically Necessary and Appropriate, and
- Performed within the scope of the Practitioner's practice.

Autism - Behavioral services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as Applied Behavioral Analysis (ABA)) are covered if the services are:

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

These services require pre-authorization.

Blood - HSP, PPO, HPN HSP and HPN PPO cover:

- Blood
- Blood products
- Blood transfusions, and
- The cost of testing and processing blood. The HSP, PPO, HPN HSP and HPN PPO do not pay for blood that has been donated or replaced on behalf of you or your covered Dependent(s).

HSP, PPO, HPN HSP and HPN PPO also cover expenses Incurred in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia. The home treatment program must be under the supervision of a State Approved Hemophilia Treatment Center. A home treatment program will not preclude further or additional treatment or care at an eligible Facility. However, the number of home treatments, according to a ratio of home treatments to benefit days, cannot exceed the total number of benefit days allowed for any other Illness under this Plan. As used above, "blood product" includes but is not limited to Factor VIII, Factor IX and cryoprecipitate, and "blood infusion equipment" includes, but is not limited to, syringes and needles.

Birthing Centers - Birthing Center services, including prenatal, delivery and postnatal care. If complications occur during labor, delivery may take place in a Hospital because of the need for emergency and/or Inpatient care. If, for any reason, the pregnancy does not go to term, HSP, PPO, HPN HSP and HPN PPO will not provide payment to the Birthing Center.

Clinical Trials - HSP, PPO, HPN HSP and HPN PPO cover certain medical expenses Incurred during participation in an approved clinical trial for a life-threatening disease, such as cancer. Expenses will be covered based on the Deductibles and Coinsurance for the HSP, PPO, HPN HSP and HPN PPO. Contact Anthem for more details.

Dental Care and Treatment - Treatment of Accidental Injury to sound natural teeth or the jaw that are Incurred within 12 months of an accident are covered. But, this is only if the Injury was not caused, directly or indirectly, by biting or chewing. Treatment includes replacing sound natural teeth lost due to Injury. Services include:

- Hospital services and supplies received for a stay required because of your condition.
- Dental work Surgery and orthodontic treatment needed to remove, repair, restore or reposition:
 - Natural teeth damaged, lost, or removed, or
 - Other body tissues of the mouth fractured or cut.

Any such teeth must have been free from decay or in good repair and are firmly attached to the jaw bone at the time of the Injury.

If crowns, dentures, bridges, or in-mouth appliances are installed due to Injury, covered expenses only include charges for:

- The first denture or fixed bridgework to replace lost teeth
- The first crown needed to repair each damaged tooth, and
- An in-mouth appliance used in the first course of orthodontic treatment after the Injury.

Diabetes Benefits - As part of the Preventive Care benefit, the HSP, PPO, HPN HSP and HPN PPO also provide benefits for diabetic self-management training, education and medical nutrition therapy when provided by a physician, or duly-certified, registered or licensed nutritionist, dietician or Nurse.

Diabetic Supply - Diabetic Supplies covered by a pharmacy plan are not covered under a medical plan; these include lancets, syringes and insulin. Diabetic Supplies not covered under a pharmacy plan are covered by the medical plan.

Diagnostic X-rays and Lab Tests - The HSP, PPO, HPN HSP and HPN PPO cover Diagnostic Services. Services include, but are not limited to:

- Lab services
- Diagnostic X-rays, and
- Diagnostic ultrasound services and tests.

Durable Medical Equipment - Charges for the rental of Durable Medical Equipment needed for therapeutic use. The HSP, PPO, HPN HSP and HPN PPO may decide to cover the purchase of such items when it is less costly and more practical than to rent them. The HSP, PPO, HPN HSP and HPN PPO do not cover:

- Replacements or repairs (covered when Medically Necessary due to normal use and wear and tear),
- The rental or purchase of any items that do not fully meet the definition of Durable Medical Equipment. Such items include air conditioners, exercise equipment, saunas and air humidifiers.

Emergency Room - Services provided by a Hospital emergency room to treat a Medical Emergency or provide a medical screening examination.

Facet Injections/Epidurals - Typically provided in an office Visit or out-patient setting, are covered only when Medically Necessary and Appropriate, and in a manner that is consistent with the prevailing treatment protocols.

Facility Charges - Hospital semi-private room and board and Routine Nursing Care provided by a Hospital on an Inpatient basis. The HSP, PPO, HPN HSP and HPN PPO limit what they cover each day to a room and board limit. Also covered are charges as an Inpatient in a Special Care Unit.

The HSP, PPO, HPN HSP and HPN PPO also cover:

- Outpatient Hospital services, including services furnished by a Hospital Outpatient clinic, and
- Emergency room care, as described above.

Fertility Services - HSP, PPO, HPN HSP and HPN PPO only cover charges for Diagnostic Services related to the diagnosis of infertility.

Food Products - The HSP, PPO, HPN HSP and HPN PPO cover medical food which must be:

- Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation, and
- Formulated to be consumed or administered under direction of a physician.

This includes Low Protein Modified Food Products, which are defined as a food product that is specifically formulated to have less than one gram of protein per serving and that is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a natural food product that is naturally low in protein.

Foot Orthotics – The HSP, PPO, HPN HSP and HPN PPO cover Foot Orthotics according to guidelines issued by the Health Care Finance Administration (HCFA) and the Center for Medicare Services (CMS) – for example: diabetes, peripheral vascular/neuropathic conditions and post-Surgery trauma.

Hearing Aids - Hearing aids are covered for up to \$2,000 every 36 months. Expenses Incurred for the purchase and fitting of hearing aids and related supplies. Coverage is limited as shown in the “Schedule of Covered Services and Supplies” section.

Hearing Exams - Routine hearing exams/evaluations.

Home Health Care - Home Health Care Services furnished by Home Health Agency. Limited to 120 visits per Calendar Year.

In order for Home Health Agency charges to be considered Covered Charges, you or your covered Dependent’s admission to Home Health Agency care may be direct, with no prior Inpatient admission.

The HSP, PPO, HPN HSP and HPN PPO do not cover:

- Services furnished to family members, other than the patient
- Services and supplies not included in the Home Health Care Plan
- Services that are primarily Custodial Care
- Services of a person who usually lives with you, or who is a member of your or your spouse’s family
- Services of a certified or licensed social worker
- Services for Infusion Therapy (except as otherwise covered under the Home Infusion Therapy benefit), or
- Transportation.

Home Infusion Therapy - The HSP, PPO, HPN HSP and HPN PPO cover Home Infusion Therapy. “Home Infusion Therapy” is a method of administering intravenous (IV) medications or nutrients via pump or gravity in the home. The services and supplies that are covered include:

- Solutions and pharmaceutical additives
- Pharmacy compounding and dispensing services
- Ancillary medical supplies

- Nursing services associated with:
 - Patient and/or alternative caregiver training
 - Visits needed to monitor intravenous therapy regimen
 - Medical Emergency care (but not for administration of Home Infusion Therapy).

Examples of Home Infusion Therapy include:

- Chemotherapy
- Intravenous antibiotic therapy
- Total parenteral nutrition
- Hydration therapy
- Continuous subcutaneous pain management therapies and continuous intrathecal pain management
- Gammaglobulin Infusion Therapy (IVIG), and
- Prolastin therapy.

To be covered, Home Infusion Therapy must be given Prior Authorization by Anthem.

Hospice Care - Hospice Care benefits will be provided for terminally Ill or Injured patients. Terminally Ill or Injured means that you or your covered Dependent's Practitioner has certified in writing that you or your covered Dependent's life expectancy is six months.

Hospice care must be furnished according to a written Hospice Care Program. The following Hospice services are covered under the HSP, PPO, HPN HSP HPN PPO:

- Part-time professional nursing services of an R.N., L.P.N. or Licensed Viatical Nurse (L.V.N.)
- Home health aide services provided under the supervision of an R.N.
- Up to 10 days of respite care
- Medical care rendered by a Hospice Care Program Practitioner
- Therapy Services
- Diagnostic Services
- Medical and Surgical supplies
- Prescription Drugs
- Oxygen and its administration
- Medical social services and pastoral services
- Psychological support services to the terminally Ill or Injured patient
- Family counseling related to the patient's terminal condition
- Dietician services
- Inpatient room, board and general nursing services, and
- Bereavement counseling.

The following Hospice benefits are NOT COVERED under the HSP, PPO, HPN HSP and HPN PPO:

- Medical care rendered by the patient's private Practitioner
- Volunteer services or services provided by others without charge
- Homemaker services
- Food or home-delivered meals
- Private-duty Nursing services
- Dialysis Treatment
- Treatment not included in the Hospice Care Program
- Funeral services and arrangements
- Legal or financial counseling or services
- Pastoral care

- Transportation, including but not limited to, Ambulance transportation, or
- Any Hospice care services that are not given Prior Authorization by Anthem.

Inpatient Physician Services - Services and supplies furnished by a physician to you or your covered Dependent that is a registered Inpatient in a Facility.

Mastectomy Benefits - Benefits for these services are subject to the same Deductible and Coinsurance as other Covered Services. Up to four mastectomy bras are covered every Calendar Year. This includes a Hospital stay of at least 72 hours following a modified radical mastectomy and a Hospital stay of at least 48 hours following a simple mastectomy. A shorter length of stay may be covered if the patient, in consultation with her physician, determines that it is Medically Necessary and Appropriate. The patient's Provider does not need to obtain Prior Authorization for the 48 or 72 hour stays, as applicable, of Inpatient care. Any other provisions of the HSP, PPO, or HPN HSP that require notification for Inpatient services still apply.

Maternity/Obstetrical Care - Medical care related to pregnancy, childbirth, or miscarriage, includes:

- The Hospital delivery, and
- A Hospital Inpatient stay for at least 48 hours after a vaginal delivery or 96 hours after a Cesarean section

This applies if:

- The attending physician determines that Inpatient care is Medically Necessary and Appropriate, or
- If it is requested by the mother (regardless of Medical Necessity and Appropriateness).

"Attending physician" includes the attending obstetrician, pediatrician or other physician attending the mother or newly born child. A Hospital Inpatient stay is deemed to start:

- At the time of delivery, or
- In the case of multiple births, at the time of the last delivery, or
- If the delivery occurs out of the Hospital, at the time the mother or newborn is admitted to the Hospital.

Services and supplies provided by a Hospital to a newborn child during the initial Hospital stay of the mother and child are covered as part of the obstetrical care benefits. But, if the child's care is given by a different physician from the one who provided the mother's obstetrical care, the child's care will be covered separately.

If Anthem gives Prior Authorization, the HSP, PPO, HPN HSP and HPN PPO also cover Birthing Center charges made by a Practitioner for:

- Pre-natal care
- Delivery
- Post-partum care for you or your covered Dependent's pregnancy, and
- Circumcisions.

Maternity Care for Child Dependents - A female child Dependent is covered under the HSP, PPO, HPN HSP and HPN PPO for any services incidental to or resulting from her pregnancy.

Medical Emergency - Charges relating to a Medical Emergency, including X-ray and lab charges Incurred due to the Medical Emergency.

Benefits include coverage of trauma at any designated level I or II trauma center, as Medically Necessary and Appropriate. The coverage continues at least until, in the judgment of the attending physician, you or your covered Dependent:

- Is medically stable
- No longer requires critical care, and
- Can be safely transferred to another Facility, if needed.

The HSP, PPO, HPN HSP and HPN PPO will also cover a medical screening exam that is:

- Rendered upon you or a covered Dependent's arrival at a Hospital
- Required under federal law to be performed by the Hospital, and
- Needed to determine whether a Medical Emergency situation exists.

In the event of a potentially life-threatening condition, you or your covered Dependent should call 911 or the local emergency response system.

Mental Illness - Covered expenses include. Inpatient and outpatient treatment for mental disorders when rendered by a licensed psychiatrist or licensed psychologist or when rendered by a physician as defined, provided the counselor is employed by and working under the direct supervision of a psychiatrist or clinical psychologist.

Benefits are payable for charges Incurred in a Hospital, psychiatric Hospital, residential treatment Facility or Provider's office for the treatment of mental disorders as follows:

Inpatient Treatment

Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a Hospital, psychiatric Hospital or residential treatment Facility.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time Inpatient in a Hospital, psychiatric Hospital or residential treatment Facility.

The HSP, PPO, and HPN HSP cover Partial Hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a Facility or program for the intermediate short-term or medically-directed intensive treatment.

Nutritional Counseling - Nutritional counseling is covered as part of the Preventive Care benefit. The nutritional counseling must be prescribed by a Practitioner.

Online Visits – Online visits are covered, including LiveHealth Online (Other than Behavioral Health & Substance Abuse; see Behavioral Health and Substance Abuse Care section for further details)

Oxygen and its Administration - Oxygen and the rental of equipment for its administration.

Oral Surgery – Oral surgeries are subject to Medical Necessity and exclude appliances and orthodontic treatment. Dental Anesthesia is covered only if it is related to a payable oral surgery. Impacted teeth are not covered.

Physical Rehabilitation - Inpatient and Outpatient treatment in a Physical Rehabilitation Center. Inpatient treatment will include the same services and supplies available to any other Inpatient Facility.

Practitioner's Charges for Non-Surgical Care and Treatment - Practitioner's charges for the non-Surgical care and treatment of an Illness, Injury, Mental Illness and/or Substance Use Disorder. This includes Medically Necessary pharmaceuticals that, in the usual course of medical practice, are

administered by a Practitioner, if the pharmaceuticals are billed by the Practitioner or by a specialty pharmaceutical Provider.

Pre-Admission Testing Charges - Pre-admission diagnostic X-ray and lab tests needed for a planned Hospital admission or Surgery. To be covered, these tests must be done on an Outpatient or Out-of-Hospital basis within seven days of the planned admission or Surgery. The HSP, PPO, HPN HSP and HPN PPO do not cover tests that are repeated after admission or before Surgery. But, this does not apply if the admission or Surgery is deferred solely due to a change in your or your covered Dependent's health.

Preventive Care - Benefits for certain Covered Services and Supplies relating to Preventive Care. Covered preventive services are as follows:

- Gynecological Examinations - Routine gynecological examinations including PAP tests
- Mammography - Each year as determined by the patient's doctor with no age limit. Charges made for one mammogram each year for female patients
- Prostate Cancer Screening - An annual medically-recognized diagnostic exam, including, but not limited to:
 - A digital rectal exam, and
 - A prostate-specific antigen test, for male patients.
- Routine Physicals and Immunizations - Routine physical exam(s) (including related X-rays and lab tests) and immunizations for you and your covered Dependent(s) starting at age eighteen
- Well Child Immunizations - To be covered, childhood immunizations must be as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health
- Colorectal Cancer Screening - Colorectal cancer screening rendered no more frequently than annually for you or your covered Dependents of any age. Covered tests include a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, any combination of these tests or the most reliable, medically recognized screening test available
- Well Child Care
- Routine Hearing Examination
- Nutritional Counseling, and
- Diabetes Education.

Preventive Care Services for Women - All contraceptive methods and certain specified screening and counseling services for women are covered at 100%. Covered preventive services include:

- Well-woman Visits
- Gestational diabetes screening
- HPV DNA testing
- Sexually transmitted infection counseling
- HIV screening and counseling
- FDA-approved contraception methods and contraceptive counseling
- Breastfeeding support, supplies and counseling, and
- Domestic violence screening and counseling.

Private Duty Nursing Care - The HSP, PPO, HPN HSP and HPN PPO cover the services of a Nurse for private duty nursing care. These conditions apply:

- The care must be ordered by a physician, and
- The care must be furnished while intensive Skilled Nursing Care is required in the treatment of an acute illness or during the acute period after an Injury, and the patient is not in a Facility that provides Nursing care. *(Note: This requirement will not be deemed to be met if the care actually furnished is mainly Custodial Care or maintenance. Also, no benefits will be provided for the*

services of a Nurse who ordinarily resides in the patient's home or is a member of the patient's immediate family.)

To be covered, private duty nursing must be given Prior Authorization by Anthem.

Prosthetic Devices - The HSP, PPO, HPN HSP and HPN PPO limit coverage for prosthetic devices. The HSP, PPO, HPN HSP and HPN PPO cover only the initial fitting and purchase of artificial limbs and eyes and other prosthetic devices. To be covered, such devices must:

- Take the place of a natural part of your or your covered Dependent's body
- Be needed due to a functional birth defect in a covered child Dependent, or
- Be needed for reconstructive breast Surgery.

Replacements are covered when Medically Necessary due to normal use and wear and tear. The HSP, PPO, HPN HSP and HPN PPO do not cover repairs of prosthetic devices or dental prosthetics or devices.

Second Opinion Charges - If you or a covered Dependent is scheduled for an elective Surgical procedure, the HSP, PPO, HPN HSP and HPN PPO cover a Practitioner's charges for a second opinion and charges for related diagnostic X-ray and lab tests. If the second opinion does not confirm the need for the Surgery, HSP, PPO, HPN HSP and HPN PPO will cover a Practitioner's charges for a third opinion regarding the need for the Surgery. The HSP, PPO, HPN HSP and HPN PPO will cover charges if the Practitioner(s) who give(s) the opinion:

- Is board certified and qualified, by reason of his/her specialty, to give an opinion on the proposed Surgery or Hospital admission,
- Is not a business associate of the Practitioner who recommended the Surgery, and
- Does not perform or assist in the Surgery, if it is needed.

Skilled Nursing Facility Charges - Bed and board (including diets, drugs, medicines and dressings and general nursing service) in a Skilled Nursing Facility. You or your covered Dependent must be admitted to the Skilled Nursing Facility within 14 days of discharge from a Hospital for continuing medical care and treatment prescribed by a Practitioner. **Pre-authorization required or a \$500 penalty applies.**

Substance Abuse - Covered expenses include charges made for the treatment of Substance Abuse by Providers. In addition to meeting all other conditions for coverage, the treatment must be prescribed and supervised by a Provider.

- *Inpatient Treatment:* The HSP, PPO, HPN HSP and HPN PPO cover room and board at the semi-private room rate and other services and supplies provided during your stay in a psychiatric Hospital or residential treatment Facility, appropriately licensed by the state Department of Health or its equivalent. Coverage includes:
 - Treatment in a Hospital for the medical complications of Substance Abuse, and
 - "Medical complications" including detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- *Outpatient Treatment:* Outpatient treatment includes charges for treatment received for Substance Abuse while not confined as a full-time Inpatient in a Hospital, psychiatric Hospital or residential treatment Facility.

The HSP, PPO, a HPN HSP and HPN PPO cover Partial Hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a Facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse.

Surgical Services – The HSP, PPO, HPN HSP and HPN PPO cover Surgery, subject to the following:

- The HSP, PPO, HPN HSP and HPN PPO will not make separate payment for pre-and post-operative care
- If more than one surgical procedure is performed during the same operation through only one route of access, the HSP, PPO, HPN HSP and HPN PPO will cover the primary procedure only. There will be no payment for any other procedures performed at the same time
- If more than one Surgical procedure is performed during the same operation through more than one route of access, the HSP, PPO, HPN HSP and HPN PPO will cover the primary procedure, plus 50% of what the HSP, PPO, HPN HSP and HPN PPO would have paid for each of the other procedures had those procedures been performed alone
- The HSP, PPO, HPN HSP and HPN PPO do not cover cosmetic Surgery except:
 - Surgery to treat a condition, including a birth defect, which impairs the function of a body organ
 - Surgery to reconstruct a breast after a mastectomy is performed (see below)
 - Treatment of newborns to correct congenital defects and abnormalities, and
 - Treatment of cleft lip.

If you or a covered Dependent is receiving benefits for a mastectomy, the HSP, PPO, HPN HSP and HPN PPO will also cover the following, as determined after consultation between the attending physician and you or your covered Dependent:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- The treatment of physical complications at all stages of the mastectomy, including lymphedemas, and
- Prosthetic devices.

Benefits for Covered Charges Incurred for a mastectomy are subject to the same Deductible and Coinsurance that apply to other covered Surgical and Practitioners' services.

Temporomandibular Joint Disorder

Any combination of Network Benefits and Non-Network Benefits is limited to \$3,000 per Covered Person per Calendar Year.

Therapeutic Manipulation - Benefits for Therapeutic Manipulations. Maintenance Therapy is **not covered**. Thirty (30) visits per Calendar Year limit,

Therapy Services - Services and supplies for the following types of therapy:

- Physical Therapy, Occupational Therapy, Speech Therapy (limited to 90 visits per year, in aggregate)
- Cognitive Therapy
- Respiratory Therapy
- Radiation Therapy
- Chemotherapy
- Dialysis Treatment

Intensive Applied Behavioral Therapy for Autism

TMJ Treatment – Treatment of temporomandibular joint syndrome (TMJ) or myofascial pain including only removable devices for TMJ repositioning and related surgery and diagnostic services are covered. This does not include fixed or removable appliances which involve movement or repositioning of teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Transplant Benefits – Pre-authorization required. Services and supplies for the following types of transplants:

- Bone marrow
- Cornea
- Heart
- Heart/lung
- Heart valve
- Kidney
- Liver
- Lung
- Muscular-skeletal
- Pancreas
- Pancreas/kidney
- Parathyroid

Benefits are available for the recipient and donor as follows:

- If both the donor and recipient have coverage, each would be responsible for having their benefits paid by their own plan.
- If you are the recipient of the transplant and the donor has no coverage from any other source, the benefits described in this SPD will be provided to both you and the donor. In this case, benefits to the donor will be charged against your benefit maximums, Deductibles and Coinsurance.
- If you are the transplant donor and no other benefits are available to you, the benefits described in this SPD will be provided to you. However, no benefits will be provided for the recipient who is not covered by the Plan.

Your benefits begin no earlier than five days prior to the transplant Surgery and continue for a period of no longer than 365 days after the transplant Surgery. Benefits will be provided for Inpatient and Outpatient Covered Services. Benefits will also be provided for the transportation of the donor organ to the location of the transplant Surgery (limited to transportation of the donor organ within the United States or Canada).

In addition to the “Non-Covered Services and Supplies” section below, the following exclusions apply to transplant Surgery:

- Cardiac rehabilitation services when not provided for the recipient within three days after discharge from a Hospital for transplant Surgery
- Transportation by air Ambulance for the donor or recipient
- Travel time and related expenses required by a Provider, and
- Investigational drugs.

Urgent Care - Covered Services and Supplies furnished for Urgent Care of you or your covered Dependent(s).

Walk-In Clinic Visits - Covered expenses include charges made by walk-in clinics for unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations administered within the scope of the clinic’s license.

Wigs Benefit - This Plan covers a wig(s) or hairpiece(s) (synthetic, human hair or blends) prescribed by a physician as a prosthetic for hair loss due to Injury, disease, or treatment of a disease for up to two wigs per Calendar Year (\$500 limit per Calendar Year). Examples of covered illnesses are:

- Burns – 2nd degree full thickness and 3rd degree burns with resulting permanent alopecia
- Alopecia areata with near complete or complete cranial hair loss, totalis and universalis

- Fungal infections not responsive to an appropriate (typically 6 week) course of antifungal treatment resulting in near complete or complete cranial hair loss
- Chemotherapy
- Radiation Therapy.

Non-Covered Services and Supplies

The following services and supplies are **not covered** under the HSP, PPO, HPN HSP and HPN PPO. The HSP, PPO, HPN HSP and HPN PPO will not pay for any charges incurred for, or in connection with them:

- Acupuncture, unless rendered in lieu of anesthesia or pain management.
- Administration of oxygen, except if Medically Necessary and Appropriate.
- Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity and urine autoinjections.
- Ambulance, except as otherwise stated in this SPD.
- Ancillary charges connected with self-administered services such as patient controlled analgesia, related diagnostic testing, self-care and self-help training.
- Anesthesia and consultation services when they are given in connection with Non-Covered Charges.
- Any part of a charge that exceeds the reasonable and customary Allowance.
- Any therapy not included in the definition of Therapy Services.
- Behavioral Health Sciences as follows:
 - Substance Abuse rehabilitation treatment on an Inpatient or Outpatient basis, except to the extent Substance Abuse is specifically covered in this SPD
 - Treatment of a covered health care Provider who specializes in the mental health care field and who receives treatment as a part of their training in that field
 - Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia or caffeine use, except to the extent specifically covered in this SPD as Mental Illness
 - Treatment of antisocial personality disorder, except to the extent specifically covered in this SPD as Mental Illness and/or Substance Use Disorder
 - Treatment in wilderness programs or other similar programs, except to the extent specifically covered in this SPD as Mental Illness and/or Substance Use Disorder
 - Treatment of mental retardation, defects, and deficiencies, except to the extent specifically covered in this SPD as Mental Illness and/or Substance Use Disorder. This exclusion does not apply to mental health services or to medical treatment of mentally retarded as otherwise covered in this SPD.
- Blood or blood plasma or other blood derivatives or components that are replaced by you or a covered Dependent.
- Broken appointments.
- Completion of claim forms.
- Conditions classified as V-codes in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*. These include relational problems such as:
 - Parent-child conflicts
 - Problems related to abuse or neglect when intervention is focused on the perpetrator, and
 - Situations not attributable to a diagnosable disorder—including bereavement, academic, occupational, religious and spiritual problems.
- Conditions related to behavior problems or learning disabilities, except to the extent otherwise covered in this SPD (e.g., Autism).

- Conditions that the Plan determines to be due to developmental disorders. These include, but are not limited to Down Syndrome, Cerebral Palsy, mental retardation, academic skills disorders or motor skills disorders. But, this does not apply to:
 - The treatment of Mental Illness or Autism, or
 - Disorders to the extent needed to provide newly born Dependents with coverage for Injury or Illness, including the necessary care and treatment of medically diagnosed congenital defects and abnormalities.
- Conditions which the Plan determines to lack a recognizable III-R classification in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*. This includes, but is not limited to, treatment for adult children of alcoholic families, or co-dependency.
- Consumable medical supplies, such as bandages (except dressing which may be covered as part of the Durable Medical Equipment benefit), Band-Aids and test-strips (covered under Prescription Drug benefit).
- Cosmetic Services except as otherwise stated in this SPD. This includes the following connected with Cosmetic Services:
 - Procedures
 - Treatments
 - Drugs
 - Biological products, and
 - Complications of cosmetic Surgery.
- Court ordered treatment that is not Medically Necessary and Appropriate.
- Custodial Care or domiciliary care, including respite care, except as otherwise stated in this SPD.
- Expenses Incurred for Day Programs.
- Dental care or treatment, except as otherwise stated in this SPD. This includes, but is not limited to:
 - The restoration of tooth structure lost by decay, fracture, attrition, or erosion
 - Endodontic treatment of teeth
 - Surgery and related services to treat periodontal disease
 - Osseous Surgery and any other Surgery to the periodontium
 - Replacing missing teeth
 - The removal and re-implantation of teeth (and related services)
 - Any orthodontic treatment, and
 - Dental implants and related services.
- Diversional/recreational therapy or activity when not being used as a treatment for mental illness and/or Substance Use Disorder.
- Elective abortions.
- Employment/career counseling.
- Expenses Incurred after any payment, duration or Visit maximum is or would be reached.
- Experimental or Investigational treatments, procedures, Hospitalizations, drugs, biological products or medical devices—except as otherwise stated in this SPD.
- Eyeglasses, contact lenses and all fittings—except as otherwise stated in this SPD, such as orthoptic therapy.
- Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility.
- Food products (including enterally administered food products) except as otherwise stated in this SPD.
- Growth/Height: Any treatment, device, drug (except as specifically covered under the prescription drug benefit, service or supply) (including Surgical procedures and devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- Home Health Care Visits solely for the purpose of administering Dialysis Treatment.
- Home uterine activity monitoring unless Medically Necessary and Appropriate.
- Hospice services, except as otherwise stated in this SPD.
- Housekeeping services, except as an incidental part of Covered Services and Supplies furnished by a Home Health Agency.

- Illness or Injury, including a condition which is the result of an Illness or Injury, which occurred on the job, and is covered or could have been covered for benefits provided under a Workers' Compensation, employer's liability, occupational disease or similar law or regulation. However, this exclusion does not apply to the following persons for whom coverage under Workers' Compensation is optional, unless such persons are actually covered under Workers' Compensation:
 - A self-employed person or a partner of a limited liability partnership, or
 - Members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.
- Immunizations, except as otherwise stated in this SPD.
- Light box therapy and the appliance that radiates the light.
- Maintenance Therapy for:
 - Physical Therapy
 - Manipulative Therapy
 - Occupational Therapy, and
 - Speech Therapy.
- Marriage, career or financial counseling or sex therapy.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Milieu therapy. Inpatient services and supplies, which are primarily for milieu therapy, even though covered treatment may also be provided. This means that the Plan has determined that:
 - The purpose of all or part of an Inpatient stay is chiefly to change or control a patient's environment, and
 - An Inpatient setting is not Medically Necessary and Appropriate for the treatment furnished, if any.
- Non-medical equipment that may be used chiefly for personal hygiene or for the comfort or convenience of you or a covered Dependent, rather than for a medical purpose. This includes air conditioners, dehumidifiers, purifiers, saunas, hot tubs, televisions, telephones, first aid kits, exercise equipment, heating pads and similar supplies which are useful to a person in the absence of Illness or Injury.
- Pastoral counseling.
- Personal comfort and convenience items.
- Prescription Drugs that in the usual course of medical practice are self-administered or dispensed by a retail or mail-order pharmacy. These drugs may be covered under the Prescription Drug benefit.
- Private duty nursing, except as otherwise stated in this SPD.
- Psychoanalysis to complete the requirements of an educational degree or residency program.
- Psychological testing for educational purpose except for mental illnesses and/or autism and subject to pre-authorization.
- Removal of abnormal skin outgrowths and other growths. This includes, but is not limited to, paring or chemical treatments to remove corns, calluses, warts, hornified nails, and all other growths— unless it involves cutting through all layers of the skin. This does not apply to services needed for the treatment of diabetes.
- Rest or convalescent cures.
- Room and board charges for any period of time during which you or your covered Dependent was not physically present in the room.
- Routine Foot Care, except as may be Medically Necessary and Appropriate for the treatment of certain Illnesses or Injuries. This includes treatment for: corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet, except as otherwise stated in this SPD.
- Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions that are not specifically the result of Mental Illness or Autism.
- Services and supplies related to the fitting of hearing aids, repairs and replacement batteries except as otherwise stated in this SPD.

- Services for Injuries resulting from a motor vehicle accident if such services are eligible for payment under the personal Injury protection or compulsory medical payments provisions of a motor vehicle insurance contract required by any federal or state no-fault motor vehicle insurance law. This exclusion applies whether or not a proper and timely claim for payment for these services is made under the motor vehicle insurance contract or if coverage is waived by the patient.
- Services involving equipment or Facilities used when the purchase, rental or construction has not been approved in compliance with applicable state laws or regulations.
- Services performed by any of these:
 - A Hospital resident, intern or other Practitioner who is paid by a Facility or other source, and is not allowed to charge for Covered Services and Supplies, whether or not the Practitioner is in training. However, Hospital-employed physician Specialists may bill separately for their services, or Anyone who does not qualify as a Practitioner.
- Services required by the Company as a condition of employment, services rendered through a medical department, clinic or other similar service provided or maintained by the Company.
- Services or supplies rendered or provided for the diagnosis and treatment of infertility other than the diagnosis of infertility in conjunction with conception through normal intercourse. Specifically excluded are all services and supplies related to artificial insemination and in-vitro fertilization including, but not limited to, gamete intra-fallopian transfer (GIFT).
- Services or supplies:
 - Eligible for payment under either federal or state programs (except Medicare and Medicaid when, by law, this Plan is primary). This provision applies whether or not you or your covered Dependent asserts the right to obtain this coverage or payment for these services
 - For which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair
 - For which the Provider has not received a certificate of need or such other approvals as are required by law
 - For which you or your covered Dependent would not have been charged if he/she did not have health care coverage
 - Furnished by one of the members of your or your covered Dependent's family, unless otherwise stated in this SPD (spouse, child, parent, in-law, brother or sister)
 - Connected with any procedure or exam not needed for the diagnosis or treatment of an Injury or Illness for which a bona fide diagnosis has been made because of existing symptoms
 - Except as required by HIPAA, needed due to an Injury or Illness to which a contributing cause was your or your covered Dependent's commission of, or attempt to commit, a felony; or to which a contributing cause was your or your covered Dependent's engagement in an illegal occupation
 - Provided by or in a Government Hospital, or provided by or in a Facility run by the Department of Defense or Veteran's Administration for a service-related Illness or Injury, unless coverage for the services is otherwise required by law
 - Provided by a licensed pastoral counselor in the course of his/her normal duties as a pastor or minister
 - Provided by a social worker, except as otherwise stated in this SPD
 - Provided during any part of a stay at a Facility, or during Home Health Care, chiefly for bed rest, rest cure, convalescence, custodial or sanatorium care, diet therapy or Occupational Therapy
 - Provided to treat an Illness or Injury related to current or previous military service
 - Rendered prior to you or your covered Dependent's Coverage Date or after you or your Dependent's coverage under this Plan ends
 - Which are specifically limited or excluded elsewhere in this SPD
 - Which are not Medically Necessary and Appropriate
 - For which you or your covered Dependent is not legally obligated to pay.
- Tobacco cessation aids of all kinds and the services of stop-tobacco Providers, except as otherwise covered under the Prescription Drug benefit.
- Special medical reports not directly related to treatment of you or your covered Dependent (e.g., employment physicals or reports prepared due to litigation).

- Stand-by (on call) services performed by Surgical assistants not employed by the Facility where the Surgical procedure is performed.
- Speech Therapy for the treatment of developmental delays or anomalies, except to the extent otherwise covered in this SPD for Mental Illness or Autism.
- Sterilization reversal.
- Strength and performance services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:
 - Exercise equipment, memberships in health or fitness clubs, training, advice or coaching
 - Drugs or preparations to enhance strength, performance or endurance, and
 - Treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparation
- Sunglasses, even if by prescription.
- Surgery, sex hormones and related medical and psychiatric services to change gender, services and supplies arising from complications of gender transformation and treatment for gender identity disorders.
- Telephone consultations, except as the HSP, PPO, and HPN HSP may request.
- Therapies and tests for any of the following treatments or procedures:
 - Aromatherapy
 - Bioenergetic therapy
 - Carbon dioxide therapy
 - Chelation therapy (except for heavy metal poisoning)
 - Computer-aided tomography (CAT) scanning of the entire body
 - Educational therapy except when required for autism
 - Gastric irrigation
 - Hair analysis
 - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds
 - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered Surgery
 - Lovaas therapy
 - Massage therapy
 - Megavitamin therapy
 - Primal therapy
 - Psychodrama
 - Purging
 - Recreational therapy except when required for autism
 - Rolfing
 - Sensory or auditory integration therapy, and
 - Thermograms and thermography.
- Transplants, except as otherwise stated in this SPD.
- Transportation: travel, except as otherwise provided in this SPD for Ambulance service.
- Vision therapy, vision or visual acuity training, orthoptics or pleoptics. Vision exams and hardware solely for the purpose of correcting poor vision that is not-related to a medical condition of the eye.
- Vitamins and dietary supplements, except as otherwise covered under the Prescription Drug benefit.
- Weight reduction or control, unless there is a diagnosis of morbid obesity, special foods, food supplements, liquid diets, diet plans or any related products, except as otherwise stated in this SPD.
- Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness, except as otherwise stated in this SPD

Prescription Drug Coverage through the HSP PPO, HPN HSP and HPN PPO

The HSP, PPO, HPN HSP and HPN PPO provide Prescription Drug coverage that is administered by Express Scripts. This Prescription Drug benefit allows you to purchase Prescription Drugs through a retail

pharmacy or by mail order. Whether you choose a retail pharmacy or mail order for your Prescription Drugs, there are no claim forms or waiting for reimbursements.

Under the pharmacy benefit, Prescription Drugs are classified into tiers. Tiers are the different cost levels you pay for a medication. Each tier is assigned a cost, which is determined by your health plan. This is how much you will pay when you fill a prescription. Tier 1 medications are your lowest-cost options. If your medication is placed in Tier 2 or 3, look to see if there is a Tier 1 option available. Discuss these options with your doctor.

- **Tier 1.** Lower cost drugs. Both brand name drugs and generics are included
- **Tier 2.** Mid-range cost drugs. Both brand name drugs and generics are included. Use Tier 2 drugs, instead of Tier 3 to help reduce your out of pocket costs.
- **Tier 3.** Highest cost drugs. Mostly higher-cost brand as well as select generic drugs. Many Tier 3 drugs lower-cost options in Tier 1 or Tier 2. As your doctor if they could work for you.

Express Scripts

You may access Express Scripts by phone, toll-free at (800) 818-6743 or via the Internet at www.express-scripts.com. If you visit Express Scripts online, you will be able to order or check information such as:

- **Refill request.** You can request mail order prescriptions from a list of ready-to-refill prescriptions for yourself and your covered Dependents.
- **Order status.** You can quickly check the status of recent orders displayed together with drug names and prescription numbers.
- **Prescription history.** As a participant in the HSP and PPO, you can view up to 13 months of prescription history with Express Scripts—including mail order, retail pharmacy prescriptions and paper claims.
- **Drug coverage.** You will see the covered drugs, find payment information for both mail order and retail pharmacy orders, and be able to view your benefit coverage.

The schedules below provide a summary of your Prescription Drug benefits under the HSP PPO, HPN HSP and HPN PPO:

Health Savings Plan and HPN HSP Prescription Drug Coverage Schedule of Benefits	
In-Network Prescription Drug Coverage	
Tier 1 retail (31-day supply)	You pay a 20% coinsurance after the Deductible. Deductible is combined for medical and Rx.
Tier 2 retail (31-day supply)	You pay a 35% coinsurance after the Deductible
Tier 3 retail (31-day supply)	You pay 50% coinsurance after the Deductible
Tier 1 mail order (90-day supply)	You pay a 20% coinsurance after the Deductible*
Tier 2 mail order (90-day supply)	You pay a 30% coinsurance after the Deductible (\$150 maximum per prescription)
Tier 3 mail order (90-day supply)	You pay 50% coinsurance after the Deductible (\$300 maximum per prescription)
Specialty medications (up to a 31-day supply). You must use an Express Scripts specialty pharmacy for biotech drugs used to treat chronic or complex conditions.	You pay a 30% coinsurance after the Deductible (maximum copayment of \$300 per prescription)

Health Savings Plan and HPN HSP Prescription Drug Coverage Schedule of Benefits	
In-Network Prescription Drug Coverage	
Preventive medications	Certain preventive medications are covered at 100% with no coinsurance. See the "Preventive Medications" section below for more details.
Note: Your Prescription Drug expenses are included as part of the Out-of-Pocket limit.	

PPO Plan and HPN PPO Prescription Drug Coverage Schedule of Benefits	
In-Network Prescription Drug Coverage	
Tier 1 retail (31-day supply)	You pay a \$10 copay
Tier 2 retail (31-day supply)	You pay a 35% coinsurance with a \$50 maximum, no deductible applies
Tier 3 retail (31-day supply)	You pay 50% coinsurance with a \$100 maximum, no deductible applies
Tier 4 retail (31-day supply)	You pay 30% coinsurance with a \$150 maximum, no deductible applies
Tier 1 mail order (90-day supply)	You pay a 20% coinsurance, no deductible applies
Tier 2 mail order (90-day supply)	You pay a 35% coinsurance with a \$150 maximum, no deductible applies
Tier 3 mail order (90-day supply)	You pay a 50% coinsurance with a \$300 maximum, no deductible applies
Tier 4 mail order (90-day supply)	You pay a 30% coinsurance with \$150 maximum, no deductible applies
Specialty medications (up to a 31-day supply). You must use an Express Scripts specialty pharmacy for biotech drugs used to treat chronic or complex conditions.	You pay a 30% coinsurance with a \$150 maximum, no deductible applies
Preventive medications	Certain preventive medications are covered at 100% with no coinsurance. See the "Preventive Medications" section below for more details.
Note: Your Prescription Drug expenses are included as part of the Out-of-Pocket limit. They do not count toward the Deductible.	

Note: If you use an Out-of-Network retail pharmacy, you are responsible for the cost of the prescription in excess of the negotiated price and the cost in excess of the negotiated price does not count toward the annual Out-of-Pocket Maximum.

Mandatory Generic Substitution

The HSP, PPO, HPN HSP and HPN PPO have a mandatory generic substitution rule. Mandatory generic substitution means that you pay the lowest cost for using a generic drug in place of the brand-name equivalent medication. When you choose to fill a prescription with a brand-name medication and a lower cost generic equivalent is available, your cost will be higher.

If you have not met your deductible, you will pay the contracted rate of the brand medication. Once you have met your deductible, you will pay the cost difference between the generic and brand medication, plus the coinsurance of the generic medication. If this amount exceeds the contracted rate for the brand medication, you will only pay the contracted rate. This difference does not count toward your annual Out-of-Pocket Maximum.

Coinsurance Prescription Drugs

Coinsurance is the percentage of charges for covered Prescription Drugs and related supplies that you or your Dependent is required to pay.

Deductibles

The HSP and HPN HSP require you to meet the medical Deductible (\$1,500 In-Network Deductible for individual and \$4,000 In-Network Deductible for family) before non-preventive Prescription Drugs are covered. Your eligible Prescription Drug expenses count toward meeting the medical Deductible.

Approved preventive drugs are an exception. HSP & HPN HSP participants can obtain drugs on Express Scripts' extensive list of approved preventive drugs without having to meet the HSP and HPN HSP annual Deductible. For more information on preventive medications, visit Express Scripts toll free, by phone at (800) 818-6743 or via the Internet at www.express-scripts.com.

The PPO & the HPN PPO plans require you to pay the copay or coinsurance amount without having to meet the Deductible. Those expenses go toward the Out-of-Pocket Maximum but not toward the Deductible.

Out-of-Pocket Maximum for Prescription Drugs

Prescription Drug costs in the HSP, PPO, HPN HSP and HPN PPO count toward your annual medical Out-of-Pocket Maximum.

Prior Authorization

Certain drugs or therapies require Prior Authorization before they are covered. These include but are not limited to anti-obesity drugs, growth hormones, medications for immune system disorders and Alzheimer therapies. Check with Express Scripts at (800) 818-6743 or via the Internet at www.express-scripts.com to determine if Prior Authorization is required.

If the medication requires Prior Authorization, your pharmacist should notify you that you will need to contact your physician to initiate the Prior Authorization process with Express Scripts.

Both you and your physician will be notified when a Prior Authorization review is completed. You can appeal any decision.

You may request the use of a specific brand drug without first using a generic in very specific circumstances for a medical necessity. Please contact Express Scripts toll-free at (800) 818-6743 for more information. Please note that a Prior Authorization approval is only available in limited cases and is based only on medical necessity.

Preventive Medications

Certain medication and prescriptions are covered In-Network at 100% with no coinsurance. These include aspirin, iron supplements and certain women's preventive services. Your physician must provide a prescription in order for these medications, including over-the-counter medications, to be fully covered. Some medications have quantity and age limits for 100% coverage. For a list of preventive medications that are fully covered without cost sharing, refer to "Covered and Non-Covered Medications" below.

Covered and Non-Covered Medications

Covered Medications

The following medications are covered:

- Compound medications of which at least one ingredient is a legend drug. A legend drug is a drug that requires a prescription to be filled.
- Federal legend drugs except those included under *Non-Covered Medications*
- Emergency allergic reaction kits
- Oral contraceptives and injectables
- Insulin*
- Insulin pumps, needles and syringes*
- Contraceptive devices including intra-uterine devices (IUDs), vaginal rings and diaphragms
- Over-the-counter diabetic supplies, including glucometers (one per Calendar Year), and
- Prescription vitamins.

Covered Preventive Medications (covered In-Network at one hundred percent (100%) with no cost sharing**)

- Aspirin (adult men ages 45-79; adult women age 55-79)
- Iron supplements (children, ages six months through 12 months)
- Oral fluoride supplements (children, age six or under)

- Folic acid supplements (adult women age 55 or under)
- Tobacco cessation is covered for members who enroll (adult men and women) through Anthem. You can get more information anytime by calling Anthem at (844) 963-0445 or by visiting www.anthem.com or the Anthem app.
- Women's preventive services – select oral contraceptives, emergency contraception injectable contraceptives, implantable/intrauterine devices and vaginal rings, transdermal patch, diaphragm and cervical cap (adult women). Limitations may apply.

* The Plan and Anthem may have certain programs in which you may receive an enhanced or reduced benefit based on your actions, such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the internet at www.express-scripts.com or by calling the number on the back of your ID card.

** Additional limitations and exclusions may apply.

For more information on limitations and exclusions, visit www.express-scripts.com or call Express Scripts at (844) 269-5758.

Non-Covered Medications

Exclusions include, but are not limited to:

- Any drug used for cosmetic procedures
- Any prescription drug refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order
- Biologicals or immunization agents (vaccines). These medications may be covered under the HSP, PPO, HPN HSP and HPN PPO's Preventive Care benefits when billed as part of the office Visit
- Charges for the administration or injection of any drug. These charges may be covered under the HSP PPO, HPN HSP and HPN PPO's medical benefits.
- Contraceptive supplies (except as otherwise stated in this SPD) including, but not limited to, condoms, jellies, ointments or foams; services to prescribe and fit contraceptive devices
- Drugs labeled "Caution – limited by federal law due to investigational use," or Experimental drugs
- Drugs to stimulate hair growth, such as Monoxidil (Rogaine)
- Drugs to treat impotency
- Fertility medications or agents
- Immunization agents, biological serum, blood or blood plasma
- Infusion devices and injection aids for the legally blind. These supplies are generally covered under the medical benefits section of the HSP, PPO, HPN HSP and HPN PPO
- Injectable drugs. Certain injectables are covered such as Insulin and Epi-pen. Please contact Express Scripts for more details
- Medications which are to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care Facility, convalescent Hospital, nursing home or similar institution that operates on its premises, or allows to be operated on its premises a Facility for dispensing pharmaceuticals. These medications are generally covered as part of the Inpatient benefit
- Non-legend drugs other than insulin and supplies related to the treatment of diabetes
- Prescriptions that you are entitled to receive without charge from any Workers' Compensation laws
- Therapeutic devices or appliances, including needles, syringes, support garments and other non-medical substances, regardless of intended use, except diabetes supplies
- Any over-the-counter medications except those specifically covered earlier or that are required to be covered as part of the Preventive Care benefit under the Patient Protection and Affordable Care Act (PPACA)

The HSP and PPO do not cover certain medications and products under the Prescription Drug benefit. For non-covered medications, the HSP, PPO, HPN HSP and HPN PPO have arranged for you to receive them at the negotiated rate with Express Scripts. You can obtain these drugs either through an In-Network pharmacy or Express Scripts mail service by paying one hundred percent (100%) of the discounted price.

Non-covered medication expenses are not reimbursable under the Prescription Drug benefit and do not count toward your Prescription Drug Out-of-Pocket Maximum.

For more information on non-covered medications, visit Express Scripts toll free, by phone at (800) 818-6743 or via the Internet at www.express-scripts.com.

How To File a Claim

Medical Claims

In most cases, In-Network medical claims are filed by your Provider directly with Anthem or its designees for processing. For Out-of-Network services and supplies, you generally will have to file a claim for benefits. However, you still have the option to file the claim on behalf of you or your covered Dependent. In the event you need to file an out-of-network claim, your claim should be sent to:

Anthem Blue Cross and Blue Shield
P.O. Box 105187
Atlanta, GA 30348-5187

Claim forms must be filed no later than 12 months after the date the services were incurred. Claim forms are available at www.anthem.com or by calling Anthem at (844) 963-0445.

Itemized bills must accompany each claim form. A separate claim form is needed for each claim filed.

In general, the bills must contain enough data to identify the:

- Patient
- Provider
- Type of service
- Charge for each service
- Provider's license number, and
- Date of service.

Bills for private duty nursing must state the Nurse is a Registered Nurse (R.N.) or a Licensed Practice Nurse (L.P.N.) and must contain the Nurse's license number.

Payment for services is made as follows:

- **In-Network Provider:** Payment is made directly to the Provider if the Provider bills the HSP, PPO, HPN HSP or HPN PPO directly for the service. For In-Network Coverage, you or your covered Dependent must show your ID card when requesting Covered Services and Supplies from a Provider.
- **Out-of-Network Provider:** Payment is generally made to you, unless you have assigned payments to the Provider. NOTE: there are no out of network benefits available under the HPN HSP or the HPN PPO plans.
- **Death or total incapacity:** If you or your covered Dependent die or become incapacitated, any payment or refund due will be made to you or your Dependent's heirs, beneficiaries, trustees or estate.
- **Non-custodial parent of a child Dependent:** The HSP, PPO, HPN HSP and HPN PPO will pay claims directly to:
 - The Provider or custodial parent, or
 - The Division of Medical Assistance and Health Services in the Department of Human Services, which administers the State Medicaid program.

If Anthem pays anyone who is not entitled to benefits under the HSP, PPO, HPN HSP and HPN PPO, it has the right to recover those payments on behalf of the HSP, PPO, HPN HSP and HPN PPO.

Prescription Drug Claims

When you choose an In-Network pharmacy, your Coinsurance for brand drugs will be based on the negotiated prescription price and you will not have to file a claim form with Express Scripts. However, if you choose to use an Out-of-Network retail pharmacy, you will pay 100% of the prescription price, and it is possible that your price will be higher than the negotiated prescription price at an In-Network pharmacy. To receive reimbursement for Covered Services, you will need to submit a paper claim form along with the original prescription receipt(s) to Express Scripts. In most cases, using a non-network retail pharmacy will cost you more as the HSP, PPO, HPN HSP and HPN PPO will only reimburse you up to the reasonable and customary price.

- You can contact Express-Scripts at 800-818-6743 to obtain the form to submit an out-of-network pharmacy claim. Information needed on the form is below. Patient name
- Prescription number

- Pharmacy name and address of NABP number
- Drug name/strength or NDC number, metric quantity/days supply
- Dispense as written (DAW) code, if applicable
- Doctor's name or DEA number, purchase date
- Total charge

Important Terms to Know

There are certain medical terms that have specific meanings under the HSP, PPO, HPN HSP and HPN PPO plan. This section explains those terms to help you better understand your benefits. Definitions that are more detailed may be provided in the Plan document or Anthem guidelines.

Allowance: An amount determined by the HSP, PPO, HPN HSP and HPN PPO that is the least of the following amounts:

- The actual charge made by the Provider for the service or supply
- In the case of In-Network Providers, the amount that the Provider has agreed to accept for the service or supply; or
- In the case of Out-of-Network Providers, the amount determined as 90% of the reimbursement rates specified for the Covered Service or Supply in the databases developed by FAIRHealth, Inc. (FAIRHealth) would cover for the services.
- Exceptions:
 - (1) With respect to (i) a Medical Emergency; or (ii) Covered Services and Supplies provided in an In-Network Hospital, the Allowance determined in accordance with Out-of-Network Providers shall be increased as needed to ensure that the Covered Person has no greater liability than he/she would have if they were provided by In-Network Providers. But this (ii) shall not apply if the Covered Person: (a) had or was given the opportunity to select In-Network Providers to provide the Covered Services or Supplies; and (b) elected the services of Out-of-Network Providers.
 - (2) With respect to the third bullet point, above, if the databases developed by FAIR Health do not prescribe a reimbursement rate for a Covered Service or Supply, the Allowance for the Covered Service or Supply will be determined as 180% of the amount that would be reimbursed for the Covered Service or Supply under Medicare.
 - And if Medicare does not prescribe a reimbursement rate for the Covered Service or Supply, the Allowance for it will be determined based on: (a) profiles compiled by Anthem based on usual and prevailing payments made to Providers for similar services or supplies in specific geographical areas; or (b) similar profiles compiled by outside vendors other than FAIR Health.

Alternate Treatment: Those services and supplies that meet both of these tests:

- They are determined, in advance, by Anthem to be Medically Necessary and Appropriate and cost-effective in meeting the long-term or intensive care needs of you or your covered Dependent:
 - In connection with a Catastrophic Illness or Injury, or
 - In completing a course of care outside of the acute Hospital setting (for example, completing a course of IV antibiotics at home)
- Benefits for charges Incurred for them would not otherwise be covered under the HSP, PPO, HPN HSP and HPN PPO.

Ambulance: A certified transportation vehicle that transports Ill or Injured people and contains all life-saving equipment and staff as required by state and local law.

Ambulatory Surgical Center: A Facility mainly engaged in performing Outpatient Surgery that must:

- Be staffed by Practitioners and Nurses under the supervision of a physician
- Have permanent operating and recovery rooms
- Be staffed and equipped to give Medical Emergency care, and
- Have written back-up arrangements with a local Hospital for Medical Emergency care.

The HSP, PPO, HPN HSP and HPN PPO will recognize the Facility as an Ambulatory Surgical Center if it carries out its stated purpose under all relevant state and local laws, and it is either:

- Accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care, or
- Approved for its stated purpose by Medicare.

The HSP, PPO, HPN HSP and HPN PPO do not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Approved Hemophilia Treatment Center: A health care Facility licensed by the State of New Jersey for the treatment of hemophilia, or one that meets the same standards if located in another state.

Birthing Centers: A Facility that mainly provides care and treatment for women during uncomplicated pregnancy, routine full-time delivery and the immediate post-partum period that must:

- Provide full-time Skilled Nursing Care by or under the supervision of Nurses
- Be staffed and equipped to give Medical Emergency care, and
- Have written back-up arrangements with a local Hospital for Medical Emergency care.

The HSP, PPO, HPN HSP and HPN PPO will recognize the Facility as a Birthing Center if:

- It carries out its stated purpose under all relevant state and local laws
- It is approved for its stated purpose by the Accreditation Association for Ambulatory Care, and
- It is approved for its stated purposes by Medicare.

The HSP, PPO, HPN HSP and HPN PPO do not recognize a Facility as a Birthing Center if it is part of a Hospital.

Calendar Year: A one-year period starting January 1 and ending December 31.

Catastrophic Illness or Injury: One of the following:

- Head Injury requiring an Inpatient stay
- Spinal cord Injury
- Severe burn over 20 percent or more of the body
- Multiple injuries due to an accident
- Premature birth
- CVA or stroke
- Congenital defect which severely impairs a bodily function
- Brain damage due to an Injury, cardiac arrest or a Surgical procedure
- Terminal Illness, with a prognosis of death within six months
- Acquired Immune Deficiency Syndrome (AIDS)
- Substance Abuse
- A Mental Illness, or
- Any other Illness or accidental Injury determined to be catastrophic.

Coinsurance: The percent applied to Covered Charges (not including Deductibles) for certain Covered Services or Supplies in order to calculate the amount of benefits payable under the HSP, PPO, HPN HSP and HPN PPO. These are shown in the “Schedule of Covered Services and Supplies” section. For example, if the HSP’s, PPO’s, or HPN HSP’s Coinsurance for an item of expense is **80%**, then you or your covered Dependent’s Coinsurance for that item is **20%**. Unless the context indicates otherwise, the Coinsurance percentages shown in this SPD are the percentages that the HSP, PPO, HPN HSP, or HPN PPO will pay.

Cosmetic Services: Services (including Surgery) rendered to refine or reshape body structures or surfaces that are not functionally impaired. They are to improve appearance or self-esteem, or for other psychological, psychiatric or emotional reasons as opposed to services for treatment of a medical condition. The following are **not** considered “cosmetic”:

- Surgery to correct the result of an Injury
- Surgery to treat a condition, including a birth defect, which impairs the function of a body organ
- Surgery to reconstruct a breast after a mastectomy is performed
- Treatment of newborns to correct congenital defects and abnormalities, and
- Treatment of cleft lip.

The following are some procedures that are **always** considered “cosmetic”:

- Surgery to correct gynecomastia
- Breast augmentation procedures, including their reversal for women who are asymptomatic
- Reversal of breast augmentation procedures for asymptomatic women who had reconstructive Surgery or who previously had breast implants for cosmetic purposes
- Rhinoplasty, except when performed to treat an Injury
- Lipectomy, and
- Ear or other body piercing.

Coverage Date: The date on which coverage under the HSP, PPO, and HPN HSP begins for you or your covered Dependents.

Covered Charges: The authorized charges, up to the Allowance, for Covered Services and Supplies. A covered charge is Incurred on the date the covered service or supply is furnished.

Covered Services and/or Supplies: The types of services and supplies described in the “Schedule of Covered Services and Supplies” section. Except as otherwise provided in this SPD, the services and supplies must be:

- Furnished or ordered by a Provider, and
- For Preventive Care, or Medically Necessary and Appropriate to diagnose or treat an Illness (including Mental Illnesses) or Injury.

Custodial Care: Care that provides a level of routine maintenance for the purpose of meeting personal needs. This is care that can be provided by a layperson that does not have professional qualifications or skills.

Custodial Care includes, but is not limited to: help in walking or getting into or out of bed; help in bathing, dressing and eating; help in other functions of daily living of a similar nature; administration of or help in using or applying creams and ointments; outline administration of medical gasses after a regimen of therapy has been set up; routine care of a patient, including functions such as changes of dressings, diapers and protective sheets and periodic turning and positioning in bed; routine care and maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags and indwelling catheters; routine tracheostomy care; general supervision of exercise programs, including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled services.

Even if you or a covered Dependent is in a Hospital or other recognized Facility, the HSP, PPO, HPN HSP and HPN PPO do not cover care if it is custodial in nature.

Day Programs: Outpatient personalized or packaged programs that:

- Are designed primarily for patients who are medically stable enough to live at home, but who may require certain therapies
- Offer multiple therapies in a day setting, and
- Are usually scheduled for three to five days a week and five to nine and a half hours per day.

Some examples of the therapies offered are: cognitive therapy; recreation therapy; work hardening programs; vocational therapy; group cognitive/interpersonal therapy; remedial treatments; and treatments to improve interpersonal communication and social skills. Day Programs do not include Outpatient programs for the treatment of Mental Illnesses and/or Substance Use Disorder.

Deductible: The amount of Covered Charges that you or a covered Dependent must pay before the HSP or PPO provide any benefits for such charges. The term does not include Coinsurance and Non-Covered Charges for medical care. In the HSP, eligible medical as well as eligible Prescription Drug expenses count toward the Deductible. In the PPO, eligible copays and non-preventive prescription drug costs do not count toward the Deductible but do count toward the Out-Of-Pocket Maximum. See the "Schedule of Covered Services and Supplies" and "Prescription Drug Coverage" sections.

Dependent: A lawful spouse or eligible child Dependent whom the retiree enrolls for coverage under the Plan as described in this SPD.

Detoxification Facility: A Facility licensed as a Detoxification Facility for the treatment of alcoholism and other substance use disorders.

Diagnostic Services: Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

- Radiology, ultrasound and nuclear medicine
- Lab and pathology, and
- EKGs, EEGs and other electronic diagnostic tests.

Durable Medical Equipment: Medically Necessary and Appropriate equipment that the Plan determines to fully meet these requirements:

- It is designed for and able to withstand repeated use
- It is primarily and customarily used to serve a medical purpose
- It is generally not useful to a person in the absence of an Illness or Injury, and
- It is suitable for use in the home.

Some examples are walkers, wheelchairs (manual or electric), Hospital-type beds, breathing equipment and apnea monitors.

Some examples of services and supplies that are not considered to be Durable Medical Equipment are adjustments made to vehicles, furniture, scooters, all-terrain vehicles (ATVs), non-Hospital-type beds, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Elective Surgical Procedure: Non-emergency Surgery that may be scheduled for a day of the patient's choice without risking the patient's life or causing serious harm to the patient's bodily functions.

Experimental or Investigational: Any treatment, procedure, Facility, equipment, drug, device or supply (collectively, "Technology") which, as determined by the HSP, PPO, HPN HSP and HPN PPO, fails to meet any one of the requirements below:

- The Technology must either be:
 - Approved by the appropriate federal regulatory agency and have been in use for the purpose defined in that approval (in the case of a Prescription Drug, for at least six months), or
 - Proven to the Plan's satisfaction to be the standard of care.

This applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from:

- The FDA, or
- Any other federal government body with authority to regulate the Technology. But, such approval does not imply that the technology will automatically be deemed by the Plan as Medically Necessary and Appropriate and the accepted standard of care.
- There must be sufficient proof, published in peer-reviewed scientific literature that confirms the effectiveness of the technology. That proof must consist of well-designed and well-documented investigations. But, if such proof is not sufficient or is questionable, the Plan may consider opinions about and evaluations of the Technology from appropriate specialty advisory committees and/or specialty consultants.
- The Technology must result in measurable improvement in health outcomes, and the therapeutic benefits must outweigh the risks, as shown in scientific studies. "Improvement" means progress toward a normal or functional state of health.
- The Technology must be as safe and effective as any established modality. (If an alternative to the Technology is not available, the Plan may, to determine the safety and effectiveness of a Technology, consider opinions about and evaluations of the Technology from appropriate specialty advisory committees and/or specialty consultants.)
- The Technology must demonstrate effectiveness when applied outside of the investigative research setting.

The Plan will evaluate a Prescription Drug for uses other than those approved by the FDA. For this to happen, the drug must be recognized to be Medically Necessary and appropriate for the condition for which it has been prescribed in one of these:

- The American Hospital Formulary Service Drug Information.
- The United States Pharmacopeia Drug Information.

Even if such an "off-label" use of a drug is not supported in one or more of the above compendia, the Plan may still deem it to be Medically Necessary and Appropriate if supportive clinical evidence for the particular use of the drug is given in a clinical study or published in a major peer-reviewed medical journal, and meets the Plan's criteria. But, in no event will this Plan cover any drug that the FDA has determined to be Experimental, Investigational or contraindicated for the treatment for which it is prescribed.

Also, regardless of anything above, this Plan will provide benefits for services and supplies furnished to you or a covered Dependent for medical care and treatment associated with an approved cancer clinical trial in the HSP, PPO, or HPN HSP's Service Area. This coverage includes, to the extent coverage would be provided other than for an approved cancer clinical trial:

- Practitioners' fees
- Lab fees
- Hospital charges

- Treating and evaluating you or your covered Dependent during the course of treatment or regarding a complication of the underlying illness, and
- Other routine costs related to the patient's care and treatment, to the extent that these services are consistent with usual and customary patterns and standards of care furnished whenever you or a covered Dependent receives medical care associated with an approved cancer clinical trial.

This coverage does not include:

- The cost of Experimental or Investigational drugs or devices themselves
- Non-health services that the patient needs to receive the care and treatment
- The costs of managing the research, or
- Any other services, supplies or charges that this Plan would not cover for treatment that is not Experimental or Investigational.

Eye Examination: A comprehensive medical exam of the eye performed by a Practitioner, including:

- A diagnostic ophthalmic exam:
 - With or without definitive refraction as medically indicated
 - With medical diagnosis and initiation of diagnostic and treatment programs.
- Prescription of medication and lenses
- Post-cycloplegic Visit if needed, and
- Verification of lenses, if prescribed.

Facility: An entity or institution that provides health care services within the scope of its license, as defined by applicable law and which the Plan either:

- Is required by law to recognize, or
- Determines in its sole discretion to be eligible under the HSP, PPO, HPN HSP and HPN PPO.

FDA: The Food and Drug Administration.

Foot Orthotics: Custom-made supportive devices designed to restrict, immobilize, strengthen or protect the foot.

Government Hospital: A Hospital operated by a government or any of its subdivisions or agencies, including but not limited to: a federal, military, state, county or city Hospital.

Home Health Agency: A Provider, which mainly provides care for an ill or injured person in the person's home under a Home Health Care program, designed to eliminate Hospital stays. The HSP, PPO, HPN HSP and HPN PPO will recognize it if it is licensed by the state in which it operates or is certified to take part in Medicare as a Home Health Agency.

Home Health Care: Nursing and other Home Health Care Services rendered to you or a covered Dependent in his/her home. For Home Health Care to be covered, these rules apply:

- The care must be given on a part-time or intermittent basis, except if full-time or 24-hour services are Medically Necessary and Appropriate on a short-term basis.
- Continuing Inpatient stay in a Hospital would be needed in the absence of Home Health Care.
- The care is furnished under a physician's order and under a Plan of care that is established:
 - By that physician and the Home Health Care Provider
 - Within 14 days after Home Health Care starts, and
 - Is periodically reviewed and approved by the physician.

Home Health Care Services: Any of these services needed for the Home Health Care Plan, including: nursing care, Physical Therapy, Occupational Therapy, medical social work, nutrition services, Speech Therapy, home health aide services, medical appliances and equipment, drugs and medicines, lab services and special meals, to the extent these would have been Covered Services and Supplies if you or your covered Dependent was a Hospital Inpatient, diagnostic and therapeutic services (including Surgical services) performed in a Hospital Outpatient department, a physician's office, or any other licensed health care Facility, to the extent these would have been Covered Services and Supplies under the HSP, PPO, or HPN HSP, if furnished during a Hospital Inpatient stay.

Hospice: A Provider that mainly provides palliative and supportive care for terminally ill or terminally injured people under a Hospice Care Program. The HSP, PPO, and HPN HSP will recognize a Hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

- Approved for its stated purpose by Medicare, or
- Accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospice Care Program: A health care program that provides an integrated set of services designed to provide Hospice care. Hospice services are centrally coordinated through an interdisciplinary team directed by a Practitioner.

Hospital: A Facility that mainly provides Inpatient care for ill or injured people. The HSP, PPO, and HPN HSP will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

- Accredited as a Hospital by the Joint Commission, or
- Approved as a Hospital by Medicare.

Among other things, a Hospital is not any of these: a convalescent home, a rest or nursing Facility, an infirmary, a Hospice, a Substance Abuse center or a Facility (or part of it) which mainly provides: domiciliary or Custodial Care, educational care, non-medical or ineligible services or supplies or rehabilitative care. A Facility for the aged is also not a Hospital. "Hospital" shall also not include a satellite Facility of a Hospital for which a separate Facility license is required by law, unless the satellite also meets this definition in its own right.

The HSP, PPO, HPN HSP and HPN PPO will pay benefits for Covered Services and Supplies Incurred at Hospitals operated by the United States government only if the services or supplies are for treatment on an emergency basis, or the services or supplies are provided in a Hospital located outside of the United States or Puerto Rico.

The above limitations do not apply to military retirees, their Dependents and the Dependents of active-duty military personnel who have both military health coverage and the Plan coverage and receive care in Facilities run by the Department of Defense or Veteran's Administration.

Illness: A sickness or disease suffered by you or a covered Dependent.

Incurred: A charge is Incurred on the date you or a covered Dependent receives a service or supply for which a charge is made.

Injury: All damage to a person's body due to an accident, and all complications arising from that damage.

In-Network: A Provider, or the Covered Services and Supplies provided by a Provider, who has an agreement to furnish Covered Services or Supplies under the HSP, PPO, HPN HSP or HPN PPO.

In-Network Coverage: The level of coverage, shown in the "Schedule of Covered Services and Supplies" section, which is provided if an In-Network Provider provides the service or supply.

Inpatient: You, or a covered Dependent, which is physically confined as a registered bed patient in a Hospital or other Facility, or the services or supplies provided to you or your covered Dependent, depending on the context in which the term is used.

Intensive Behavioral Therapy (IBT) - outpatient behavioral services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is Applied Behavior Analysis (ABA).

Joint Commission: The Joint Commission on the Accreditation of Health Care Organizations.

Maintenance Therapy: That point in the therapeutic process at which no further improvement in the gaining or restoration of a function, reduction in disability or relief of pain is expected. Continuation of therapy at this point would be for the purpose of holding at a steady state or preventing deterioration.

Medical Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to: severe pain, psychiatric disturbances, Mental Illness and/or symptoms of Substance Use Disorder) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention would result in:

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

With respect to a pregnant woman who is having contractions, a Medical Emergency exists where there is not enough time to make a safe transfer to another Hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of a Medical Emergency include, but are not limited to heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning and loss of consciousness.

Medically Necessary and Appropriate: This means or describes a health care service that a health care Provider, exercising his/her prudent clinical judgment, would provide to you or a covered Dependent for the purpose of evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice, clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for you or your covered Dependent's Illness, Injury or disease, not primarily for the convenience of you or your covered Dependent or the health care Provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of you or your covered Dependent's Illness, Injury or disease.

"Generally accepted standards of medical practice," as used above, means standards that are based on:

- Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community,
- Physician and health care Provider specialty society recommendations and
- The views of physicians and health care Providers practicing in relevant clinical areas.

Mental Illness: A condition which manifests symptoms which are primarily mental or nervous, whether organic or non-organic, biological or non-biological, chemical or non-chemical in origin and irrespective of cause, basis or inducement, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication. Mental Illness includes, but is not limited to psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality dysfunction of the brain or related neurohormonal systems.

Non-Covered Charges: Charges for services and supplies which:

- Do not meet the HSP, PPO, HPN HSP and HPN PPO definition of Covered Charges
- Exceed any of the coverage limits shown in this SPD, and
- Are specifically identified in this SPD as Non-Covered Charges.

Nurse: A Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), or a nursing Specialist such as a Nurse mid-wife or Nurse Anesthetist, who:

- Is properly licensed or certified to provide medical care under the laws of the state where he/she practices, and
- Provides medical services, which are within the scope of his/her license or certificate and are covered by this Plan.

Out-of-Hospital: Services or supplies provided to you or a covered Dependent other than as an Inpatient or Outpatient.

Out-of-Network: A Provider, or the services and supplies furnished by a Provider, who does not have an agreement with Anthem to provide Covered Services or Supplies, depending on the context in which the term is used.

Out-of-Network Benefits: The coverage shown in the "Schedule of Covered Services and Supplies" section that is provided if an Out-of-Network Provider provides the service or supply.

Out-of-Pocket Maximum: The maximum dollar amount that you or a covered Dependent must pay as Deductible and/or Coinsurance for Covered Services and Supplies during any Calendar Year. Once that dollar amount is reached, no further payments are required for the remainder of that Calendar Year, subject to any separate frequency or dollar limits for certain services.

Outpatient: You or a covered Dependent who receives services at a Hospital and who is other than an Inpatient, or the services and supplies provided to you or a covered Dependent, depending on the context in which the term is used.

Partial Hospitalization: Intensive short-term non-residential day treatment services that are:

- For Mental Illnesses, chemical dependency or alcoholism, and
- Rendered for any part of a day for a minimum of four consecutive hours per day.

Physical Rehabilitation Center: A Facility that mainly provides therapeutic and restorative services to Ill or Injured people. The Plan will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

- Accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities, or
- Approved for its stated purpose by Medicare.

Plan: The Schlage Lock Company LLC Pre-65 Retiree Health and Welfare Plan.

Practitioner: A person that the Plan is required by law to recognize who:

- Is properly licensed or certified to provide medical care under the laws of the state where he/she practices, and
- Provides medical services, which are within the scope of the license or certificate and is covered by the HSP, PPO, HPN HSP and HPN PPO.

Practitioners include, but are not limited to, the following: physicians, chiropractors, dentists, optometrists, pharmacists, chiropodists, psychologists, physical therapists, audiologists, speech language pathologists, certified Nurse Mid-wives, registered professional Nurses, Nurse Practitioners and clinical Nurse Specialists.

Prescription Drugs: Drugs, biological and compound prescriptions that are dispensed only by prescription and are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without A Prescription." The term also may include other drugs and devices (such as insulin) as determined by the Plan.

Preventive Care: Services or supplies that are not provided for the treatment of an Injury or Illness, but rather to help detect or prevent Illness. It includes, but is not limited to routine physical exams, including: related X-rays and lab tests, immunizations and vaccines, screening tests, well child care and well adult care.

Prior Authorization: Authorization by Anthem or Express Scripts, as applicable, for a Practitioner to provide specified treatment or to dispense a prescription drug to you or your covered Dependent(s).

Provider: A Facility or Practitioner of health care in accordance with the terms of the HSP, PPO, HPN HSP or HPN PPO.

Routine Foot Care: The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, dermatomes, keratosis, onychia, onychocryptosis, tylomas or symptomatic complaints of the feet.

Routine Nursing Care: The appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Skilled Nursing Care: Services which:

- Are more intensive than Custodial Care
- Are provided by an R.N. or L.P.N., and
- Require the technical skills and professional training of an R.N. or L.P.N.

Skilled Nursing Facility: A Facility that mainly provides full-time Skilled Nursing Care for Ill or Injured people who if it do not need to be in a Hospital. The HSP, PPO, HPN HSP and HPN PPO will recognize the Facility as a Skilled Nursing Facility carries out its stated purpose under all relevant state and local laws, and it is either:

- Accredited for its stated purpose by the Joint Commission, or
- Approved for its stated purpose by Medicare.

In some places, a Skilled Nursing Facility may be called an "extended care center" or a "skilled nursing center."

Special Care Unit: A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff and special equipment and supplies on hand at all times. Some types of Special Care Units are:

- Intensive care units
- Cardiac care units
- Neonatal care units, and
- Burn units.

Specialist: A health care Practitioner who provides medical care in any generally accepted medical or Surgical specialty or sub-specialty.

Substance Abuse: The abuse or addiction to alcohol, drugs or controlled substances.

Surgery/Surgical:

- The performance of generally accepted operative and cutting procedures, including: Surgical diagnostic procedures, specialized instrumentations, endoscopic exams and other invasive procedures
- The correction of fractures and dislocations
- Pre-operative and post-operative care, or
- Any of the procedures designated by C.P.T. codes as Surgery.

Therapeutic Manipulation: The treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves, causing discomfort. Some examples of such treatment are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, Doppler, whirlpool or hydro-therapy or other treatments of a similar nature.

Therapy Services: The following services and supplies when they are:

- Ordered by a Practitioner
- Performed by a Provider, and
- Medically Necessary and Appropriate for the treatment of you or a covered Dependent's Illness or accidental Injury.

Chemotherapy: The treatment of malignant disease by chemical or biological antineoplastic agents.

Dialysis Treatment: The treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy: The administration of antibiotic, nutrient or other therapeutic agents by direct infusion.

Occupational Therapy: The treatment to develop or restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy: The treatment by physical means to relieve pain, develop or restore normal function and prevent disability following Illness, Injury or loss of limb.

Radiation Therapy: The treatment of disease by X-ray, radium, cobalt or high-energy particle sources. Radiation Therapy includes the rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Speech Therapy: Therapy that is by a qualified speech therapist and is described below:

- Speech Therapy to restore speech after a loss or impairment of a demonstrated, previous ability to speak. Two examples of Speech Therapy that will not be covered are therapy to correct pre-speech deficiencies, and therapy to improve speech skills that have not fully developed.
- Speech Therapy to develop or improve speech after Surgery to correct a defect that both existed at birth, and impaired or would have impaired the ability to speak.

Urgent Care: Outpatient and Out-of-Hospital medical care which, as determined by the HSP, PPO, and HPN HSP or an entity designated by the HSP, PPO, and HPN HSP, is needed due to an unexpected Illness,

Injury or other condition that is not life threatening, but that needs to be treated by a Provider within 24 hours.

Visit: An occasion during which treatment or consultation services are rendered in a Provider's office, in the Outpatient department of an eligible Facility, or by a Provider on the staff of (or under contract or arrangement with) a Home Health Agency to provide covered Home Health Care Services or supplies.

Non-Duplication of Benefits

This Plan contains a provision called “non-duplication of benefits.” This provision is applied when you and your covered Dependents receive services that are eligible for payment under more than one group health program. If you or your Dependents are covered by another medical plan, the benefits are coordinated between this Plan and the other plan so that the combined payments do not amount to more than the amount this Plan would pay if it were the only plan.

PLAN ADMINISTRATION

This section of the SPD provides you with legal and administrative information for the Plan.

We encourage you to read this Administrative Information document carefully. It should serve as a valuable reference when you need to understand your rights, procedures to follow and the appropriate contacts for certain situations.

Extension of Certain Plan Administration Time Periods Relating to COVID-19

For purposes of this section,:

- “Agencies” means the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, and Department of the Treasury.
- “National Emergency” means the March 13, 2020 Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak and the separate letter dated March 13, 2020 determining, under Section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121 *et seq.*, that a national emergency exists nationwide beginning March 1, 2020, as the result of the COVID-19 outbreak.
- “Outbreak Period” means the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency or such other date announced by the Agencies.

Subject to the statutory duration limitation in ERISA Section 518 and Code Section 7508A, the plans in this SPD that are group health plans, disability plans, and employee welfare benefit plans that are subject to the guidance issued May 4, 2020 entitled Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak, 85 Fed. Reg. 26351, 26353 (29 C.F.R. pt. 54 and 29 C.F.R. pts. 2560 and 2590) (the “COVID-19 Extension”) shall disregard the Outbreak Period for all Plan Participants, Beneficiaries, qualified beneficiaries, and claimants in determining the following periods and dates:

- The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA Section 701(f) and Code Section 9801(f);
- The 60-day election period for COBRA continuation coverage under ERISA Section 605 and Code Section 4980B(f)(5);
- The date for making CORBA premium payments pursuant to ERISA Section 602(2)(C) and (3) and Code Section 4980B(f)(2)(B)(iii) and (C);
- The date for individuals to notify the Plan of a qualifying event or determination of disability under ERISA Section 606(a)(3) and Code Section 4980B(f)(6)(C);

- The date within which individuals may file a benefit claim under the Plan's claims procedures pursuant to 29 C.F.R. § 2560.503-1;
- The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedure pursuant to 29 C.F.R. § 2560.503-1(h);
- The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination pursuant to 29 C.F.R. § 2590.715-2719(d)(2)(i) and 26 C.F.R. § 54.9815-2719(d)(2)(i); and
- The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29 C.F.R. § 2590.715-2719(d)(2)(ii) and 26 C.F.R. § 54.9815-2719(d)(2)(ii).

Additionally, with respect to the plans that are group health plans, the Outbreak Period shall be disregarded when determining the date for providing a COBRA election notice under ERISA Section 606(c) and Code Section 4980B(f)(6)(D).

FILING A CLAIM AND APPEALING A DENIED CLAIM

Health Care Claims

How to File a Medical Claim (including prescription drug claims)

If you receive care from providers who are part of the medical plan's network, generally, you will not need to file a claim. However, you will need to file a claim for:

- Services from an out-of-network provider, or
- A medical emergency or accidental injury when care is provided by an out-of-network provider.

Your claim must include:

- Patient's name
- Medical plan identification number
- Name of the provider who performed the service
- Provider's license number (bills for private duty nursing must state that the nurse is a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) and must contain the nurse's license number)
- Date and description of services performed
- Charge for each service, and
- Itemized bill for the services provided.

The claim should be sent to the address on the claim form. Claim forms are available on your Claims Administrator's website or by calling the Claims Administrator directly. For contact information, please see the "Plan Benefit Identification Information" section of this document.

You must file claims within 12 months of the date the service was provided. Any claim filed after 12 months will not be eligible for payment.

How to File a Dental Claim

If you receive care from a Dental Preferred Provider, your dentist will, in most cases, file your claim directly with the Claims Administrator. You do not have to file a claim. If you receive care from a provider who is not in the Dental Preferred Provider network, either you or your dentist must submit the claim. Claim forms are available on the Claims Administrator's website or by calling the Claims Administrator directly. For contact information, please see the "Plan Benefit Identification Information" section.

You must file your claims within 12 months of the date the service was provided. Any claims filed after 12 months will not be eligible for payment.

How to File a Vision Claim

If you receive vision care from a network doctor, the Plan pays the doctor directly. You pay the doctor directly for your share of the cost (your copayment), and you do not need to file a claim.

If you use a non-network provider, you will need to file a claim for reimbursement. The Plan reimburses you for non-network services up to the Plan benefit. When using non-network providers, you need to:

- Pay the provider the full amount of the bill when you receive care. Request a copy of the bill. Make sure the bill shows the amount you paid for the service and the type of service you received (e.g., eye exam, lens type and/or frames).
- Submit, on a separate piece of paper:
 - Your name, phone number and address
 - The patient's name, relationship to you, date of birth, phone number and address, and
 - Your employer's name
- Keep a copy of both the itemized bill(s) and separate paper with claim information and send the originals to the appropriate vendor.

For contact information, see the "Plan Benefit Identification Information" section of this SPD.

You need to file a claim for reimbursement within six months of receiving care from a non-network provider or your claim may not be eligible for payment. You are also responsible for any charges the Plan does not pay.

Responding to Your Health Care Claim (Medical, Prescription Drug, Dental and Vision)

- **Urgent Care Claims** — An urgent care claim is any claim for health care or treatment where the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In the event of a claim that involves urgent care, you will be notified whether your claim has been approved or denied within 72 hours (36 hours for each appeal if the Claims Administrator provides two levels of appeal for urgent care claims) after the Claims Administrator receives your claim. If your claim is incomplete, you or your provider will be notified of the additional information you need to submit within 24 hours after the Claims Administrator receives the claim and the deadline for providing this information. The deadline for providing the additional information will not be less than 48 hours after you are notified. Failure to provide additional requested information may result in the denial of the claim. In this instance, you or your provider will be notified of the claim determination within 48 hours after the Claims Administrator receives the information or, if later, within 48 hours after the deadline for submitting the additional information. Notification may be provided orally or in writing. In the case of oral notification, you will receive a formal written notice within three days after the oral notice.

- **Concurrent Care Decisions** — Special rules apply where the Plan has approved an ongoing course of treatment either for a specific period of time or for a specific number of treatments.

A reduction or termination of the course of treatment before the approved time period or number of treatments will be considered a claim denial (except for Plan amendment or termination). In this case, the Claims Administrator will notify you in advance so you can appeal the decision before the

benefit is reduced or terminated. A concurrent care claim may be treated as an urgent care, pre-service or post-service claim. How it is treated depends on when during the course of your care you file the claim.

You or your provider may request to extend the course of treatment beyond the approved time period or number of treatments. If this involves urgent care, the Claims Administrator will notify you whether your request has been approved or rejected within 24 hours of receiving your request, as long as the request is made at least 24 hours before the approved time period or number of treatments expires.

- **Pre-service Claims** — A pre-service claim is any request for approval of a benefit where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining health care (for example for pre-certification). The Claims Administrator will notify you, within 15 days of receiving your claim, whether your claim has been approved or denied. If you or your provider fail to follow the Plan procedures for filing a pre-service claim, you or your provider will be notified that the procedures were not followed and you or your provider will be provided with an explanation of the proper procedures. You'll be notified within five days after the original claim is filed.

The original 15-day period to respond to your claim may be extended for another 15 days if you or your provider is notified that the extension is necessary due to matters beyond the control of the Claims Administrator before the end of the original 15-day period. The notice will explain the reason for the extension and when the Claims Administrator expects to rule on your claim. If the extension is needed because you or your provider failed to provide the information needed to decide the claim, the notice will tell you or your provider what additional information you need to furnish. In this event, you or your provider will have 45 days from the date you receive the notice to provide the additional information. Failure to provide additional requested information may result in the denial of the claim.

- **Post-service Claims** — Post-service claims refer to all other claims that cannot be categorized as urgent care, concurrent care or pre-service claims. The Claims Administrator will notify you or your provider whether a post-service claim has been denied within 30 days of receiving your claim. This period may be extended for another 15 days if you or your provider is notified that the extension is necessary due to matters beyond the control of the Claims Administrator before the end of the original 30-day period. The notice will explain the reason for the extension and when the Claims Administrator expects to rule on your claim. If the extension is needed because you or your provider failed to provide the information needed to decide the claim, the notice will tell you or your provider what additional information is needed. In this event, you or your provider will have 45 days from the date you receive the notice to provide the additional information. Failure to provide additional requested information may result in the denial of the claim.
- **Claims Denial Notice** — The notice of the Claims Administrator's decision will be given in writing or electronically. In the event that your claim is denied, in whole or in part, the notification will include:
 - Information sufficient to identify the claim involved, including the date of the service, the health care provider and the claim amount (if applicable)
 - The specific reasons for the denial
 - A reference to the specific Plan provisions on which the decision is based, including a description of the Plan's standard, if any, used in denying the claim, and in the case of a final adverse determination, a discussion of the decision
 - A description of any additional material or information necessary for the claim to be completed and an explanation of why such material or information is necessary

- A description of the Plan's internal and external appeal procedures, information about how to initiate an appeal and the time limits applicable to such procedures, including your right to bring a civil action in court following exhaustion of these claims and appeals procedures
- A description of any internal rules, guidelines, protocols or other similar criteria that were relied upon in the decision-making, or a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material will be provided upon request, free of charge, along with a discussion of the claims denial decision
- An explanation of how to request diagnosis and treatment codes (and their corresponding meanings)
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical or dental necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to your medical or dental circumstances, or a statement that such explanation will be provided upon request, free of charge, along with a discussion of the claims denial decision; and
- For a claims denial involving an urgent care claim, a description of the expedited review process applicable to such claims.

If you have any questions about a denied claim, you should contact the Claims Administrator.

Appealing a Denied Health Care Claim (Medical, Prescription Drug, Dental or Vision)

The health plan has a two-step appeals process. You (or your authorized representative) will have 180 days after receiving notice that your claim is denied to appeal the decision in writing to the Claims Administrator. You may submit written comments, testimony, documents, records and other information relevant to the claim. In addition, you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. The filing of an appeal is mandatory if you later decide you want to initiate a lawsuit under ERISA Section 502(a).

- **Appeal (with Anthem)** — When you submit your claim for an appeal, someone who neither had a role in the initial claim denial nor is the subordinate of anyone who did will review your appeal, and the review will be an independent one, without giving the original denial any special consideration. The Claims Administrator will provide to you, free of charge, any new or additional evidence considered, relied upon or generated in the process of the review before a final determination on appeal is made, and you will be given an opportunity to submit additional information to the claims administrator for final consideration in the review process and decision. If a medical judgment is involved, the person reviewing your appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who neither had a role in the initial claim denial nor is the subordinate of anyone who did have a role in the denial. You may request the identity of the medical or vocational experts whose advice was obtained.

In the case of urgent care claims (which may include concurrent care claim reduction or termination), there is an expedited review process that allows you to call or write the Claims Administrator, and all necessary information regarding the review will be provided to you promptly. You and the Claims Administrator can communicate by telephone, facsimile or other expeditious method. You or your provider will be notified of the decision on your appeal as soon as possible, taking into account medical or dental requirements, but no later than 72 hours (36 hours for each appeal if the Claims Administrator provides two levels of appeal for urgent care claims) after the Claims Administrator receives your request for review. If your claim involves a pre-service determination (which may include concurrent care claim reduction or termination), you or your provider will be notified of the decision on your appeal within a reasonable period that is appropriate for your medical or dental condition, but no later than 30 days after the Claims Administrator receives your request for review.

If your claim involves a post-service determination, you will be notified of the decision on your appeal within 30 days after the Claims Administrator receives your request for review. For urgent

care claims only, the decision made upon completion of a level one appeal shall be final and binding on all parties.

- **Appeal Denial Notice** — In the event that your appeal is denied in whole or in part, you will be notified in writing. Such notice will include the following:
 - Information sufficient to identify the claim involved, including the date of the service, the health care provider and the claim amount (if applicable)
 - The specific reasons for the denial
 - A reference to the specific Plan provisions on which the decision was based, including a description of the Plan's standard, if any, used in denying the claim, and in the case of a final adverse determination, a discussion of the decision
 - A description of any additional material or information for the claim to be completed and an explanation of why such material or information is necessary
 - Your right to request access to or copies of all information relevant to your claim
 - Your right to bring a civil action in court after exhaustion of these claims and appeals procedures
 - An explanation of how to request diagnosis and treatment codes (and their corresponding meanings)
 - A description of any specific internal rules, guidelines, protocols or other similar criteria that were relied on in making the decision, or a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material will be provided upon request, free of charge, along with a discussion of the claims denial decision; and
 - An explanation of the scientific or clinical judgment used in the decision in the case of decisions regarding medical or dental necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to your medical or dental circumstances, or a statement that such explanation will be provided upon request, free of charge, along with a discussion of the claims denial decision.

You and the Claims Administrator may also have the right to other voluntary alternative dispute resolution options, such as mediation. To find out more information, contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

You have the right to bring a civil action in court up to 12 months from the date of final adverse benefit determination. In the case of a medical claim (other than a claim based on eligibility or a health care or limited expense FSA claim), you have the right to go directly to the external review process.

- **External Appeal Reviews – Health Care Claims**

The external review process applies only to claims denied based on medical necessity or coverage rescission. If the Claims Administrator issued a final internal adverse benefit determination in response to your internal appeal request, you may have the right to request an external appeal review.

Your initial and final internal adverse benefit determination from the Claims Administrator will describe the detailed process under the applicable plan. In general:

- You have four months to file your request for an external appeal review after receipt of the final adverse benefit determination
- Your request for an external appeal review must be filed with the Claims Administrator
- The Claims Administrator has five business days to complete a preliminary review to confirm if:
 - o The claimant is or was covered under the Plan at the time the health care item or service was requested or provided

- The adverse benefit determination or the final adverse benefit determination did not relate to the claimant's failure to meet the requirements for eligibility under the plan
- The claimant has exhausted the Plan's internal appeal process, unless the claimant is otherwise not required to exhaust the process before requesting external review
- The Claims Administrator will send out an acknowledgement notice to you within one business day of the completion of preliminary review
 - If the request for external appeal review is incomplete, the notice will describe the information or materials needed to make the request complete; you must refile your external appeal review request with complete information within 48 hours or within the original four-month filing period, whichever is later
 - If the request is not eligible for external review, the notification will include the reasons it was not eligible and your right to contact the Employee Benefits Security Administration regarding such matters
- The Claims Administrator must assign the file to an independent review organization (IRO) or other similar nationally recognized accrediting organization
- The Claims Administrator will provide the full file to the IRO within five business days of assigning the case to them
- The IRO will send acknowledgement to you that they have been assigned to review your appeal and may offer you the opportunity to present additional information
- The IRO will review the following types of information and documents received on a timely basis without regard to any previous decisions or conclusions:
 - Your medical records
 - Your attending health care professional's recommendation
 - Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or provider
 - The terms of the Plan under which you have coverage
 - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal governments, national or professional medical societies, boards and associations
 - The IRO's clinical reviewer's opinion
 - The Plan's applicable clinical review criteria, unless the criteria are inconsistent with the terms of the Plan or with applicable law
- The IRO will issue written notice of the final external review decision to both you and the Claims Administrator as described under "External Review Determinations" below.

Expedited External Appeal Reviews

If you have a medical condition that meets the requirements for an urgent care claim or if the final internal adverse benefit determination concerns admission, availability of care, continued stay or a health care item or service for which you received emergency services and you have not yet been discharged, you may be eligible for an expedited external appeal review.

The difference between an external appeal review and an expedited external appeal review is the time frame allowed for making a determination as noted below.

External Review Determinations

The IRO will notify you and the Claims Administrator of the final external review determination:

- In writing within 45 days after the IRO receives the request for the external appeal review, or
- Within 72 hours after the IRO receives the request for expedited external appeal review; notice may be verbal with written confirmation to be issued within 48 hours of verbal notification.

The determination notice is binding on all parties and will contain:

- A general description of the reason for the request
- Identification of the claim issue: date of service, provider, claim amount, diagnosis code and corresponding meaning, procedure code and corresponding meaning and the previous reason for denial
- The date the IRO received the assignment to conduct the review
- The date of the IRO decision
- A discussion of the principal reason or reasons for its decision, including references to the evidence and documentation reviewed, and specific plan provisions and evidence-based standards used in reaching a decision
- A statement that the determination is binding on all parties except to the extent that other remedies may be available under state or federal law
- A statement that judicial review may be available to the claimant, and
- Current contact information, including phone number for any applicable state's ombudsman or other official office that assists with filing appeals.

If the determination is favorable and:

- It is a pre-service appeal, the Plan will issue the necessary authorization for the service.
- It is a post-service appeal, the Plan will promptly process the claim for benefits.
- Services were rendered by a network provider, any benefit payment due will be made to the provider directly. You remain responsible for any applicable copayment, deductible or coinsurance under the Plan.

The records will be maintained by the IRO for a period of six years and will be available for examination by you, the Plan or Claims Administrator, and state or federal oversight agencies upon request, except where such disclosure would violate HIPAA privacy laws.

COORDINATION OF BENEFITS—MEDICAL, PRESCRIPTION DRUGS, DENTAL AND VISION BENEFITS

Coordination of benefits applies when you or a covered family member is insured by more than one medical, dental or vision plan, including:

- A health plan sponsored by another employer
- A medical component of a group long-term care plan, such as skilled nursing care
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy
- Medical benefits payable under any premises liability or other type of liability coverage; or
- Medicare or other governmental health benefit.

The following guidelines determine which plan pays benefits first:

- When the other plan does not have a "Coordination of Benefits" provision, then that plan pays first.
- The plan covering the retiree always pays first for the retiree's expenses.
- If you are receiving COBRA continuation coverage under another employer plan, the Plan will pay benefits first.
- If your dependent child is covered under two plans and his or her parents are not separated or divorced, the plan of the parent whose birthday comes first in the calendar year pays for covered dependent children first; if both parents have the same birthday, the plan covering the parent for the longer time pays first.

- If the dependent child's parents are separated or divorced, the following applies:
 - The plan of the parent with custody of the child pays first;
 - Then, the plan of the spouse (if any) of the parent with custody of the child pays, and
 - Finally, the plan of the parent without custody of the child pays.
 - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, that parent's plan pays first.
- The plan that covers a person as an active retiree or his or her dependent will pay before the plan that covers such person as a laid off or retired employee or his or her dependent.
- When none of the above rules determines which coverage is a primary circumstance, the plan that has covered the individual claimant for the longest time pays first.

If you receive payments that are more than you should have when your benefits are coordinated, you will be expected to repay any overpayment, either through an offset to future benefit payments or via a separate check. Further, depending on the circumstances, the Company may commence a collection proceeding to recover benefits.

Medical and Dental Plan

The Plan coordinates benefits using a provision called "non-duplication of benefits" (also referred to as "maintenance of benefits") for medical (except prescription drugs) and dental services. One plan is the primary payer of benefits and the other plan is secondary. When the Plan is primary, it pays benefits first without regard to the other plan. When the Plan is secondary, it pays reduced benefits so that the combined payments do not equal an amount that is more than the Plan would pay if it were the only plan.

For medical (except prescription drugs) and dental claims, when the Plan is secondary (pays second), it will first calculate benefits for allowable expenses as if it were the only plan (without considering other plans' benefits). Then, it will subtract benefits payable under all other plans for the same allowable expenses. The difference, if any, is payable by the Plan. In no event will the Plan pay more than it would have if it were the primary plan.

Prescription Drug

The prescription drug benefit administered by Express Scripts does not apply coordination of benefits. If the prescription drug claim is first submitted to Express Scripts, Express Scripts will process the claim as primary whether the Plan is primary or secondary. If the claim is first submitted to the other plan, the prescription drug claim will not be treated as a covered expense under the Plan, unless the other plan is Medicare.

Vision Plan

The Plan coordinates vision benefits under the Vision Service Plan (VSP) option (the "VSP option") using a method called "traditional" coordination of benefits. When the Plan is the secondary plan for vision benefits under the VSP option, it coordinates benefits under all plans so that benefits paid under the VSP option, when combined with benefits paid under the other plan(s), do not exceed 100% of allowable expenses under the VSP option.

For vision claims under the VSP option, when the Plan is secondary, it will pay all or a part of the allowable expenses that are not paid by the primary plan(s). You will never receive more than 100% of your allowable expenses from all plans combined, and the Plan will not pay for a service or supply that it does not cover.

No-Fault Automobile Insurance

In states with no-fault automobile insurance, the automobile insurance carrier is the primary insurance for injuries resulting from an automobile accident even if you have elected to make the no-fault plan secondary. You should always elect at least the minimum medical benefits required by state law under your no-fault

automobile insurance as primary coverage. In no-fault states, all medical expenses related to an automobile accident should be submitted to the automobile insurance carrier first. The Plan will pay covered expenses not payable under the no-fault automobile insurance according to the Plan's Coordination of Benefits rules.

Coordination with Medicare – Medical Plan

If you or your dependents are covered by Medicare and the Plan, **the Plan is primary to Medicare if:**

- You are an eligible active employee age 65 or older and you are entitled to Medicare benefits.
- Your dependent spouse is age 65 or older, or under age 65 and disabled according to Social Security, and covered by the Plan based on your active employment status. This includes the first six months when you are out of work due to a disability.
- You or your spouse or dependent is eligible for Medicare due to having end-stage renal disease (“ESRD”) under the conditions and for the time periods specified by federal law. The Plan is primary during the first 30 months of Medicare due to ESRD received by any covered person who became eligible on or after February 5, 1996.

If the Plan is primary and you are entitled to Medicare **but** you want Medicare as your primary coverage, you must decline coverage under the Plan. If you elect Medicare as your primary medical coverage, the Plan is not permitted to supplement Medicare payments.

The Plan is secondary to Medicare for you, your spouse or other covered dependents if you or your dependents are eligible for Medicare and:

- You receive a determination from Social Security that you are totally and permanently disabled.
- You are a retired employee and covered under a health plan for retirees.

If you or a covered dependent is disabled, the disabled individual should apply for Social Security benefits, which generally can take up to five months for approval. After 24 months of being Social Security disabled, disabled individuals are eligible for Medicare. **At this time, the Plan will assume that the disabled individual has applied for full Medicare Part A and B coverage, and Medicare becomes the primary plan, and the Plan becomes the secondary plan.** As the secondary plan, the Plan will reduce benefits to reflect whatever Medicare would have paid had the disabled individual elected the full Medicare Part A and B coverage.

If you or a dependent are Medicare-eligible, the Medicare-eligible individual will not be covered for prescription drug benefits under the Plan if that individual elects Medicare Part D.

Coordination with Medicare – Medical Plan

The Plan is secondary to Medicare for you, your spouse or other covered dependents if you or your dependents are eligible for Medicare and:

- You receive a determination from Social Security that you are totally and permanently disabled.
- You are a retired employee and covered under a health plan for retirees.

If you or a covered dependent is disabled, the disabled individual should apply for Social Security benefits, which generally can take up to five months for approval. After 24 months of being Social Security disabled, disabled individuals are eligible for Medicare. **At this time, the Plan will assume that the disabled individual has applied for full Medicare Part A and B coverage, and Medicare becomes the primary plan, and the Plan becomes the secondary plan.** As the secondary plan, the Plan will reduce benefits to reflect whatever Medicare would have paid had the disabled individual elected the full Medicare Part A and B coverage.

If you or a dependent are Medicare-eligible, the Medicare-eligible individual will not be covered for prescription drug benefits under the Plan if that individual elects Medicare Part D.

Termination Before the End of the Maximum Coverage Period

Continuation coverage may end prior to the expiration of the maximum coverage period. The following events will cause the elected continuation coverage to terminate immediately:

- The Company no longer provides group health coverage to any of its employees or retirees
- Failure to timely pay the premium for the continuation coverage elected (i.e., within 45 days of the initial election of coverage or within 30 days of the first day of the month)
- Your family members become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any pre-existing condition that the individual has, after the date continuation coverage is elected. (This rule applies only to the individual who becomes covered under the other group health plan), or Your family members become eligible for Medicare after COBRA coverage has begun (COBRA coverage ends only for the person becoming eligible for Medicare. Other family members will continue to be covered.).

Keep Your Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

OTHER IMPORTANT PLAN INFORMATION

Qualified Medical Child Support Order ("QMCSO")

A Qualified Medical Child Support Order ("QMCSO") is a court order or judgment requiring coverage for your child under the Plan. If the Plan Administrator determines that the court order is a valid QMCSO, the child must be covered under the Plan as required by the QMCSO and to the extent permitted under the Plan's eligibility rules. You must pay for the coverage.

For a child support order to be "qualified," it must meet certain legal requirements. The Plan Administrator follows the Plan's QMCSO procedures when determining if a child support order is qualified. You can obtain a copy of the Plan's procedures governing Qualified Medical Child Support Orders free of charge by contacting the Benefits Department.

Any payment made as the result of a QMCSO will not violate the rule that benefits may not be transferred or assigned. You should notify the Benefits Department of any pending or potential child support order.

Assignment of Benefits

The Plan is designed to provide benefits exclusively for you and your dependents. Therefore, you may not sell, transfer, assign, or otherwise encumber your interest in the Plan except as provided by law or by the Plan's terms. All or some of your medical benefits may be assigned to a former spouse or a dependent child under a Qualified Medical Child Support Order.

Right to Release and Obtain Necessary Information

The Plan Administrator or the Claims Administrator may, without the consent, or notice to, any person, release to or obtain from any other person any information that it deems necessary to determine whether the coordination of benefits provision or other general claim administration provisions apply. You must

provide the Plan Administrator or Claims Administrator with information needed to implement the Coordination of Benefits provision or other general claims administration provisions.

Facility of Payment

If payments that should have been made under the terms of this Plan's coordination of benefits provision or other general claim administration provisions are made under other medical plans, the Plan Administrator or the Claims Administrator may pay the appropriate amount to any person who made such payment. To the extent of such payments, the Plan Administrator and the Company will be discharged from liability under this Plan.

Right to Recovery

If the Plan Administrator or the Claims Administrator makes payments with respect to covered expenses in excess of the payment necessary to satisfy the coordination of benefits provision or other general claim administration provisions, it will have the right to recover such excess for the Company from any persons with respect to whom such payments were made and from any organization that should have made such payments.

Subrogation and Reimbursement

The Plan with respect to medical, prescription drug, dental, vision and disability benefits contains subrogation and reimbursement provisions. Subrogation and reimbursement provisions may be different for insured benefits.

If you or your covered dependent(s) are injured or otherwise harmed due to the conduct of another party, the Plan Administrator has the right to recover from you, your covered dependents and/or any other person, entity or trust in possession of the benefits paid by any of the benefit plans for which you or they recover monies from a third party. The Plan shall have a first priority lien for the full amount of the benefits that are paid to you and/or your covered dependents and against future benefits due under the Plan in the amount of any claims paid should you seek to recover any monies from the third party that caused the injuries. These amounts may come directly from the third party or his or her insurance company, or any other source (including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile coverage or any first-party insurance), or from any amount received by you or your covered dependents from the third party, his or her insurance company or any other source. The lien shall attach as soon as any person or entity agrees to pay any money to or on behalf of you (or your covered dependent) that could be subject to the Plan's right of recovery if and when received by you (or your covered dependent). This is referred to as the Plan's right of "subrogation and reimbursement." This right exists with respect to any amount received or receivable through a "third-party" claim, lawsuit, settlement or any other manner, whether or not characterized as related to medical expenses. The Plan may seek recovery through subrogation and/or any other equitable or legal relief available under state or federal law.

The Plan Administrator may delegate to our Claims Administrators all or any portion of its rights and/or obligations regarding the Plan's right of subrogation and reimbursement.

We strongly recommend that if you are injured as a result of the negligence or wrongful act of a third party, you should contact your attorney for advice and counsel. However, this Plan cannot and does not pay for the fees your attorney might charge. Furthermore, the Plan does not require you to seek any recovery whatsoever against a third party, and if you do not receive any recovery from the party, you are not obligated in any way to reimburse the Plan for any of the benefits that you applied for and accepted.

When you accept benefits from the Plan, you are agreeing to reimburse the Plan the full amount of any benefits paid to you or your covered dependents from the proceeds of any compromise, settlement,

judgment and/or verdict to the extent permitted by law. The Plan Administrator, in its own discretion, may also commence an action against any party it feels caused an injury to you or a covered dependent for which the Plan provided benefits. The Plan will not provide you with legal representation if you decide to commence your own legal action.

You also must take any reasonably necessary action to protect the Plan's subrogation and reimbursement right. By accepting Plan benefits, you agree to notify the Plan Administrator or its delegate within 10 days after either you or your attorney first attempt to recover monies, or institute a lawsuit, or other action, or enter into settlement negotiations with another party (including his/her insurance company) in connection with or related to the conduct of another party. You must also cooperate with the reasonable requests of the Plan Administrator or its delegate concerning the Plan's subrogation and reimbursement rights and keep the Plan Administrator informed of any important developments in your actions and also provide the Plan Administrator or its delegate with any information or documents, upon request, that pertain to or are relevant to your actions. If litigation is commenced, you are required to give at least five days' notice to the Plan Administrator prior to any action to be taken as part of such litigation, including, but not limited to, any pretrial conferences or other court dates. Representatives of the Plan reserve the right to attend pretrial conferences or other court proceedings.

In the event that you fail to notify the Plan as provided for above, and/or fail to reimburse the Plan as provided for above, the Plan reserves the right, in addition to all other remedies available to it at law or equity, to withhold any other monies that might be due to you from the Plan for past or future claims, until such time as the lien is discharged and/or satisfied. Your failure to cooperate may also result in the treatment of prior claims as overpayments recoverable by offset against future benefits or by other action of the Plan Administrator. You are legally obligated to avoid doing anything that would prejudice the Plan's right to reimbursement, and failure to cooperate may result in your disqualification from receipt of further benefits from the Plan.

By applying for benefits, you agree that the proceeds of any compromise, settlement, judgment and/or verdict received from a third party, his or her insurance carrier and/or any other source, if paid directly to you or your legal representative, will be held by you in constructive trust for the Plan. The receipt of such funds makes you a fiduciary for the Plan with respect to such funds and, therefore, subject to the fiduciary provisions and obligations of ERISA.

By applying for benefits, you agree that the proceeds of any compromise, settlement, judgment and/or verdict received from the third party, his or her insurance carrier and/or any other party settling on his behalf, and paid to a person or entity other than you, including but not limited to, a trust, an attorney or an agent thereof, shall be held by such other person, entity or trust in constructive trust for the Plan. The recipient of such funds is a fiduciary for the Plan with respect to such funds and is subject to the fiduciary provisions and obligations of ERISA. The Plan reserves the right to seek recovery from such person, entity or trust and to name such person, entity or trust as a defendant in any litigation arising out of the Plan's subrogation or restitution rights.

By applying for benefits, you agree that any lien the Plan may seek will not be reduced by any attorney fees, court costs or disbursements that you and/or your attorney might incur in your action to recover from the third party, and these expenses may not be used to offset your obligation to reimburse the Plan for the full amount of the lien. Further, you agree that any recovery will not be reduced by and is not subject to the application of any common fund doctrine, fund doctrine or attorney's fund doctrine for the recovery of attorney's fees.

If you or your covered dependent have received Plan benefits and also receive payment from a third party, his or her insurance company or any other source as a result of an injury or harm due to the conduct of another party, you must reimburse the Plan first for the amount of medical expenses paid on your or your covered dependent's behalf by the Plan. The amount you (or your covered dependent) receive from a third party may not compensate you (or your covered dependent) fully for all of the financial expenses incurred. Where the recovery from a third party is partial or incomplete, the Plan's right to reimbursement takes priority over your or your covered dependents' right of recovery, regardless of whether you or your covered

dependents have been made whole for injuries or losses. The Plan does not recognize and is not bound by application of any of the “make whole” “collateral source” or “common fund” doctrines.

Health Care Fraud

If you willfully and knowingly engage in any activity intended to defraud the Plan, that act can result in disciplinary action up to and including termination of coverage. If you receive money from the Plan to which you are not entitled, you will be required to fully reimburse the Plan.

Insurance Fraud

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

Your Rights under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)

HIPAA – Your Right to Privacy

A federal law, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan’s privacy notice, which was distributed to you and is available upon request from the HIPAA Privacy Office. The Privacy Office can be reached via fax at 1-317-810-3986.

The Plan includes the following provisions as a condition of its ability to disclose any protected health information to the Company:

- The Plan, will not use or further disclose information that is protected by HIPAA (“protected health information” or “PHI”) except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law.
- When using or disclosing PHI or when requesting PHI from the Plan, the Company shall make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purposes of the use, disclosure or request.
- By law, the Plan has required all of its business associates to enter into agreements to observe HIPAA’s privacy rules.
- Except as permitted by HIPAA and other applicable privacy laws, the Plan will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company.
- The Company shall report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures allowed under the Plan and/or applicable law.
- The Company will, if feasible, return or destroy all PHI in whatever form or medium received from the Plan when the PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to do so, the Company will limit further uses and disclosures to those purposes that make the return of the PHI infeasible.

The following classes of employees may be given access to PHI received from the Plan or a health insurance issuer or business associate servicing the Plan:

- Privacy Office
- Benefits Administration Committee
- Corporate Benefits Department
- Corporate Legal Department

- Plan administrators
- HRIS staff who work with health plan data
- Corporate Audit staff responsible for audit of health plan administration, and
- Financial Analysts who require access to health claims data.
- This list includes every class of employees who may receive PHI relating to payment under health care operations of, or other matters pertaining to, the Plan in the ordinary course of business. The class of employees listed above will have access to PHI only to perform the plan administration functions that the Company provides to the health plan. These individuals will be subject to appropriate disciplinary action, up to and including termination of employment, for any use of PHI in violation of the provisions of the Plan documents. We will impose appropriate disciplinary action on each employee causing the violation and will work to mitigate any harmful effect of the violation on any participant or beneficiary whose privacy has been violated.
- Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, in certain circumstances, amend the information. You also have the right to file a complaint with the Plan Administrator or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.
- The Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, if you have any questions about the privacy of your health information or if you wish to file a complaint under HIPAA, please contact the HIPAA Privacy Office via facsimile at (317) 810-3986.

If There Is a Breach of Your Protected Health Information

If there is a breach of your unsecured PHI, HIPAA requires that the Plan notify you without unreasonable delay, but no later than 60 days after the Plan's discovery of the breach. The notice must be written in plain language and contain the following information to the extent possible:

- A brief description of what happened, including the date of the breach and the date of discovery
- The types of PHI involved (name, SSN, date of birth, diagnosis, etc.)
- Any steps you should take to protect yourself from potential harm resulting from the breach
- A brief description of the steps the Plan is taking to investigate, mitigate losses and protect against further breaches; and
- Contact information for you to ask questions, including a toll-free number, email address, website or postal address.

If a breach of your unsecured PHI occurs, a notice will be sent by first-class mail to your last known address, or if you agree to electronic notice, by email.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers cannot 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 normal vaginal delivery
- Less than 96 hours following a Cesarean section, or
- Require a provider to obtain authorization from the Plan for a length of stay that is within these time periods. However, if the mother agrees, either mother or newborn may be released earlier.

Women’s Health and Cancer Rights Act

In compliance with the Women’s Health and Cancer Rights of 1998, the Plan provides medical and surgical benefits for mastectomies. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the individual’s attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses, and
- Treatment of physical complications resulting from the mastectomy (including lymphedemas).

These mastectomy-related benefits are subject to deductibles and coinsurance limitations that are consistent with those applicable to other medical and surgical benefits under your health plan. Call your health plan for more information.

Genetic Information Nondiscrimination Act (“GINA”)

The Genetic Information and Nondiscrimination Act (“GINA”) prohibits health coverage discrimination based on genetic information about Plan participants and employees/retirees and the family members of Plan participants and employees/retirees.

Genetic information includes:

- Genetic tests
- The request for, or receipt of, genetic counseling or other genetic services, and
- The manifestation of a disease or disorder in an individual or their family member.

The availability of genetic testing and the results of any genetic testing you undergo will be treated as confidential, as required by HIPAA and GINA. Likewise, any health risk appraisal conducted by a service provider of the Plan will be conducted in strict compliance with requirements of HIPAA and GINA.

Plan Continuation and Reservation of Rights

The Company presently intends to continue the Plan, but reserves the right to amend, suspend, discontinue or terminate any or all of the benefits, coverage, plans or programs, in whole or in part, at any time and for any reason. For example, the Company reserves the right to amend, suspend, discontinue or terminate covered expenses, benefit copayments, lifetime maximums and reserves the right to increase retiree contributions and to implement any cost control measures that it may deem advisable.

The Company’s decision (through the Board of Directors or authorized delegate) to amend, suspend, discontinue or terminate any of the Plan or programs may be due to changes in federal or state laws governing health and welfare benefits, the requirements of the Internal Revenue Code or the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), the provision of a contract or policy involving an insurance company, Company policy or any other reason.

Interpretation of the Plan

The Plan Administrator administers the Plans. The Plan Administrator may appoint/employ the persons necessary to provide advice with respect to any responsibility of the Plan Administrator under the Plans. Additionally, the Plan Administrator may delegate any responsibility under the Plans to Schlage Lock Company LLC employees or other persons.

Under several of the benefit plans (for example, the insured plans), the Plan Administrator has delegated claims administration responsibility to a third-party “Claims Administrator.” To the extent the Plan

Administrator has delegated such responsibility, the Claims Administrator has the discretionary authority and responsibility to make all factual determinations necessary to administer a Plan's claims administration procedures. This includes claim denial reviews, determining the amount of benefits and interpreting the meaning and intention of the terms of the Plan. The Plan Administrator's decision on all such matters shall be final and binding on all parties. See the "Plan Identification Information" section for the Plan Administrator and Claims Administrator by benefit plan. Correspondence to the Plan Administrator/Claims Administrator should be sent to the addresses listed in this section.

The Plan Administrator and/or its duly authorized designee(s) has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan, including this SPD, any trust agreements and any other Plan documents. The administrator or designee(s) decides all matters (including factual matters) that arise in connection with the operation or administration of the Plan and any trust agreements.

Without limiting the generality of the above described authority, the Plan Administrator and/or its duly authorized designee(s) has sole and absolute discretionary authority to:

- Take all actions and make all decisions (including factual decisions) about eligibility and the amount of benefits payable under the Plan
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan according to the terms of the Plan
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan
- Resolve and/or clarify any ambiguities, inconsistencies and omissions (including factual determinations) arising under the Plan, including this summary, any trust agreements or other Plan documents
- Process and approve or deny benefit claims, and
- Determine the standard of proof required in any legal case or claim.

Plan Documents

This section of the Summary Plan Description describes the important terms of the Plan and does not attempt to cover all the details with respect to administration.

Additional details may be provided in the Plan documents and insurance and/or service contracts, which legally govern the Plan. The additional documents may be seen in the Plan Administrator's office during normal working hours. These documents include any documents filed with the Internal Revenue Service, the annual financial reports and may include contracts and other documents used by the Claims Administrator. You may obtain copies of these documents by sending a written request to the Plan Administrator. There will be a charge to cover copying costs. In the event of any discrepancy between this Summary Plan Description and the other controlling documents, the controlling documents will prevail.

Your Rights under the Employee Retirement Income Security Act of 1974

As a participant in the Plan, you are entitled to certain federal rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, through the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration ("EBSA").

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series), and updated Summary Plan Descriptions (“SPDs”). The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plans’ annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of the Summary Annual Reports.

Continue Group Health Plan Coverage

Continue health care coverage for your spouse or dependents, if there is a loss of coverage under the Plan as the result of a qualifying event, you or your dependents may have to pay for such coverage. Review this Summary Plan Description (“SPD”) and the documents governing the Plan for the rules governing your COBRA continuation of coverage rights.

Duties of the Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called “fiduciaries,” have a duty to do so prudently and in the interest of Plan participants and beneficiaries. No one, including the Company, or any other person, may discriminate against you in any way to prevent you from obtaining a welfare benefit available under the Plan or exercising your rights under ERISA.

Steps You Can Take to Enforce Your Rights

ERISA specifically provides for circumstances under which you may take legal action as a Plan participant.

If your claim for a benefit is ignored or denied, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you or your beneficiary can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan Administrator, and do not receive them within 30 days, you may bring suit in federal court. The court may require the Plan Administrator to provide the materials, and pay you up to \$110 a day until you receive the materials. The provision does not apply, however, if the materials were not sent to you for reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is ignored or denied, in whole or in part, you or your beneficiary may file suit in a state or federal court. In addition, if you disagree with the Plan Administrator’s decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If the Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you or your beneficiary may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If you or your beneficiary is successful, the court may order the person you have sued to pay these costs and fees. But if you lose (if, for example, the case is considered frivolous) you or your beneficiary may have to pay all costs and fees.

Timeframe in Which to Bring Legal Action

Legal action to recover any benefits under this Plan must be filed no later than 12 months from the date of the Plan Administrator’s decision on your final appeal (or if no decision on your appeal is furnished within 120 days after receipt by the Plan Administrator of your appeal, 12 months from the 120th day after the Plan Administrator receives your appeal). If you fail to initiate legal action within this 12-month period, you will forfeit your right to assert any legal claims with regard to the underlying disputed claim.

If You Have Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration (“EBSA”), U.S. Department of Labor listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications concerning your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN IDENTIFICATION INFORMATION

Plan Identification Information	
Official Name of Plan	Schlage Lock Company LLC Health and Welfare Benefit Plan
Plan Sponsor	Schlage Lock Company, LLC 11819 N. Pennsylvania Street Carmel, IN 46032
Plan Administrator	Benefits Administration Committee
Plan Type	Welfare benefits plan
Plan Year	January 1 – December 31
Employer Identification Number	54-2139412
Plan Number	502
Plan Funding	<ul style="list-style-type: none"> • Medical and Dental — Funded by a combination of retiree and employer contributions
Agent for Service of Legal Process	Benefits Administration Committee Schlage Lock Company LLC 11819 N. Pennsylvania Street Carmel, IN 46032
Type of Administration	Contract administration with the Claims Administrators listed in this section. Medical and prescription drug Claims Administrators provide administrative services only. Benefits are provided in accordance with the provisions of the Plan.

Claims Administrators:	
Prescription Drug	Express Scripts 1 Express Way St. Louis, MO 63121 www.express-scripts.com (800) 818-6743

Claims Administrators:	
Dental	Delta Dental P.O. Box 9085 Farmington Hills, MI 48333 www.deltadentalin.com (800) 524-0149
Vision	VSP 3400 Morse Crossing Columbus, OH 43219 www.vsp.com (800) 877-7195
Type of Administration	Contract administration with the Claims Administrators listed in this section. Medical and prescription drug Claims Administrators provide administrative services only. Benefits are provided in accordance with the provisions of the Plan.

