THE LUBRIZOL CORPORATION
WICKLIFFE OH

Health Benefit Summary Plan Description
7670-00-415412

BENEFITS ADMINISTERED BY

A UnitedHealthcare Company

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THE LUBRIZOL CORPORATION

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan, as well as with information on a Covered Person's rights and obligations under THE LUBRIZOL CORPORATION Group Health Benefit Plan (the "Plan"). You are a valued Employee of THE LUBRIZOL CORPORATION, and Your employer is pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact the Lubrizol Benefits Center 1-844-747-1641 or Included Health your first call for benefits related inquiries 1-855-431-5532 if You have questions or if You have difficulty translating this document.

THE LUBRIZOL CORPORATION is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims and CVS Caremark for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, since they are solely claims-paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with capital letters, even though suchterms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each individual covered under this Plan will be receiving an identification card that they may present to providers whenever they receive services. On the back of this card are phone numbers to call in case of questions or problems.

This document contains information on the benefits and limitations of the Plan. It is being furnished to You in accordance with ERISA. If there is a conflict between the information in this SPD and the terms of the Plan, the Plan terms will govern.

This document became effective on January 1, 2023.

PLAN INFORMATION

Plan Name	THE LUBRIZOL CORPORATION GROUP HEALTH BENEFIT PLAN
Name And Address Of Employer	THE LUBRIZOL CORPORATION 29400 LAKELAND BLVD WICKLIFFE OH 44092
Name, Address, And Phone Number Of Plan Administrator	THE LUBRIZOL CORPORATION 29400 LAKELAND BLVD WICKLIFFE OH 44092 440-943-4200
Named Fiduciary	THE LUBRIZOL CORPORATION
Claims Appeal Fiduciary For Medical Claims	UMR
Employer Identification Number Assigned By The IRS	34-0367600
Plan Number Assigned By The Plan	506
Type Of Benefit Plan Provided	Self-funded Health and Welfare Plan providing group health benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	THE LUBRIZOL CORPORATION 29400 LAKELAND BLVD WICKLIFFE OH 44092
Funding Of The Plan	Employer and Employee Contributions Benefits are provided by a benefit Plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
ERISA Plan Year	January 1 through December 31

ERISA And Other Federal Compliance

It is intended that this Plan comply with all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator and, in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN MEDICAL SCHEDULE OF BENEFITS

(Plus Plan, Standard Plan, Core Plan

This Plan has the required elements for You to be able to contribute to a tax-advantaged Health Savings Account (HSA).

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Benefits listed in this Schedule of Benefits are subject to all provisions of this Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

PLAN FEATURES	NETWORK / NON-NETWORK		
	Core	**Standard**	**Plus**
Annual Deductible: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Deductible.*** • Individual • Employee Plus One • Employee Plus Family	 $4,250 $6,375 $8,500	 $3,250 $4,875 $6,500	 $2,250 $3,375 $4,500
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	80%		60%
Annual Total Out-Of-Pocket Maximum: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.*** • Individual • Employee Plus One • Employee Plus Family	 $5,750 $7,875 $10,000	 $4,750 $6,375 $8,000	 $3,750 $4,875 $6,000
	IN-NETWORK		**OUT-OF-NETWORK**
Ambulance Transportation: • Paid By Plan After In-Network Deductible	80%		80%
Breast Pumps: • Paid By Plan	100% (Deductible Waived)		100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Contraceptive Methods And Contraceptive Counseling Approved By The FDA:		
For Men:		
• Paid By Plan After Deductible	80%	60%
For Women:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Durable Medical Equipment:		
• Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment:		
Urgent Care:		
• Paid By Plan After Deductible	80%	60%
Walk-In Retail Health Clinics:		
• Paid By Plan After Deductible	80%	60%
Emergency Room / Emergency Physicians:		
• Paid By Plan After In-Network Deductible	80%	80%
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility:		
• Maximum Days Per Calendar Year	120 Days	
• Paid By Plan After Deductible	80%	60%
Hearing Services:		
• Maximum Benefit Every 2 Calendar Years	$500	
Exams, Tests:		
• Paid By Plan After Deductible	80%	60%
Hearing Aid Exams: Included In Maximum		
• Paid By Plan After Deductible	80%	60%
Hearing Aids: Included In Maximum		
• Paid By Plan After Deductible	80%	60%
Implantable Hearing Devices:		
• Paid By Plan After Deductible	80%	60%
Bone-Anchored Hearing Aids (BAHA):		
• Maximum Benefit Per Lifetime	1 Bone-Anchored Hearing Aid (BAHA)	
• Paid By Plan After Deductible	80%	60%
Home Health Care Benefits:		
• Maximum Visits Per Calendar Year	120 Visits	
• Paid By Plan After Deductible	80%	60%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.		
Visit Limit Does Not Apply To Home Infusion.		

	IN-NETWORK	OUT-OF-NETWORK
Hospice Care Benefits:		
Hospice Services:		
• Paid By Plan After Deductible	80%	60%
Bereavement Counseling:		
• Paid By Plan After Deductible	80%	60%
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	80%	60%
Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:		
• Paid By Plan After Deductible	80%	60%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Advanced Imaging Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-Ray Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	80%	60%
Physician Clinic Visits In An Outpatient Hospital Setting:		
• Paid By Plan After Deductible	80%	60%
Manipulations:		
• Maximum Visits Per Calendar Year	20 Visits	
• Paid By Plan After Deductible	80%	60%
Visit Maximums Are Applied Based On Provider Designation And Procedure Code.		
If A Provider Bills For A Manipulation And A Therapy On The Same Claim, Only One Visit Will Be Applied To The Manipulation Maximum Based On The Provider's Designation.		
Maternity:		
Routine Prenatal Services:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Non-Routine Prenatal Services, Delivery, And Postnatal Care:		
• Paid By Plan After Deductible	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits: • Paid By Plan After Deductible	80%	60%
Nursery And Newborn Expenses: • Paid By Plan After Deductible ***Note: Deductible Will Be Waived For Newborn Charges, Initial Stay (Days 0-5) For Both In-Network And Out-Of-Network.***	80%	60%
Orthotic Appliances: • Paid By Plan After Deductible	80%	60%
Foot Orthotics: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	1 Pair Of Foot Orthotics 80%	60%
Compression Stockings / Tights (Both Over-The-Counter And Custom-Made Surgical Support Stockings): • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	2 Pairs Of Compression Stockings / Tights (Both Over-The-Counter And Custom-Made Surgical Support Stockings) 80%	60%
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting: **This Section Does Not Apply To:** ➢ **Preventive / Routine Services** ➢ **Manipulation Services Billed By Any Qualifying Provider** ➢ **Dental Services Billed By Any Qualifying Provider** ➢ **Therapy Services Billed By Any Qualifying Provider** ➢ **Any Services Billed From An Outpatient Hospital Facility Except For Physician Clinic Visits In An Outpatient Hospital Setting** • Paid By Plan After Deductible	80%	60%
Physician Office Services: • Paid By Plan After Deductible	80%	60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: **Preventive / Routine Physical Exams At Appropriate Ages:** • Paid By Plan **Immunizations:** • Paid By Plan ***Note: Foreign Travel Immunizations Will Not Be Covered.***	100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		
• Maximum Exams Per Calendar Year Including 3D Mammograms For Preventive Screenings	1 Exam	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
3D Mammograms For Preventive Screenings: Included In Preventive / Routine Mammograms And Breast Exams Maximum		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit:		
• Paid By Plan After Deductible	80%	60%
Preventive / Routine Pelvic Exams And Pap Tests:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Screening For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** • Paid By Plan ***These Services May Also Apply To Men.**	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include: **Preventive / Routine Physical Exams:** • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Immunizations: • Paid By Plan ***Note: Foreign Travel Immunizations Will Not Be Covered.***	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Screenings At Appropriate Ages: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab, And X-Rays: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Prosthetic Devices: • Paid By Plan After Deductible	80%	60%
Replacement: • Maximum Benefit Every 3 Calendar Years	1 Replacement Of A Type Of Prosthetic Device	
• Paid By Plan After Deductible	80%	60%
Sterilizations: **For Men:** • Paid By Plan After Deductible	80%	60%
For Women: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Telemedicine Provided By Doctor On Demand: **General Medicine:** • Paid By Plan After Deductible	80%	
Behavioral Health: • Paid By Plan After Deductible	80%	
Temporomandibular Joint Disorder Benefits: • Paid By Plan After Deductible	80%	60%
Therapy Services: • Paid By Plan After Deductible ***Note: Medical Necessity Will Be Reviewed After 25 Visits.***	80%	60%
Travel And Lodging For Restrictive Services - Refer To The Covered Medical Benefits Section For Details: Included In The Transplant, Optum Bariatric Resource Services, Optum Cancer Resource Services, Optum Congenital Heart Disease Resource Services, Optum Fertility Solutions, Optum Kidney Resource Services, And Orthopedic Health Support Maximum • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	$10,000 80%	
Urinary Drug Screening: **Presumptive Testing:** • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	18 Visits 80%	60%
Definitive Testing: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	18 Visits 80%	60%
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	$500 80%	60%
All Other Covered Expenses: • Paid By Plan After Deductible	80%	60%

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN MEDICAL SCHEDULE OF BENEFITS

(Out-of-Area Plan)

This Plan has the required elements for You to be able to contribute to a tax-advantaged Health Savings Account (HSA).

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Benefits listed in this Schedule of Benefits are subject to all provisions of this Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

LUBRIZOL OOA FEATURES	LUBRIZOL OOA	
	IN-NETWORK	**OUT-OF-NETWORK**
Annual Deductible: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Deductible.*** • Individual • Employee Plus One • Employee Plus Family	 $3,250 $4,875 $6,500	
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	 80%	
Annual Total Out-Of-Pocket Maximum: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.*** • Individual • Employee Plus One • Employee Plus Family	 $4,750 $6,375 $8,000	
Ambulance Transportation: • Paid By Plan After In-Network Deductible	80%	80%
Breast Pumps: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Contraceptive Methods And Contraceptive Counseling Approved By The FDA:		
For Men:		
• Paid By Plan After Deductible	80%	80%
For Women:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Durable Medical Equipment:		
• Paid By Plan After Deductible	80%	80%
Emergency Services / Treatment:		
Urgent Care:		
• Paid By Plan After Deductible	80%	80%
Walk-In Retail Health Clinics:		
• Paid By Plan After Deductible	80%	80%
Emergency Room / Emergency Physicians:		
• Paid By Plan After In-Network Deductible	80%	80%
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility:		
• Maximum Days Per Calendar Year	120 Days	
• Paid By Plan After Deductible	80%	80%
Hearing Services:		
• Maximum Benefit Every 2 Calendar Years	$500	
Exams, Tests:		
• Paid By Plan After Deductible	80%	80%
Hearing Aid Exams: Included In Maximum		
• Paid By Plan After Deductible	80%	80%
Hearing Aids: Included In Maximum		
• Paid By Plan After Deductible	80%	80%
Implantable Hearing Devices:		
• Paid By Plan After Deductible	80%	80%
Bone-Anchored Hearing Aids (BAHA):		
• Maximum Benefit Per Lifetime	1 Bone-Anchored Hearing Aid (BAHA)	
• Paid By Plan After Deductible	80%	80%
Home Health Care Benefits:		
• Maximum Visits Per Calendar Year	120 Visits	
• Paid By Plan After Deductible	80%	80%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.		
Visit Limit Does Not Apply To Home Infusion.		

	IN-NETWORK	OUT-OF-NETWORK
Hospice Care Benefits:		
Hospice Services:		
• Paid By Plan After Deductible	80%	80%
Bereavement Counseling:		
• Paid By Plan After Deductible	80%	80%
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	80%	80%
Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:		
• Paid By Plan After Deductible	80%	80%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	80%	80%
Outpatient Advanced Imaging Charges:		
• Paid By Plan After Deductible	80%	80%
Outpatient Lab And X-Ray Charges:		
• Paid By Plan After Deductible	80%	80%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	80%	80%
Physician Clinic Visits In An Outpatient Hospital Setting:		
• Paid By Plan After Deductible	80%	80%
Manipulations:		
• Maximum Visits Per Calendar Year	20 Visits	
• Paid By Plan After Deductible	80%	80%
Visit Maximums Are Applied Based On Provider Designation And Procedure Code.		
If A Provider Bills For A Manipulation And A Therapy On The Same Claim, Only One Visit Will Be Applied To The Manipulation Maximum Based On The Provider's Designation.		
Maternity:		
Routine Prenatal Services:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Non-Routine Prenatal Services, Delivery, And Postnatal Care:		
• Paid By Plan After Deductible	80%	80%

	IN-NETWORK	OUT-OF-NETWORK
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits: • Paid By Plan After Deductible	80%	80%
Nursery And Newborn Expenses: • Paid By Plan After Deductible ***Note: Deductible Will Be Waived For Newborn Charges, Initial Stay (Days 0-5) For Both In-Network And Out-Of-Network.***	80%	80%
Orthotic Appliances: • Paid By Plan After Deductible **Foot Orthotics:** • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible **Compression Stockings / Tights (Both Over-The-Counter And Custom-Made Surgical Support Stockings):** • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	80% 1 Pair Of Foot Orthotics 80% 2 Pairs Of Compression Stockings / Tights (Both Over-The-Counter And Custom-Made Surgical Support Stockings) 80%	80% 80% 80%
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting: **This Section Does Not Apply To:** ➢ **Preventive / Routine Services** ➢ **Manipulation Services Billed By Any Qualifying Provider** ➢ **Dental Services Billed By Any Qualifying Provider** ➢ **Therapy Services Billed By Any Qualifying Provider** ➢ **Any Services Billed From An Outpatient Hospital Facility Except For Physician Clinic Visits In An Outpatient Hospital Setting** • Paid By Plan After Deductible	80%	80%
Physician Office Services: • Paid By Plan After Deductible	80%	80%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: **Preventive / Routine Physical Exams At Appropriate Ages:** • Paid By Plan **Immunizations:** • Paid By Plan ***Note: Foreign Travel Immunizations Will Not Be Covered.***	100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		
• Maximum Exams Per Calendar Year Including 3D Mammograms For Preventive Screenings	1 Exam	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
3D Mammograms For Preventive Screenings: Included In Preventive / Routine Mammograms And Breast Exams Maximum		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit:		
• Paid By Plan After Deductible	80%	80%
Preventive / Routine Pelvic Exams And Pap Tests:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Screening For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** • Paid By Plan ***These Services May Also Apply To Men.**	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include: **Preventive / Routine Physical Exams:** • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Immunizations: • Paid By Plan ***Note: Foreign Travel Immunizations Will Not Be Covered.***	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Screenings At Appropriate Ages: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab, And X-Rays: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Prosthetic Devices: • Paid By Plan After Deductible	80%	80%
Replacement: • Maximum Benefit Every 3 Calendar Years	1 Replacement Of A Type Of Prosthetic Device	
• Paid By Plan After Deductible	80%	80%
Sterilizations: **For Men:** • Paid By Plan After Deductible	80%	80%
For Women: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Telemedicine Provided By Doctor On Demand: **General Medicine:** • Paid By Plan After Deductible	80%	
Behavioral Health: • Paid By Plan After Deductible	80%	
Temporomandibular Joint Disorder Benefits: • Paid By Plan After Deductible	80%	80%
Therapy Services: • Paid By Plan After Deductible ***Note: Medical Necessity Will Be Reviewed After 25 Visits.***	80%	80%
Travel And Lodging For Restrictive Services - Refer To The Covered Medical Benefits Section For Details: • Maximum Benefit Per Calendar Year Included In The Transplant, Optum Bariatric Resource Services, Optum Cancer Resource Services, Optum Congenital Heart Disease Resource Services, Optum Fertility Solutions, Optum Kidney Resource Services, And Orthopedic Health Support Maximum	$10,000	
• Paid By Plan After Deductible	80%	
Urinary Drug Screening: **Presumptive Testing:** • Maximum Visits Per Calendar Year	18 Visits	
• Paid By Plan After Deductible	80%	80%
Definitive Testing: • Maximum Visits Per Calendar Year	18 Visits	
• Paid By Plan After Deductible	80%	80%
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata: • Maximum Benefit Per Calendar Year	$500	
• Paid By Plan After Deductible	80%	80%
All Other Covered Expenses: • Paid By Plan After Deductible	80%	80%

TRANSPLANT SCHEDULE OF BENEFITS

The program for Transplant Services at Designated Transplant Facilities is:

Optum

(Plus Plan, Standard Plan, Core Plan, Out-of-Area Plan)

Transplant Services: Designated Transplant Facility **Transplant Services:** • Paid By Plan After Deductible **Travel And Housing:** Included In The Travel And Lodging For Restrictive Services, Optum Bariatric Resource Services, Optum Cancer Resource Services, Optum Congenital Heart Disease Resource Services, Optum Fertility Solutions, Optum Kidney Resource Services, And Orthopedic Health Support Maximum • Maximum Benefit Per Transplant Calendar Year • Paid By Plan After Deductible Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	90% $10,000 100%	
	IN-NETWORK	**OUT-OF-NETWORK**
Transplant Services: Non-Designated Transplant Facility **Transplant Services:** • Paid By Plan After Deductible **Travel And Housing:** • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	80% $10,000 100%	80% 100%

OPTUM BARIATRIC RESOURCE SERVICES SCHEDULE OF BENEFITS (Plus Plan, Standard Plan, Core Plan, Out-of-Area Plan)	
Bariatric Resources Services (BRS) Designated Centers of Excellence (COE) Facility:	
Bariatric Resource Services: • Paid By Plan After Deductible	 90%
Travel And Housing If The Recipient Lives More Than 50 Miles From The Facility: • Maximum Benefit Per Day Included In The Travel And Lodging For Restrictive Services, Transplant, Optum Cancer Resource Services, Optum Congenital Heart Disease Resource Services, Optum Fertility Solutions, Optum Kidney Resource Services, And Orthopedic Health Support Maximum • Maximum Benefit Per Calendar Year • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	 $50 Per Person, Not To Exceed $100 Per Day $10,000 1 Surgery 100%
Bariatric Resources Services (BRS) Non-Designated Centers of Excellence (COE) Facility:	No Benefit

OPTUM CANCER RESOURCE SERVICES SCHEDULE OF BENEFITS (Plus Plan, Standard Plan, Core Plan, Out-of-Area Plan)		
Cancer Resource Services (CRS) Designated Centers Of Excellence (COE) Facility: **Cancer Resource Services:** • Paid By Plan After Deductible **Travel And Housing If The Recipient Lives More Than 50 Miles From The Facility:** • Maximum Benefit Per Day Included In The Travel And Lodging For Restrictive Services, Transplant, Optum Bariatric Resource Services, Optum Congenital Heart Disease Resource Services, Optum Fertility Solutions, Optum Kidney Resource Services, And Orthopedic Health Support Maximum • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	90% $50 Per Person, Not To Exceed $100 Per Day $10,000 100%	
	IN-NETWORK	**OUT-OF-NETWORK**
Cancer Resource Services (CRS) Non-Designated Centers Of Excellence (COE) Facility: **Cancer Resource Services:** • Paid By Plan After Deductible	80%	60%

OPTUM CONGENITAL HEART DISEASE RESOURCE SERVICES SCHEDULE OF BENEFITS (Plus Plan, Standard Plan, Core Plan, Out-of-Area Plan)		
Congenital Heart Disease Resource Services (CHDRS) Designated Centers Of Excellence (COE) Facility: **Congenital Heart Disease Resource Services:** • Paid By Plan After Deductible **Travel And Housing If The Recipient Lives More Than 50 Miles From The Facility:** • Maximum Benefit Per Day Included In The Travel And Lodging For Restrictive Services, Transplant, Optum Bariatric Resource Services, Optum Cancer Resource Services, Optum Fertility Solutions, Optum Kidney Resource Services, And Orthopedic Health Support Maximum • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	90% $50 Per Person, Not To Exceed $100 Per Day $10,000 100%	
	IN-NETWORK	**OUT-OF-NETWORK**
Congenital Heart Disease Resource Services Non-Designated Centers Of Excellence (CHDRS) Facility: **Congenital Heart Disease Resource Services:** • Paid By Plan After Deductible	80%	60%

OPTUM FERTILITY SOLUTIONS SCHEDULE OF BENEFITS (Plus Plan, Standard Plan, Core Plan, Out-of-Area Plan)	
Fertility Solutions (FS) Designated Provider:	
Treatment Services:	
• Maximum Benefit Per Lifetime	$25,000
• Paid By Plan After Deductible	90%
• Prescription Maximum Benefit Per Lifetime	$15,000
Note: Covered Procedures Are Listed In The Fertility Solutions Provision.	
Travel And Housing If The Recipient Lives More Than 50 Miles From The Facility:	
• Maximum Benefit Per Day Included In The Travel And Lodging For Restrictive Services, Transplant, Optum Bariatric Resource Services, Optum Cancer Resource Services, Optum Congenital Heart Disease Resource Services, Optum Kidney Resource Services, And Orthopedic Health Support Maximum	$50 Per Person, Not To Exceed $100 Per Day
• Maximum Benefit Per Calendar Year	$10,000
• Paid By Plan After Deductible	100%
Fertility Solutions (FS) Non-Designated Provider:	No Benefit

OPTUM KIDNEY RESOURCE SERVICES SCHEDULE OF BENEFITS (Plus Plan, Standard Plan, Core Plan, Out-of-Area Plan)		
Kidney Resource Services (KRS) Designated Centers Of Excellence (COE) Facility: **Kidney Resource Services:** • Paid By Plan After Deductible **Travel And Housing If The Recipient Lives More Than 50 Miles From The Facility:** • Maximum Benefit Per Day Included In The Travel And Lodging For Restrictive Services, Transplant, Optum Bariatric Resource Services, Optum Cancer Resource Services, Optum Congenital Heart Disease Resource Services, Optum Fertility Solutions, And Orthopedic Health Support Maximum • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	90% $50 Per Person, Not To Exceed $100 Per Day $10,000 100%	
	IN-NETWORK	**OUT-OF-NETWORK**
Kidney Resource Services (KRS) Non-Designated Centers Of Excellence (COE) Facility: **Kidney Resource Services:** • Paid By Plan After Deductible	80%	60%

OPTUM ORTHOPEDIC HEALTH SUPPORT SCHEDULE OF BENEFITS (Plus Plan, Standard Plan, Core Plan, Out-of-Area Plan)		
Orthopedic Health Support (OHS) Designated Centers Of Excellence (COE) Facility: **Orthopedic Health Support:** • Paid By Plan After Deductible **Travel And Housing If The Recipient Lives More Than 50 Miles From The Facility:** • Maximum Benefit Per Day Included In The Travel And Lodging For Restrictive Services, Transplant, Optum Bariatric Resource Services, Optum Cancer Resource Services, Optum Congenital Heart Disease Resource Services, Optum Fertility Solutions, And Optum Kidney Resource Services Maximum • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	90% $50 Per Person, Not To Exceed $100 Per Day $10,000 100%	
	IN-NETWORK	**OUT-OF-NETWORK**
Orthopedic Health Support (OHS) Non-Designated Centers Of Excellence (COE) Facility: **Orthopedic Health Support:** • Paid By Plan After Deductible	80%	60%

OUT-OF-POCKET EXPENSES AND MAXIMUMS

DEDUCTIBLES

A Deductible is an amount of money paid once per Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits. Generally, the applicable Deductible must be met before any benefits will be paid under this Plan. However, certain covered benefits may be paid first dollar.

The Deductible amounts that the Covered Person incurs for Covered Expenses, including covered Pharmacy expenses, will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

(Applies to Plus Plan, Standard Plan, Core Plan) The Deductible amounts that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the applicable benefit level's total individual and family Deductible.

(Applies to Out-of-Area Plan) The Deductible amounts that the Covered Person incurs at an in-network provider will apply to the in-network total individual and family Deductible. The Deductible amounts that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total individual and family Deductible.

PLAN PARTICIPATION (COINSURANCE)

Coinsurance is the percentage of Covered Expenses that the Covered Person is responsible for paying after the Deductible is met. The Covered Person pays this percentage until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Coinsurance rate is shown on the Schedule of Benefits.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is the most the Covered Person pays each year for Covered Expenses. There are in-network and out-of-network out-of-pocket maximums for this Plan. Annual out-of-pocket maximums are shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). If the Covered Person's out-of-pocket expenses in a Plan Year exceed the annual out-of-pocket maximum, the Plan pays 100% of the Covered Expenses through the end of the Plan Year.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Pharmacy out-of-network Co-pays and out-of-network Plan Participation amounts for Prescription benefits.
- Expenses Incurred as a result of failure to comply with prior authorization requirements.
- Any amounts over the Recognized Amount, Usual and Customary amount, Negotiated Rate, or established fee schedule that this Plan pays.

(Applies to Plus Plan, Standard Plan, Core Plan) The eligible out-of-pocket expenses that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the total out-of-pocket maximum.

(Applies to Out-of-Area Plan) The eligible out-of-pocket expenses that the Covered Person incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays, or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses may not be waived by a provider under any "fee forgiveness," "not out-of-pocket," or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that they paid the out-of-pocket expenses under the terms of this Plan.

The Covered Person's ability to contribute to a Health Savings Account (HSA) on a tax favored basis may be affected by any arrangement that waives this Plan's Deductible.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other, similarly situated Employees.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full-time 20 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Leased Employees.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business on a full-time, regular basis.

A regular Employee generally does not include:

- Any person employed solely to work during the summer or as a seasonal Employee (meaning that the Employee's customary period of annual employment is six months or less);
- Any person who renders service solely as a director, independent contractor, or temporary worker who provides services through an agreement with a third party or otherwise;
- A person employed as a student intern or in connection with a cooperative educational program with any college, university, or other post-secondary school (although he or she may be eligible to participate in THE LUBRIZOL CORPORATION Health Plan, as described above);
- Any person employed as a vo-education student employee; and
- Any other person working in a category that THE LUBRIZOL CORPORATION has determined is not a regular Employee category.
- Any person employed under a collective bargaining agreement, unless the agreement specifically provides for participation in this Plan.

However, You and Your Dependents are eligible for coverage under the Plan if You are an Employee employed as a student intern or in connection with a cooperative educational program with any college, university, or other post-secondary school, if You are reasonably anticipated to work at least an average of 20 hours per week over a bi-weekly period during Your periods of active employment.

If You are a regular Employee of THE LUBRIZOL CORPORATION but are not reasonably anticipated to work an average of 20 hours or more per week or have variable hours, You may be still eligible to participate in THE LUBRIZOL CORPORATION Health Plan under rules adopted under the Affordable Care Act. Under those rules, if You actually work an average of at least 30 hours per week during an applicable "measurement period," You will be eligible to participate in THE LUBRIZOL CORPORATION Health Plan for the following "stability period."

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, which may be combined with the employer's short-term disability policy, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. COBRA is not applicable until short-term disability is exhausted. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency, or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits. An **eligible Dependent** includes:

- Your legal spouse, provided they are not covered as an Employee under this Plan. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce or who no longer meets the definition of a Common-Law Marriage spouse. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

- Your Domestic Partner, as long as they meet the definition of Domestic Partner as stated in the Glossary of Terms, and the person is not covered as an Employee under this Plan. When a person no longer meets the definition of Domestic Partner, that person no longer qualifies as Your Dependent.

- A Dependent Child until the Child reaches their 26th birthday. The term "**Child**" includes the following Dependents:

  - A natural biological Child;
  - A stepchild;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
  - A Child under Your (or Your spouse's or Domestic Partner's) Legal Guardianship as ordered by a court;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);
  - A foster Child;
  - A Child of a Domestic Partner.

- A Dependent does not include the following:

  - A grandchild;
  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
  - Any other relative or individual unless explicitly covered by this Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

Eligibility Criteria: To be an eligible Totally Disabled Dependent Child, the following conditions must all be met:

- A Totally Disabled Dependent Child age 26 or over must be unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

- A Totally Disabled Dependent Child age 26 or over must be unmarried.
- The Employee must submit written proof of the Totally Dependent Child's continuous incapacity within 30 days after the child ceases to qualify for the Plan due to reaching age 26 or, for a new Employee, the Employee's date of hire.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Human Resources Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

The Dependent Child must also fit the following category:

If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may, for three years, ask for additional proof at any time, after which the Plan may ask for proof not more than once per year. Coverage may continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable); and
- The Employee must still be covered under this Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor or Included Health within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of the following dates:

- If You apply within 30 days of hire, Your coverage will become effective Your date of hire; or
- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 30 calendar days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of the following dates:

- The date Your coverage under the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 60 calendar days of acquiring the Dependent through birth or adoption; or
- The date You acquire Your Dependent if application is made within 30 calendar days of acquiring the Dependent through marriage or loss of coverage; or
- The date set forth under the Special Enrollment Provision if Your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within 60 calendar days following birth or adoption; or
- The date set forth under the Special Enrollment Provision if Your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within 30 calendar days following marriage or loss of coverage; or
- The date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

If You or Your Dependents do not enroll within the time limits described above, You will be able to enroll for coverage in the same Plan Year of eligibility effective on the first day of the month following enrollment. Otherwise, You will need to wait until the next Annual Open Enrollment.

A contribution will be charged from the first day of coverage for the Dependent if an additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Employees will be able to make changes in coverage for themselves and their eligible Dependents.

If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person’s coverage; and
- The Effective Date of coverage will be January 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives an eligible person special enrollment rights if the person experiences a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other, similarly situated Employees.

LOSS OF HEALTH COVERAGE

You and Your Dependents may have a special opportunity to enroll for coverage under this Plan if You experience a loss of other coverage.

In order for You to be eligible for special enrollment rights, You must meet the following conditions:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan was offered; and

- The coverage under the other group health plan or health insurance policy was:

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage was offered; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 30 calendar days after the date the other coverage ended.

If You or Your Dependents do not enroll within the time limits described above, You will be able to enroll for coverage in the same Plan Year of eligibility effective on the first day of the month following enrollment. Otherwise, You will need to wait until the next Annual Open Enrollment.

You and/or Your Dependents were covered under a Medicaid plan or state child health plan and coverage for You or Your Dependents was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

A current Employee and their Dependents may be eligible for a special enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependents are determined to be eligible for such assistance.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status.

If a person becomes an eligible Dependent through marriage, attestation of Domestic Partnership, birth, adoption or Placement for Adoption, the Employee, spouse, and newly acquired Dependent(s) who are not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The Employee must request and apply for coverage within 30 calendar days of the marriage or attestation of Domestic Partnership or 60 calendar days of the birth, adoption, or Placement for Adoption.

If You or Your Dependents do not enroll within the time limits described above, You will be able to enroll for coverage in the same Plan Year of eligibility effective on the first day of the month following enrollment. Otherwise, You will need to wait until the next Annual Open Enrollment.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of marriage, on the date of the marriage (note that eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or
- In the case of loss of coverage, on the date following loss of coverage.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

TERMINATION

For information about continuing coverage, refer to the COBRA Continuation of Coverage section of this SPD.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:
  - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave, provided the applicable Employee contribution is paid when due. Refer to Your employer's Employee handbook, internal policies, and/or procedures.
  - If You are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends; or
- The last day of the month in which Your Dependent is no longer Your legal spouse or does not meet the definition of Common Law Marriage spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or
- The last day of the month in which Your Dependent no longer qualifies as a Domestic Partner; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or
- If Your Dependent Child qualifies for extended Dependent coverage because they are Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment section; or

- The date Dependent coverage is no longer offered under this Plan; or

- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment, or at annual open enrollment periods; or

- The day of the month in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent submits a false claim or is involved in any other fraudulent act related to this Plan or any other group plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect;
- it is attributable to non-payment of premiums or contributions; or
- it is initiated by You or Your personal representative.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again within 30 days from the date Your coverage ended, Your coverage will be reinstated into the same benefit plan prior to Your break in coverage. If You do not qualify for eligibility under this Plan again within 30 days from the date Your coverage ended, and You did not perform any hours of service that were credited within the 30-day period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee.

COBRA CONTINUATION OF COVERAGE

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact Lubrizol Benefits Center at 1-844-747-1641 with any questions related to this coverage or service.

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

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

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event (outlined below). When a Qualifying Event causes (or will cause) a Loss of Coverage, the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage, even if You or Your Dependent is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If You are an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage may be extended. See the section below entitled “The Right to Extend the Length of COBRA Continuation Coverage” for more information.)

The spouse of an Employee will become a Qualified Beneficiary if they lose coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The Employee dies	up to 36 months
• The Employee’s hours of employment are reduced	up to 18 months
• The Employee’s employment ends for any reason other than their gross misconduct	up to 18 months
• The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• The Employee and spouse become divorced or legally separated	up to 36 months

The Dependent Children of an Employee will become Qualified Beneficiaries if they lose coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee’s employment ends for any reason other than their gross misconduct	up to 18 months
• The parent-Employee’s hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child loses eligibility for coverage under the Plan as a Dependent	up to 36 months

Note: A spouse or a Dependent Child newly acquired through birth or adoption during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent other than a newborn or newly adopted Child who is acquired and enrolled after the original Qualifying Event is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

In order to be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child’s loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrator, whether to Your employer or to the COBRA Administrator.

A Qualified Beneficiary’s written notice must include all of the following information (a form for notifying the COBRA Administrator is available upon request):

- The Qualified Beneficiary’s name, current address, and complete phone number,
- The group number and the name of the Employee’s employer,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes to the addresses of family members. Keep copies of all notices You send to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to the Employee's termination of employment or reduction in hours, the death of the Employee, or the Employee's becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days of when one of these events occurs.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar-day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, the covered Employee, or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that should be completed in order to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing or via the online portal, if available, in order to continue group health coverage and must make the required payments when due in order to remain covered. If online election is available, You will receive instructions for online election when Your election notice is provided. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated retroactively to the date coverage was lost, provided the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will become effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contributions. This cost may also include a 2% additional fee to cover administrative expenses (or, in the case of the 11-month extension due to disability, a 50% additional fee). The cost of continuation coverage is subject to change at least once per year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope or, if online election is available, the date Your election is submitted electronically. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage. However, the Qualified Beneficiary will receive specific payment information, including due dates when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary with information regarding what needs to be done to correct the mistake.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, written notice to the COBRA Administrator is required within 30 calendar days of the date any one of the following events occurs:

- The Qualified Beneficiary marries. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A final determination is made by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- Any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.

Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information in the timeframe outlined in the request document.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents: 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before their termination of employment or reduction in hours, then the covered spouse and Dependent Children will be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only: 36 months from the Qualifying Event if coverage is lost due to one of the following events:

  - The Employee's death.
  - The Employee's divorce or legal separation.
  - The former Employee's enrollment in Medicare.
  - A Dependent Child's loss of eligibility as a Dependent as defined by the Plan.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided written notice is given to the COBRA Administrator as soon as possible, but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA, in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualified Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination before the end of the initial 18-month period and within 60 days of the later of:

- The date of the Social Security Administration disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or

- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events (Dependents Only): If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B, or both) or is divorced or legally separated, or if the Dependent Child loses eligibility under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in the case of a newborn Child being added as a result of a HIPAA special enrollment right. Dependents acquired during COBRA continuation (other than newborns and newly adopted Children) are not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will lead to the extension only when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

In general, if You do not enroll in Medicare Part A or B when You are first eligible because You are still employed, after the Medicare initial enrollment period You have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of (a) the month after Your employment ends, or (b) the month after group health plan coverage based on current employment ends.

If You do not enroll in Medicare and elect COBRA continuation coverage instead, You may have to pay a Part B late enrollment penalty and You may have a gap in coverage if You decide You want Part B later. If You elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate Your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if You enroll in the other part of Medicare after the date of the election of COBRA coverage. If You are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (as the primary payer) and COBRA continuation coverage will pay second. For more information visit https://www.medicare.gov/medicare-and-you.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan under which the Qualified Beneficiary is covered, but still maintains another group health plan for other, similarly situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same.)

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE

If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose their special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with their HIPAA special enrollment rights.

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before a Qualifying Event. A Qualified Beneficiary may be an Employee, the spouse of a covered Employee, or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.

- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).

- A reduction in work hours of the covered Employee.

- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for their spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

- The covered former Employee becomes enrolled in Medicare.

- A Dependent Child no longer qualifies as a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before a Qualifying Event. Loss of Coverage includes a change in coverage terms, a change in plans, termination of coverage, partial Loss of Coverage, an increase in Employee cost, and other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after a Qualifying Event, but must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA rights.

CONTINUED COVERAGE FOR DOMESTIC PARTNERS

Domestic Partners do not qualify as Qualified Beneficiaries under federal COBRA law. Therefore, under federal law, a Domestic Partner does not have the right to elect COBRA independently and separately from an eligible Employee.

However, this Plan allows Domestic Partners to elect to continue coverage under a "COBRA-like" extension, separately and independently of eligible Employees, subject to the same terms and conditions that are outlined for Qualified Beneficiaries under COBRA, when a Qualifying Event occurs.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, and for more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

The Plan Administrator:
THE LUBRIZOL CORPORATION
29400 LAKELAND BLVD
WICKLIFFE OH 44092

The COBRA Administrator:
LUBRIZOL BENEFITS CENTER
DEPT 14613
PO BOX 64050
THE WOODLANDS TX 77387-4050

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leaves of absence or furloughs. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence may not be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- A period beginning on the day that the service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which their service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed service, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election of, payment for, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Continuation of Coverage section, to the extent the COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount they would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENTLY

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

PROTECTION FROM BALANCE BILLING

This section is to be interpreted in accordance with the No Surprises Act, as amended. Covered health care services that are subject to the No Surprises Act requirements will be reimbursed according to this section. Retiree-only plans are not subject to the Protection from Balance Billing requirements.

Emergency health care services provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

Covered health care services provided at certain network facilities by Out-of-Network Physicians, when not Emergency health care services, will be reimbursed as set forth under Allowed Amounts below. For these covered health care services, the term “certain network facility” is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

Air Ambulance Transportation provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

ALLOWED AMOUNTS

For covered health care services that are Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are non-Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians who have not satisfied the notice and consent criteria, or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are Emergency health care services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD. Note: You may receive balance bills for post-stabilization services after an Emergency if Your attending Emergency Physician or treating provider determines that You can travel to an In-Network facility using non-medical or non-Emergency transportation but You choose to stay at the Out-of-Network facility, if the notice and consent requirements have been satisfied and the provider or facility acts in compliance with applicable state laws.

For covered health care services that are air Ambulance Transportation services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

Allowed amounts are determined in accordance with the claims administrator’s reimbursement policy guidelines or as required by law, as described in this SPD.

OUT-OF-NETWORK BENEFITS

When covered health care services are received from an Out-of-Network provider as described below, allowed amounts are determined as follows:

- For non-Emergency covered health care services received at certain network facilities from Out-of-Network Physicians when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary of Health and Human Services (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, You are not responsible, and an Out-of-Network Physician may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For Emergency health care services provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For air Ambulance Transportation provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

After the Plan has issued payment for covered health care services, the Plan may be required to pay the provider an additional amount or discount to resolve and settle the provider’s balance bill.

PROVIDER NETWORK

The word **"Network"** means an organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the Negotiated Rates as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Plan Participation amounts, or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing to which Network a provider belongs will help a Covered Person determine how much they will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons should receive services from In-Network providers. However, this Plan does not limit a Covered Person's right to choose their own provider of medical care at their own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out to which Network a provider belongs, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  UnitedHealthcare Choice Plus (Plus Plan, Standard Plan, Core Plan)
  UnitedHealthcare - Options PPO (Out-of-Area Plan)
  Doctor on Demand (Plus Plan, Standard Plan, Core Plan, Out-of-Area Plan)

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits.

EXCEPTIONS TO THE PROVIDER NETWORK BENEFITS

In addition to services required to be covered as specified under the Protection from Balance Billing section of this SPD, some benefits may be processed at In-Network benefit levels when provided by Out-of-Network providers. When Out-of-Network charges are covered in accordance with Network benefits, the charges may be subject to Plan limitations. The following exceptions may apply:

- Non-air Ambulance Transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Covered services (including Preventive Services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist will be payable at the In-Network level of benefits when services are referred by an In-Network Physician, even if the provider is an Out-of-Network provider.
- Covered services provided by a Physician (excluding surgeons and assistant surgeons) during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.

Provider Directory Information

Each covered Employee, COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in their household. If a covered spouse or Dependent wants a separate provider list, they may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

CONTINUITY OF CARE

You or Your Dependents have the option of requesting extended care from Your current health care provider or facility if the provider or facility is no longer working with Your health Plan and is no longer considered In-Network. Retiree-only plans are not subject to the Continuity of Care requirements.

The In-Network benefit level may continue for up to 90 days or until You no longer meet the criteria below, whichever is earlier, despite the fact that these expenses are no longer considered In-Network due to provider or facility termination from the Network. In order to be eligible, You or Your Dependents must have been, and must continue to be, under a treatment plan by a provider or facility who was a member of the participating Network. You must also be one of the following:

- An individual undergoing a course of treatment for a serious and complex condition that is either:
  - An acute Illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm.
  - A chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.
- An individual undergoing Inpatient or institutional care.
- An individual scheduled for non-elective surgical care, including necessary postoperative care.
- An individual who is pregnant and being treated.
- An individual who is terminally ill and receiving treatment for such Illness by a provider or facility.

To obtain a Continuity of Care form that You and Your provider will need to complete for the request to be considered, call the number on the back of Your ID card or access the benefit portal.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

1. **3D Mammograms,** for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care benefits.

2. **Abortions (Elective).**

3. **Acupuncture Treatment** in lieu of anesthesia only.

4. **Allergy Treatment,** including injections and sublingual drops, testing and serum.

5. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically appropriate Hospital. Medically Necessary Ambulance Transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport is to the nearest facility able to provide appropriate medical care.

   Coverage includes non-Emergency Ambulance Transportation by a licensed ambulance service (either ground or air ambulance) between health care facilities when the Ambulance Transportation is any of the following:

   - From a non-network Hospital to a network Hospital;
   - To a Hospital that provides a required higher level of care that was not available at the original Hospital;
   - To a more cost-effective acute care facility; or
   - From an acute facility to a subacute setting.

6. **Anesthetics and Their Administration.**

7. **Aquatic Therapy.** (See Therapy Services below.)

8. **Augmentation Communication Devices** and related instruction or therapy.

9. **Autism Spectrum Disorders (ASD) Treatment.**

   ASD treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.

   Treatment is subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services).

   Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district).

10. **Bariatric Surgery.** (Refer to Bariatric Resources Services (BRS) section of this SPD.)

11. **Botox Injections** for FDA-approved diagnosis codes only.

12. **Breast Pumps** and related supplies. Benefits for breast pumps include the lesser cost of purchasing or renting one breast pump per pregnancy in conjunction with childbirth.

13. **Breast Reductions** if Medically Necessary.

14. **Breastfeeding Support, Supplies, and Counseling** in conjunction with each birth. The Plan also covers comprehensive lactation support and counseling by a trained provider during pregnancy and in the postpartum period.

15. **Cardiac Pulmonary Rehabilitation** when Medically Necessary when needed as a result of an Illness or Injury.

16. **Cardiac Rehabilitation** programs are covered when Medically Necessary, if referred by a Physician, for patients who have certain cardiac conditions.

    Covered services include:

    - Phase I cardiac rehabilitation, while the Covered Person is an Inpatient.
    - Phase II cardiac rehabilitation, while the Covered Person is in a Physician-supervised Outpatient, monitored, low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure, and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

17. **Cataract or Aphakia Surgery** as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.

18. **Christian Science Providers.**

19. **Circumcision** and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

20. **Cleft Palate and Cleft Lip,** benefits will be provided for initial and staged reconstruction of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

21. **Contraceptives and Counseling:** All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling.

    The following contraceptives will be processed under the medical Plan:

    - Contraceptive injections (such as Depo-Provera) and their administration regardless of purpose.
    - Contraceptive devices such as IUDs and implants, including their insertion and removal regardless of purpose.

22. **Cornea Transplants** are payable at the percentage listed under "All Other Covered Expenses" on the Schedule of Benefits.

23. **Dental Services** include:

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), or for treatment of cleft palate, including implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
    - Inpatient or Outpatient Hospital charges, including professional services for X-rays, laboratory services, and anesthesia while in the Hospital, if necessary due to the patient's age of 5 years or under, due to intellectual disabilities, or because an individual has medical conditions that may cause undue medical risk.
    - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.
    - Dental care (oral exam, X-rays, extractions, and non-surgical elimination of oral infection) required for the direct treatment of a medical condition, limited to:
        - Dental services related to medical transplant procedures;
        - Initiation of immunosuppressives; and
        - Direct treatment of acute traumatic Injury, cancer, or cleft palate.

24. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs, diabetic shoes and nutritional counseling.

25. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Coverage also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same as for any other Illness.

26. **Durable Medical Equipment,** subject to all of the following:

    - The equipment must meet the definition of Durable Medical Equipment in the Glossary of Terms. Examples include, but are not limited to, crutches, wheelchairs, Hospital-type beds, and oxygen equipment.
    - The equipment must be prescribed by a Physician.
    - The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
    - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to the growth of the person or if changes to the person's medical condition require a different product, as determined by the Plan.
    - If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries, or replacement only if required:
        - due to the growth or development of a Dependent Child;
        - because of a change in the Covered Person's physical condition; or
        - because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered, and replacement is subject to prior approval by the Plan.

The Plan covers ostomy supplies and disposable supplies necessary for the use of Durable Medical Equipment, including:

- Insulin pump cartridges.
- Supplies for continuous glucose monitors.
- Ostomy supplies such as pouches, face plates, belts, irrigation sleeves, bags, ostomy related irrigation catheters, and skin barriers. Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.
- Urinary catheters and supplies.

All other disposable medical supplies excluded.

27. **Emergency Room Hospital and Physician Services,** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

28. **Extended Care Facility Services** for both mental and physical health diagnoses. Charges will be paid under the applicable diagnostic code. The following services are covered:

    - Room and board.
    - Miscellaneous services, supplies, and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

29. **Eye Refractions** if related to a covered medical condition.

30. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.
    - Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
    - Physician office visit for diagnosis of bunions. The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed.

31. **Gender Dysphoria:**

    Benefits for the treatment of Gender Dysphoria include only the following treatments if those treatments are determined to be Medically Necessary and appropriate for an individual:

    - Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses
    - Cross-sex hormone therapy:
        - Cross-sex hormone therapy administered by a medical provider (for example, during an office visit)
        - Cross-sex hormone therapy dispensed from a pharmacy
    - Puberty-suppressing medication injected or implanted by a medical provider in a clinical setting
    - Laboratory testing to monitor the safety of continuous cross-sex hormone therapy
    - Surgery for the treatment of Gender Dysphoria, including the surgeries listed below:
      Male to Female:
        - Clitoroplasty (creation of clitoris)
        - Labiaplasty (creation of labia)
        - Orchiectomy (removal of testicles)
        - Penectomy (removal of penis)

- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

Female to Male:

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - The Covered Person has experienced persistent, well-documented Gender Dysphoria.
  - The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
  - The Covered Person must be 18 years of age or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - The Covered Person has experienced persistent, well-documented Gender Dysphoria.
  - The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
  - The Covered Person must be 18 years of age or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - The Covered Person must complete at least 12 months of successful, continuous, full-time, real-life experience in the desired gender.
  - The Covered Person must complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

- The treatment plan must be based on identifiable external sources, including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Coverage does not include procedures that are cosmetic as stated in the General Exclusions section of this SPD. Cosmetic procedures include, but are not limited to, the following:

- Abdominoplasty.
- Blepharoplasty.
- Body contouring, such as lipoplasty.

- Breast enlargement, including augmentation mammoplasty and breast implants.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Injection of fillers or neurotoxins.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction, reduction thyroid chondroplasty, or trachea shave (removal or reduction of the Adam's apple).
- Voice lessons and voice therapy.
- Voice modification surgery.

32. **Genetic Testing or Genetic Counseling in relation to Genetic Testing** based on Medical Necessity.

    Genetic testing MUST meet the following requirements:

    The test must not be considered Experimental, Investigational, or Unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person.

    Genetic testing must also meet at least one of the following:

    - The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
    - Conventional diagnostic procedures are inconclusive.
    - The patient has risk factors or a particular family history that indicates a genetic cause.
    - The patient meets defined criteria that place them at high genetic risk for the condition.

33. **Hearing Services** include:

    - Exams, tests, services, and supplies to diagnose and treat a medical condition.
    - Purchase or fitting of hearing aids.
    - Implantable hearing devices, including semi-implantable hearing devices. The benefit for bone-anchored hearing aids (BAHA) is limited to Covered Persons who have either of the following:
        - Craniofacial anomalies where the abnormal or absent ear canals preclude the use of a wearable hearing aid.
        - Hearing loss of sufficient severity that would not be adequately remedied by a wearable hearing aid.

    The benefit for BAHA is limited to a Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Plan. Repairs and / or replacements of BAHA are not covered unless the BAHA malfunctions.

34. **Home Health Care Services:** (Refer to the Home Health Care Benefits section of this SPD.)

35. **Hospice Care Services:** Treatment given at a Hospice Care facility must be in place of a stay in a Hospital or Extended Care Facility, and may include:

    - **Assessment,** which includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care required to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time Home Health Care services.
    - **Outpatient Care,** which provides or arranges for other services related to the Terminal Illness, including the services of a Physician or Qualified physical or occupational therapist or nutrition counseling services provided by or under the supervision of a Qualified dietician.
    - **Bereavement Counseling** services that are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and the charges for which are bundled with other hospice charges. Counseling services must be provided by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable. The services must be furnished within six months of death.

    The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. However, services are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

36. **Hospital Services (Including Inpatient Services, Surgical Centers, and Inpatient Birthing Centers).** The following services are covered:

    - Semi-private and private room and board services:
        - For network charges, this rate is based on the network agreement. Semi-private rate reductions may apply.
        - For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to the Protection from Balance Billing allowed amount, Usual and Customary charges, or Negotiated Rate, whichever is applicable.
    - Intensive care unit room and board.
    - Miscellaneous and Ancillary Services.
    - Blood, blood plasma, and plasma expanders, when not available without charge.

    Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

37. **Hospital Services (Outpatient).**

    Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

38. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

39. **Infertility Treatment.** (Refer to Optum Fertility Solutions section of this SPD.)

40. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits. Charges by a pathologist for interpretation of computer-generated automated laboratory test reports are not covered by the Plan.

41. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

42. **Maternity Benefits** for Covered Persons include:

    - Hospital or Birthing Center room and board.
    - Vaginal delivery or Cesarean section.
    - Non-routine prenatal care.
    - Postnatal care.
    - Diagnostic testing.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Outpatient Birthing Centers.
    - Home births.
    - Midwives.

43. **Medical and/or Routine Services Provided in a Foreign Country,** except that no coverage is provided if the sole purpose of travel to that country is to obtain medical services and/or supplies.

44. **Mental Health Treatment.** (Refer to the Mental Health Benefits section of this SPD.)

45. **Nursery and Newborn Expenses, Including Circumcision,** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

46. **Nutritional Counseling.**

47. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** that are prescribed by a Physician and administered through a tube, provided they are the sole source of nutrition or are part of a chemotherapy regimen. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings), provided the feedings are prescribed by a Physician and are the sole source of nutrition or are part of a chemotherapy regimen.

48. **Occupational Therapy.** (See Therapy Services below.)

49. **Oral Surgery** includes:

    - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examinations.
    - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
    - Reduction of fractures and dislocations of the jaw.
    - External incision and drainage of cellulitis.
    - Incision of accessory sinuses, salivary glands, or ducts.
    - Excision of exostosis of jaws and hard palate.

50. **Orthognathic, Prognathic, and Maxillofacial Surgery** when Medically Necessary.

51. **Orthotic Appliances, Devices, and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic appliances and devices include custom molded shoe / foot orthotics, supports, trusses, elastic compression stockings / tights (both over-the-counter and custom-made surgical support stockings), and braces. Cranial banding / helmets are covered when Medically Necessary.

52. **Oxygen and Its Administration.**

53. **Pharmacological Medical Case Management** (medication management and lab charges).

54. **Physical Therapy.** (See Therapy Services below.)

55. **Physician Services** for covered benefits.

56. **Pre-Admission Testing** if necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

57. **Prescription Medications** that are administered or dispensed as take-home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility, or Skilled Nursing Facility) and that require a Physician's Prescription. Coverage does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

58. **Preventive / Routine Care** as listed under the Schedule of Benefits.

    The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility, or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes, and include the following as required under applicable law:

    - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
    - With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
    - Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
    - Well-women Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-women visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

        - Screening for gestational diabetes;
        - Human papillomavirus (HPV) DNA testing;
        - Counseling for sexually transmitted infections;
        - Counseling and screening for human immune-deficiency virus;
        - Screening and counseling for interpersonal and domestic violence; and
        - Breast cancer genetic test counseling (BRCA) for women at high risk.

    Please visit the following links for additional information:

    https://www.healthcare.gov/preventive-care-benefits/
    https://www.healthcare.gov/preventive-care-children/
    https://www.healthcare.gov/preventive-care-women/

59. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) that replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

    - Due to the growth or development of a Dependent Child; or
    - When necessary because of a change in the Covered Person's physical condition; or
    - Because of deterioration caused from normal wear and tear.

    The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

60. **Qualifying Clinical Trials** as defined below, including routine patient care costs Incurred during participation in a Qualifying Clinical Trial for the treatment of:

    - Cancer or other Life-Threatening Disease or Condition. For purposes of this benefit, a Life-Threatening Disease or Condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
    - Cardiovascular disease (cardiac/stroke) that is not life-threatening, for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below; and

    Surgical musculoskeletal disorders of the spine, hip, and knees that are not life-threatening, for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below .

    Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a Qualifying Clinical Trial.

    Benefits are available only when the Covered Person is clinically eligible for participation in the Qualifying Clinical Trial as defined by the researcher.

    Routine patient care costs for Qualifying Clinical Trials may include:

    - Covered health services (e.g., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
    - Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
    - Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

    Routine costs for clinical trials do not include:

    - The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial.
    - Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
    - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
    - Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Diseases or Conditions, a Qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and that meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip, and knees, a Qualifying Clinical Trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - National Institutes of Health (NIH), including the National Cancer Institute (NCI);
    - Centers for Disease Control and Prevention (CDC);
    - Agency for Healthcare Research and Quality (AHRQ);
    - Centers for Medicare and Medicaid Services (CMS);
    - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or Veterans Administration (VA);
    - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or
    - The Department of Veterans Affairs, the DOD, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
        - It is comparable to the system of peer review of studies and investigations used by the NIH; and
        - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (*IRBs*) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

61. **Radiation Therapy and Chemotherapy** when Medically Necessary.

62. **Radiology and Interpretation Charges.**

63. **Reconstructive Surgery** includes:

- Surgery following a mastectomy under the Women's Health and Cancer Rights Act (WHCRA). Under the WHCRA, the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments that include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
- Surgery to restore a bodily function that has been impaired by a congenital Illness or anomaly, or by an Accident, or from an infection or other disease of the involved part.

64. **Respiratory Therapy.** (See Therapy Services below.)

65. **Second Surgical Opinion** if given by a board-certified Specialist in the medical field related to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

66. **Sexual Function:** Diagnostic services in connection with treatment for male or female impotence.

67. **Sleep Disorders** if Medically Necessary.

68. **Sleep Studies.**

69. **Speech Therapy.** (See Therapy Services below.)

70. **Sterilizations.**

71. **Substance Use Disorder Services.** (Refer to the Substance Use Disorder and Chemical Dependency Benefits section of this SPD.)

72. **Surgery and Assistant Surgeon Services.**

    - If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the allowance for the primary procedure performed. For in-network providers, the assistant surgeon's allowable amount will be determined per the network contract.
    - If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the allowance for the primary procedure; and a percentage of the allowance for the subsequent procedure(s). If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the allowance for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the allowable amount for that procedure.

73. **Telehealth.** Consultations made by a Covered Person to a Physician.

74. **Telemedicine.** (Provided by Doctor on Demand.)

75. **Temporomandibular Joint Disorder (TMJ) Services** include:

    - Diagnostic services.
    - Surgical treatment.
    - Non-surgical treatment (including intraoral devices or any other non-surgical method to alter occlusion and/or vertical dimension).

    Coverage does not include orthodontic services.

76. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    - **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.
    - **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
    - **Respiratory therapy** by a Qualified respiratory therapist (RT) or other Qualified Provider, if applicable.

- **Aquatic therapy** by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if applicable.
- **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or Autism Spectrum Disorder.

77. **Tobacco Addiction:** Preventive / Routine Care as required by applicable law.

78. **Transplant Services.** (Refer to the Transplant Benefits section of this SPD.)

79. **Travel and Lodging for Restrictive Services.**

    The Plan provides a Covered Person with a travel and lodging allowance related to a covered health service that is not available within 50 miles of the Covered Person's residence due to law or regulation, as legally permissible.

    The Plan provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their address, as reflected in our records, to receive the covered health service.

    This Plan provides an allowance for Incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Covered Person. Lodging expenses are further limited to $50 per night for the Covered Person, or $100 per night for the Covered Person with a travel companion. Allowance is subject to an annual limit of $10,000.00 per Covered Person.

    Please remember to save travel and lodging receipts to submit for reimbursement. Travel and lodging reimbursements that exceed IRS limits may be subject to IRS codes for taxable income. If You would like additional information regarding travel and lodging, You may contact us at www.umr.com or at the telephone number on Your ID card.

80. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

81. **Urinary Drug Screening** for presumptive and definitive testing.

82. **Walk-In Retail Health Clinics:** Charges associated with medical services provided at Walk-In Retail Health Clinics.

83. **Wigs (Cranial Prostheses), Toupees, and Hairpieces** for hair loss due to cancer treatment or alopecia related to a medical condition.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients when Medically Necessary, as determined by the Utilization Review Organization.

A Home Health Care Visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a 4-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.

Information regarding Private Duty Nursing can be found elsewhere in this SPD.

Prior authorization may be required before receiving services. Please refer to the UMR CARE section of this SPD for more details. Covered services may include:

- Home visits instead of visits to the provider's office that do not exceed the maximum allowable under this Plan.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed 4 hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a Qualified dietician or other Qualified Provider, if applicable.
- Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a Qualified therapist or other Qualified Provider, if applicable.
- Medical supplies, drugs, laboratory services, or medication prescribed by a Physician.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners, and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports, or transportation.
- Expenses for the normal necessities of living, such as food, clothing, and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS

Refer to the UMR CARE section of this SPD for prior authorization requirements

The program for Transplant Services at Designated Transplant Facilities is:

Optum

This coverage provides You with a choice for transplant care. The Plan provides incentives to You and Your covered Dependents by giving You the option of using a Designated Transplant Facility. While the Plan does not require You to use a Designated Transplant Facility in order to receive benefits, You may receive better benefits if You do so. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outcomes that include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing, and Ancillary Services.

Designated Transplant Facility means a facility that has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include a facility that is listed as a participating provider.

Organ and Tissue Acquisition / Procurement means the harvesting, preparation, transportation, and storage of human organ and tissue that is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells and may include chimeric antigen receptor T-cell therapy (CAR-T).

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated or Non-Designated Transplant Facility due to an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary charge, or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant-related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be an individual Plan exclusion.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated or Non-Designated Transplant Facility for Organ and Tissue Acquisition / Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including a bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition / Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition / Procurement. Coverage includes the cost of donor testing, blood typing, and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor-related complications during the transplant period, per the transplant contract, if the recipient is a Covered Person under this Plan.

The Plan will provide donor services at a Non-Designated Transplant Facility for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects, or injuries are not covered unless the donor is a Covered Person.

Benefits are payable for the following transplant types:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by care management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous), which may include chimeric antigen receptor T-cell therapy (CAR-T) for certain conditions.
- Small bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the transplant facility, the Plan will allow them to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant-related services or supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS

TRAVEL EXPENSES (Applies to a Covered Person who is a recipient or to a covered or non-covered donor if the recipient is a Covered Person under this Plan)

If the Covered Person or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing related to the transplant, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility, including:

  - Airfare.
  - Tolls and parking fees.
  - Gas/mileage.

- Lodging at or near the transplant facility, including:

  - Apartment rental.
  - Hotel rental.
  - Applicable tax.

  Lodging for purposes of this Plan does not include private residences.

  Lodging reimbursement that is greater than $50 per person per day may be subject to IRS codes for taxable income.

Benefits will be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Note: This Plan will pay travel and housing benefits for a non-covered living donor only after any other coverage that the living donor has is exhausted.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.

- Expenses for Organ and Tissue Acquisition / Procurement and storage of cord blood, stem cells, or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.

- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.

- Transplants considered Experimental, Investigational, or Unproven unless covered under a Qualifying Clinical Trial.

- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.

- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG BENEFITS

Administered by CVS Caremark

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact the benefit manager or Your employer with any questions related to this coverage or service.

The Pharmacy Benefits described on the following pages are NOT administered by UMR. The administrator for the Pharmacy Benefits is CVS Caremark.

Participants in all of Lubrizol's medical options will receive their prescription coverage through CVS Caremark. The prescription drug benefit offers coverage at network retail pharmacies or through the mail service pharmacy for covered drugs prescribed to treat illness or injury. All covered prescription expenses will be applied to the Annual Deductible and annual Out-of-Pocket Maximums. Once the Annual Deductible is satisfied, a portion of the prescription benefit will be paid by the participant based on the applicable coinsurance percentage amount as described in the chart below. This will continue until the appropriate annual Out-of-Pocket Maximum is met.

Ask your doctor to consider prescribing, when medically appropriate, a preferred medicine from the most current Advanced Control Formulary List. Take this list the next time you or a covered family member sees a doctor. Access the most up-to-date Advanced Control Formulary List on the benefits website at the benefits.lubrizol.com.

If a generic drug is available and you choose a brand name instead, you will pay the generic coinsurance, plus the difference between the cost of the brand and the generic. If you request a generic drug and no generic is available, you will pay the brand coinsurance.

For more information call CVS/Caremark at 1-844-742-5087 or reach out to Included Health.

Summary of Prescription Drug Benefits	
Retail Prescriptions	**Coinsurance Percentage**
Preventive	0%
Generic	10%
Brand Formulary	20%
Brand Non-formulary	30%
Lifestyle	50%
Mail Prescriptions	**Coinsurance Percentage**
Generic	10%
Brand Formulary	20%
Brand Non-formulary	30%
Biotech/Specialty	35%
Preventive Services Drugs*	0%

[1] Drugs considered "Preventive" are included on CVS Caremark's "High Deductible Health Plan (HDHP) – Health Savings Account (HSA) Generics Only Preventive Therapy Drug List." Visit www.caremark.com or call 1-844-742-5087 for the current list.

*** The following categories of drugs are covered at 100% based on The U.S. Preventive Services Task Force (USPTF) guidelines and the Health Resources and Services Administration Health Plan Coverage Guidelines:**

Aspirin to prevent cardiovascular disease	**For men 45-79 years old and women 55- 79 years old**
Iron Supplementation in Children	**Children 6 to 12 months**
Oral Fluorides	**Children less than 6 years old**
Folic Acid	**Women to age 55**
Tobacco Cessation	**Annual limit 2 cycles of treatment (12 weeks per cycle)**
Immunizations	**Children birth to age 18**
Contraceptive method	**Women with reproductive capacity**

Certain drugs used for Medication Assisted Treatment will be available with no member cost-sharing:

Drug Name	Strength
buprenorphine sublingual tab	2 mg
	8 mg
buprenorphine-naloxone sublingual tab	2 mg-0.5 mg
	8 mg-2 mg
naltrexone tablet	50 mg

Enrollment

Prescription coverage is provided with your Lubrizol medical benefit. If you choose to waive Lubrizol medical coverage, you will not have the option to enroll in prescription only coverage.

Administrator

The prescription benefit is administered by CVS Caremark. Most retail pharmacies, including all the large discount chains like CVS, Target, Wal-Mart and Walgreen's, and many small, independent pharmacies, are part of the CVS Caremark network. The prescription benefit also offers mail service and mail at retail features. After you enroll in the program, you will receive a brochure describing the program, an identification card and a form to use the mail pharmacy service.

The prescription drug benefit is administered by:

CVS Caremark 800 Biermann Court Mount Prospect, IL 60056-2173	
Mail Service Program:	CVS Caremark P.O. Box 94467 Palatine, IL 60094-4467
Paper Claims:	CVS Caremark Claims Department P.O. Box 52196 Phoenix, AZ 85072-2196
CVS Caremark Customer Care (Participants):	1-800-776-1355
CVS Caremark Customer Care (Pharmacists):	1-800-421-2342

Prescription Program

The prescription program is included in your Lubrizol medical coverage and features four tiers of payment for retail pharmacies and the mail service pharmacy program. There are different levels of coinsurance amounts for generic drugs, brand formulary (Primary Drug List), brand non-formulary, and biotech/specialty. Using brand formulary medications may save you money when generic drugs are not available.

Under the prescription program, you and the Plan each pay a percentage (coinsurance) of the cost of your prescriptions. All covered expenses including prescription drug, medical, behavioral health, and substance abuse will be applied to the annual general deductible and annual out-of-pocket maximums. When the annual out-of-pocket maximum has been reached, the Plan will pay 100% of the cost of covered prescriptions obtained through network providers for the remainder of the calendar year.

PRESCRIPTION PROGRAM FEATURES

Retail Pharmacy Benefit

Use a participating Caremark network retail pharmacy for short-term prescriptions of 30 days or less (with one refill). You will pay your coinsurance amount (after your deductible is met) directly to the pharmacy. The Plan will pay the remainder of the cost

Mail Service Pharmacy Benefit

The mail service pharmacy benefit allows you to obtain up to a 90-day supply* of maintenance or long-term prescription drugs. The program is easy and convenient. When your physician prescribes a new maintenance medication, ask him or her to write two prescriptions:

1. The first for up to a 90-day* supply plus refills, to be ordered through the mail service program; and

2. The second to be filled immediately at a Caremark participating retail pharmacy for use until you receive your prescription order from the mail service program.

*Please note: By law, Caremark must fill your prescription for the exact quantity prescribed, up to the 90-day limit. A prescription written for "30 days plus two refills" will be filled with one 30-day supply at a time; it does not equal a prescription written for "90 days." Lower limits may apply for certain categories of drugs.

Maintenance Choice - CVS Mail at Retail Pharmacy Program

Caremark has a special program which allows you to purchase a 90-day prescription at a CVS retail pharmacy for the same coinsurance as the 90-day mail order cost. This is a convenient option and provides access to a neighborhood pharmacist to discuss any concerns about your medications.

Not all drugs are eligible for this program. There are a limited number of drugs that are only available through the mail order pharmacy. Examples of drugs not eligible for Maintenance Choice include biotech and specialty drugs.

Generic Substitution

The prescription program requires generic drugs (A-rated only) to be substituted for brand name drugs, when available. If you request or your physician requires brand name drugs to be dispensed, you will pay the difference between the cost of the brand name drug and the generic drug in addition to any applicable deductible or coinsurance.

Biotech and Specialty Drugs

Biotech drugs are those produced from living sources like microorganisms, and often are administered intravenously. They are used for the treatment of genetic diseases, autoimmune diseases, infectious diseases, chronic diseases and cancers. Among the drugs included in these categories are Rebif and Avonex (multiple sclerosis), Herceptin (cancer), Remicade and Enbrel (arthritis), human growth hormones, Rebetrol (severe infections) and other oncology therapies.

Specialty drugs are those used to treat specific, low-incidence chronic and/or genetic conditions. These products are typically very expensive and may require member-specific dosing, medical devices to administer the medication, and/or special handling and delivery.

Biotech and specialty drugs carry a coinsurance of 35% for mail service program and are only available through CVS Caremark Specialty Pharmacy.

CVS Caremark Specialty Pharmacy is a comprehensive pharmacy program that provides these products directly to you, along with the supplies, equipment and any care coordination needed.

OTHER PROGRAMS – CONTACT CVS/CAREMARK AT 1-844-742-5087

Pharmacy Advisor

The Pharmacy Advisor program provides comprehensive support for participants with diabetic and cardiovascular chronic conditions. Pharmacists offer timely, personalized counseling by phone for participants that use CVS/Caremark Mail Service and face to face at CVS/Pharmacies. Employees eligible for the program will also receive Web-based tools and education materials.

Specialty Guideline Management (SGM)

The Specialty Guideline Management program helps ensure appropriate utilization of specialty medications. This program will only impact participants with a specialty prescription (includes biotech). Specialty drugs are typically used for the treatment of genetic diseases, autoimmune diseases, infectious diseases, oncological diseases and chronic diseases. These medications are typically very expensive and often require specific dosing, medical devices to administer the medication, and/or special handling and delivery. For continued treatment, a clinical review is required. Caremark will obtain the necessary clinical information from impacted participants' doctor's office and conduct the review. No action is required from impacted participants at this time.

Generic Copay Incentive

The Generic Copay Incentive program is being implemented to encourage the use of generic drugs over more costly brand drugs. Select brand drugs have been identified and impacted participants will receive a targeted communication explaining they are eligible for one free fill of the appropriate generic alternative to their brand drug. Please note, not all brand drugs are eligible for the Generic Copay Incentive program.

Generic Step Therapy

Members will be required to try a cost-effective generic before non-preferred single source brands are covered. Certain drug classes will require members to try more than one cost- effective generic before the non-preferred single source brands are covered.

Advanced Control Specialty Formulary™

The formulary includes both specialty generics and clinically effective brand therapies. The formulary also has drug exclusions in several classes where multiple, therapeutically equivalent products exist (similar safety and efficacy).

Broad Vaccination network (BVN) & covers seasonal vaccines only.

- Seasonal vaccines can only be administered once the vaccine has been released to the marketplace by the manufacturer. Vaccines intended for the treatment of avian flu are not covered items under the BVN Program.
- The BVN Program is effective from August 1st through April 30th annually (flu season) or per state requirements for influenza vaccinations.
- Standard Program terms, with coverage for all available Seasonal Vaccines including: Standard Influenza, Cell Culture-based Influenza, Intranasal Influenza, Recombinant Influenza, Adjuvanted Influenza, High Dose Influenza

LIMITATIONS AND EXCLUSIONS

The prescription program generally covers any FDA-approved A-rated generic or FDA- approved non-generic drug, and any of a select list of FDA-unapproved, legally marketed drugs identified as clinically appropriate by the plan's pharmacy benefit manager, prescribed in writing by a physician and which is an appropriate treatment of the participant's diagnosed injury or illness and which is not otherwise covered under another schedule of the Plan.

However, in addition to the limitations described elsewhere in this SPD, the following apply:

Preauthorization is required for any compounded prescription drug for which the ingredient cost exceeds $300. Authorization will be given only if any individual ingredient component being requested is FDA approved in the same finished dosage form of the compound. Coverage will be limited to one compounded drug per 25-day period per individual.

Certain categories and types of drugs require prior authorization to be eligible for coverage, based on information given by your physician to the Caremark pharmacy benefit representative. These include (but are not limited to): anabolic steroids, androgens (Androgel), medication for the treatment of hypoactive sexual desire disorder and testosterone.

Acne medications such as Retin A, Tretinoin, and Avita are covered for participants under age 26 by mail order only. Retinoids and other drugs in this category are not covered for participants who are 26 or older regardless of diagnosis.

Drugs that do not, by U.S. federal law, require a doctor's prescription, and are dispensed by a pharmacy or organization licensed to dispense drugs, are not covered.

Drugs with the sole purpose of promoting hair growth (e.g., Rogaine, Propecia) or those used for cosmetic purposes only (Renova) are not covered.

Erectile dysfunction drugs are only covered with a prescription from a physician and in the amount of up to six doses per month.

Experimental drugs or procedures are not covered. The term "experimental drugs" is defined as follows:

- the drug cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug is furnished; or
- the ***drug required the patient to sign an informed consent document utilized with the drug,*** which was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- the drug is considered by any governmental agency or subdivision as experimental or investigational, not reasonable and necessary, or any similar finding; or
- the drug is not covered under the Medicare reimbursement laws, regulations, or interpretations; or
- ***reliable evidence shows that the drug is the subject of ongoing phase I or phase II clinical trials***; is the research, experimental, study or investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- ***reliable evidence shows that the prevailing opinion among experts regarding the drug is that further studies or clinical trials*** are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug; or the written informed consent used by the treating facility or by another facility studying substantially the same drug.

Infertility drugs are limited to $15,000 benefit in a lifetime.

Lidocaine Quantity Limit and Post-Limit Prior Authorization – FDA-approved products that are lidocaine or lidocaine-containing formulations will be subject to a quantity limit with a post-limit prior authorization requirement (Emla (30gm), Lidocaine 2% gel (30gm), Lidocaine 4% gel (30gm), Lidocaine 5% ointment (50gm), Lidocaine 4% solution (50ml), Pliaglis 7-7% cream (30gm), Synera 70-70mg patch (2)).

Mail Service Pharmacy only – Certain categories and types of drugs are available only through the mail service pharmacy. These include anabolic steroids, androgens, and growth hormones. ***Nutrition and dietary supplements*** are not covered. Biotech and Specialty Drugs are only available through mail-order.

Opioid Management Program – The opioid management program contains the following limitations:

- The length of the first fill will be limited to seven days for immediate release, new, acute prescriptions for plan members with no history of prior opioid use. A physician can submit a prior authorization (PA) request if it is medically necessary to exceed the seven- day limit.

- The quantity of opioid products prescribed (including those that are combined with acetaminophen, ibuprofen or aspirin) will be limited up to 90 MME per day (based on a 30-day supply). Prescribers who believe their patient should exceed CDC Guideline recommendations can submit a PA request for up to 200 MME per day. Quantities higher than 200 MME per day would require an appeal.
- Opioid products containing acetaminophen, aspirin, or ibuprofen will be limited to 4 grams of acetaminophen or aspirin, and 3.2 grams of ibuprofen per day.
- Use of an immediate-release (IR) formulation will be required before moving to an extended-release (ER) formulation, unless the member has a previous claim for an IR or ER product, or the prescriber submits a PA.
- Opioid-naïve patients aged 19 years and younger are limited to no more than a three-day supply of short acting opioids. The strategy will include immediate release (IR) and immediate release combination opioid products. For patients whose clinical diagnosis may require a longer day supply for ongoing therapy, prescribers may apply for prior authorization on a case-by-case basis. Opioid prescriptions for cancer, sickle cell disease, hospice or palliative care are exempt from this three-day limit.

Other items not required to treat illness or injury are not covered. Over-the counter drugs,

medications, and vitamins are not covered.

Smoking cessation medications that require a prescription are available up to two 12- week supplies per calendar year.

Smoking cessation over-the-counter products are not covered.

Topical Analgesics (patches/lotions/creams) containing ingredients (alone or in combination) in strengths typically used in over-the-counter analgesics for temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness are excluded.

Drugs taken for cosmetic purposes are not covered. This category includes drugs such as depigmenting, hair growth and hair removal agents.

Diabetic supplies including test strips, needles and glucometers are covered.

Certain drugs having limited clinical value and clinically appropriate, lower cost alternatives are not covered.

IMPORTANT NOTICE FROM THE LUBRIZOL CORPORATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

If you or your family members are not currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice does not apply to you.

Please read this notice carefully. This notice has information about your current prescription drug coverage with The Lubrizol Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Lubrizol Corporation has determined that the prescription drug coverage offered by CVS Caremark is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you or your Dependent(s) decide to join a Medicare drug plan, your Lubrizol prescription drug coverage will be affected. For those individuals who enroll in a Medicare Part D plan, coverage under the Lubrizol prescription drug Plan will end for the individual and all covered Dependents.

See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with The Lubrizol Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage Contact your local benefits representative for additional information or call the Lubrizol Benefits Center at 1-844-747-1641.

NOTE: You'll get this notice each year and if the Lubrizol Prescription Drug Program has any changes which affect Medicare Part D. You also may request a copy of this notice at any time.

More Information About Your Options Under Medicare Prescription Drug Coverage More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.

- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

APPEAL PROCEDURES

An appeal may be filed if:

- an Adverse Benefit Determination has been rendered on a Claim, or
- you believe that the benefits to which you are entitled to have not been provided under the Plan.

You have the right to request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim. Your request must be made in writing to the Claims Administrator.

An appeal of an Adverse Benefit Determination must be made in writing (or orally by the attending physician, in the case of an Adverse Benefit Determination rendered on an Urgent Care Claim) and submitted to the Claims Administrator. An appeal of an Adverse Benefit

Determination must be made within 180 days after you receive notification of the Claims Administrator's Adverse Benefit Determination.

Submitting an Appeal

All appeals must be submitted to the Claims Administrator in writing. In the case of an appeal of an Adverse Benefit Determination rendered on an Urgent Care Claim, the attending physician may also call the Claims Administrator to submit an appeal.

Your appeal should include the following:

- Name of the person the appeal is for
- CVS Caremark Identification Number
- Date of Birth
- Written statement of the issue(s)
- Drug name(s) being appealed
- Documents, records or other information relating to the Claim

Your written appeal and supporting documentation may be mailed or faxed to the Claims Administrator:

CVS Caremark Appeals
Department MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

Fax Number: 1-866-689-3092

Physicians may submit urgent appeal requests by calling the physician only toll-free number: 1-866-443-1183.

Claims Administrator's Review

The Claims Administrator will review the appeal of an Adverse Benefit Determination. The period of time that applies to when the participant will receive written notice (or oral notification to the attending physician for an Urgent Care Claim, if applicable, followed by written notification) of the Claims Administrator's decision on a Claim that has been appealed depends on the nature of the Claim, for example, a Post-Service Claim.

The Claims Administrator's decision will be communicated in writing to the participant. In the event that the Claims Administrator renders an Adverse Benefit Determination on appeal, the Claims Administrator will provide written notification, which will include:

- the specific reason or reasons for the Adverse Benefit Determination;
- specific reference to pertinent Plan provision on which the Adverse Benefit Determination was based;
- a statement that the participant is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim for benefits;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination; and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge upon written request; and
- if the Adverse Benefit Determination is based on a Medical Necessity, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

Pre-Service Claim Appeal

The Claims Administrator will make a decision on an appeal of an Adverse Benefit Determination that was rendered on a Pre-Service Claim within 30 days after receipt of the appeal

Post-Service Claim Appeal

The Claims Administrator will make a decision on an appeal of an Adverse Benefit Determination that was rendered on a Post-Service Claim within 60 days after the receipt of the appeal.

Urgent Care Claim Appeal

The Claims Administrator will make a decision on an appeal of an Adverse Benefit Determination that was rendered on an Urgent Care Claim within 72 hours after the receipt of the appeal.

Scope of Review

During its review of an appeal of an Adverse Benefit Determination on a Claim, the Claims Administrator shall:

- take into account all comments, documents, records and other information submitted by the participant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim;
- follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents; and
- follow reasonable procedures to ensure that the applicable Plan provisions are applied to the participant in a manner consistent with how such provisions have been applied to other similarly-situated participants

The Claims Administrator shall serve as the final review under the prescription benefit and shall have sole and complete discretionary authority to determine conclusively for all parties, and in accordance with the terms of the documents or instruments governing the prescription benefit, any and all questions arising from:

- administration of the prescription benefit and interpretation of all prescription benefit provisions;
- determination of all questions relating to participant or eligible individuals and eligibility for benefits;
- determination of all relevant facts;
- determination of the amount and type of medical benefits to be provided to any eligible individual or covered Eligible Dependent; and
- construction of all terms of the Plan.

DEFINITIONS

Adverse Benefit Determination – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a prescription benefit, including any such denial, reduction, termination of, or a failure to provide or make a payment that is based on a determination of a participant's eligibility to participate in the Plan.

Claim – A request for a prescription benefit that is made by the participant in accordance with the Plan's established procedures for filing benefit claims under the Plan.

Claims Administrator – The health care company authorized by the prescription benefit to administer prescription benefits under the prescription benefit.

Medically Necessary (Medical Necessity) – The determination of Medical Necessity is made by the Claims Administrator and is for pre-service claim denials that were upheld in the first appeal. Care is considered Medically Necessary if:

- it is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
- it is based on recognized standards of the health care specialty involved; and
- it represents the most appropriate level of care depending on the seriousness of the condition being treated, with respect to the frequency and duration of services and the place where services are performed.

Post-Service Claim – A Claim for a benefit that is not a Pre-Service Claim.

Precertification – The process by which the Claims Administrator reviews the Medical Necessity of a particular medication and makes a determination for coverage based on a pre- defined set of criteria.

Pre-Service Claim – A Claim for a benefit that is conditioned, in whole or in part, on approval of the benefit in advance of obtaining medical care, such as a request for pre- certification of a medication.

Urgent Care Claim – A Claim for care or treatment where a delay could seriously jeopardize the life or health of the patient or the ability to regain maximum function. Such a Claim is also one involving a condition that would, in the opinion of a Physician with knowledge of the condition, subject the patient to severe pain that cannot be adequately managed without the care or treatment that is related to the Claim.

HEARING AID BENEFITS

This Plan includes a benefit that allows Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by UnitedHealthcare Hearing.

UnitedHealthcare Hearing provides a full range of hearing health benefits that deliver value, choice, and a positive experience.

UnitedHealthcare Hearing offers:

- Name-brand and private-labeled hearing aids from major manufacturers at discounted prices.
- Access to a network of credentialed hearing professionals at more than 5,000 locations nationwide.
- Convenient ordering with hearing aids available in person or through home delivery.

How To Use This Hearing Benefit:

- Contact UnitedHealthcare Hearing at 1-855-523-9355, between 8:00 a.m. and 8:00 p.m. Central Time Monday through Friday, or visit uhchearing.com to learn more about the ordering process and for a referral to a UnitedHealthcare Hearing provider location (if a hearing test is needed).
- Receive a hearing test by a UnitedHealthcare Hearing provider. During the appointment, You will decide if You would like to have Your hearing aids fitted in person with Your hearing provider or to have Your hearing aids delivered directly to Your home (for select hearing aid models only). A broad selection of name-brand and private-labeled hearing aids is available.
- If You choose to purchase hearing aids through the UnitedHealthcare Hearing provider, the hearing aids will be ordered by the provider and sent directly to the provider's office. You will be fitted with the hearing aid(s) by the local provider. If You choose home delivery, the hearing aids will be sent directly to Your home within 5-10 business days from the order date.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, contact UnitedHealthcare Hearing at 1-855-523-9355 or visit uhchearing.com.

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.

- Services provided for conflict between the Covered Person and society that is solely related to criminal activity.

Services for biofeedback.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of substance use disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance-related disorders. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes.)

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for the change. Such records must include the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE USE DISORDER EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for the following:

- Treatment or care considered inappropriate or substandard as determined by the Plan.

Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER

Utilization Management

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and are appropriate level of care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons are responsible for ensuring the provider calls the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

Special Note: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. Covered Persons who have received care on this basis are responsible for ensuring the provider contacts the Utilization Review Organization (see below) as soon as possible by phone or fax within 24 hours, or by the next business day if on a weekend or holiday, from the time coverage information is known. If notice is provided past the timeframe shown above, the extenuating circumstances must be communicated. The Utilization Review Organization will then review the services provided.

This Plan complies with the Newborns' and Mothers' Health Protection Act. Prior Authorization is not required for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR**

DEFINITIONS

The following terms are used for the purpose of the UMR CARE section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Prior Authorization is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for drugs, supplies, tests, procedures, and other services that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay.

Utilization Management is the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits Plan. This management is sometimes called "utilization review." Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization **before** receiving services for the following:

- Inpatient stays in Hospitals or Extended Care Facilities .
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over $1,500 or Durable Medical Equipment rentals over $500 per month.
- Prosthetics over $1,000.
- Qualifying Clinical Trials.
- Dialysis.
- Medical Specialty Drug Program. To encourage safe and cost-effective medication use, prior authorization may be required for some specialty drugs. Please visit Specialty Injectable | UMR for a list of Medical Specialty Drugs that may require prior authorization, including Site of Care when applicable (including select gene therapy drugs, orphan drugs, and CAR-T drugs). To request a copy of the Medical Specialty Drug list, call the toll-free number on the back of Your member identification card and the list will be provided free of charge. Prior authorization does not guarantee benefit payment. This Plan may exclude specific drugs on this list from coverage. Refer to the General Exclusions section of this SPD for possible Medical Specialty Drug exclusions.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Out-of-network non-Emergency ambulance services.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount that must be paid by a Covered Person who does not call for Prior Authorization prior to receiving certain services. A penalty of $500 may be applied to out-of-network applicable claims if a Covered Person receives services but does not obtain the required Prior Authorization.

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization.

Medical Director Oversight. A UMR CARE medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case-to-case management for review. Opportunities are identified by using a system-integrated, automated and manual trigger lists during the Prior Authorization review process. Other trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals.

Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted upon request and a determination will be issued within the required timeframe of the request, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures and a final determination will be made no later than 30 days after the request for review.

Complex Condition CARE

Complex Condition CARE is available for transplant only to all Covered Persons. CARE nurse managers evaluate and coordinate post-hospitalization needs for members who have a high probability of subsequent readmission within 30 days. Participants are identified based on historical claim factors and current admission information, including, but not limited to:

- unplanned readmission within the past 30 days or multiple unplanned admissions within the past 6 months.
- length of stay.
- complex diagnoses or comorbidities pertaining to cardiovascular conditions, kidney failure, pulmonary conditions or infections, or liver/pancreas/gastrointestinal surgery.

Additional CARE Provisions

Real Appeal Program: This Plan provides the Real Appeal Program, which represents a practical solution for weight-related conditions, with the goal of helping individuals at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support Covered Persons over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live, virtual coach. The experience will be personalized for each participant though an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers, and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Co-pays, Plan Participation, or Deductibles that need to be met when services are received as part of the Real Appeal Program. If Covered Persons would like to participate, or would like any additional information regarding the program, they can visit the Real Appeal website at Rally Coach - Login (werally.com).

Optum Bariatric Resource Services (BRS)

Bariatric Resource Services (BRS) is a surgical weight loss solution for those individuals who qualify clinically for bariatric surgery. Specialized Optum Nurse Navigators provide support through all stages of the weight loss surgery process. The program is dedicated to providing support both before and after surgery. Optum nurses help with decision support in preparation for surgery, information and education in the selection of a bariatric surgery program, and post-surgery and lifestyle management. Optum nurses can provide information on the nation's leading obesity surgery centers, known as Optum's Centers of Excellence (COE).

Enrollment for bariatric surgery must be initiated through Optum's BRS program. Covered participants seeking coverage for bariatric surgery should notify Optum as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) by calling Optum at 888-936-7246 to enroll in the program.

In addition to the requirements listed below, additional authorization requirements may apply. Refer to the Services Requiring Prior Authorization section of this SPD.

The Plan covers surgical treatment of Morbid Obesity. Refer to the Covered Medical Benefits section of this SPD.

Contact Your employer with any questions related to this coverage or service.

The use of the Bariatric Resource Services (BRS) program is required for bariatric surgery – enrollment in the program is mandatory.

Use of a BRS Optum Center of Excellence (COE) is mandatory.

If the Body Mass Index (BMI) is 35 or more, the patient must have at least one complicating comorbidity directly related to, or exacerbated by, morbid obesity. This does not apply if the Body Mass Index (BMI) is 40 or more.

The patient must be 18 years of age or older, or an adolescent must have achieved greater than 95% of estimated adult height *and* a minimum Tanner Stage of 4.

The patient must provide documentation of a motivated attempt of weight loss through a structured diet program prior to bariatric surgery, which includes Physician or other health care provider notes and/or diet or weight loss logs from a structured weight loss program.

Pre-surgical psychological evaluation will be performed to rule out major Mental Health Disorders that would contraindicate surgery and determine patient compliance with postoperative follow-up care and dietary guidelines.

A second bariatric surgery will be covered only if complications arise from the original bariatric surgery.

Gastric bypass (Roux en Y), lapband, gastric sleeve, and duodenal switch are all covered procedures.

Optum Cancer Resource Services (CRS)

Cancer Resource Services (CRS) consists of Optum Centers of Excellence (COE) network access.

If a Covered Person chooses to seek services at Roswell Park Cancer Institute, the Covered Person must contact Included Health at 855-431-5532 or services will be considered out-of-network.

If a Covered Person chooses to seek services at Huntsman Cancer Institute at the University of Utah in Salt Lake City, the Covered Person must contact Included Health at 855-431-5532 or services will be considered out-of-network.

Optum Congenital Heart Disease Resource Services (CHDRS)

Covered Persons have access to Congenital Heart Disease Resource Services (CHDRS) providers. CHDRS is a specialized network of the nation's leading Congenital Heart Disease (CHD) facilities. Each facility within the specialized network undergoes a rigorous Centers of Excellence qualification process.

If a Covered Person chooses to seek services at an Optum Congenital Heart Disease Centers of Excellence provider, the Covered Person must contact Included Health at 855-431-5532 or services may be considered out-of-network.

Optum Fertility Solutions

The Fertility Solutions program provides:

- specialized clinical consulting services (Optum Nurse Navigators) to members for education on Infertility Treatment options.
- access to specialized network facilities and Physicians for Infertility services (at Optum Centers of Excellence).

The Plan pays benefits for Infertility services only when provided by an approved Designated Facility provider in the Fertility Solutions program. If the Covered Person lives more than 60 miles from an approved Designated Facility provider the Plan will pay benefits for Infertility services when provided by an in-network provider participating in the Fertility Solutions program.

To enroll in the Fertility Solutions program, call Fertility Solutions directly at 1-866-774-4626.

In addition to the enrollment and/or possible Designated Facility requirements, eligibility is also determined by the below. Please note that additional authorization requirements may apply. Refer to the Services Requiring Prior Authorization section of this SPD.

Who Is Eligible?

Covered fertility services are available to a Covered Person who meets all eligibility requirements specified in the Plan. In addition, the provision below, Criteria for Eligibility, will apply.

Criteria for Eligibility

Dependent Children are not eligible for the Infertility benefit.

Infertility Services

Therapeutic services for the treatment of Infertility are covered when provided by or under the direction of a Physician. Diagnostic services and office visits are covered as described in this SPD. Benefits under this Optum Fertility Solutions section are limited to specific procedures that the Optum Nurse Navigator can explain based on specific benefit design.

Infertility means a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract that prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed, unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

Kidney Resource Services (KRS)

Kidney Resource Services (KRS) provides access to a preferred provider dialysis network and support from a UMR CARE Nurse Manager by collaborating with the Covered Person to delay the progression of the disease to renal failure.

UMR CARE End-Stage Renal Disease (ESRD) specialty nurses focus on clinical support and treatments.

If a Covered Person chooses to seek services at a KRS preferred provider, the Covered Person must contact Included Health at 855-431-5532.

Optum Orthopedic Health Support (OHS)

Orthopedic Health Support (OHS) is a surgical program for Covered Persons 18 and older providing support before, during, and after surgery. Nurses help direct participants to quality Optum Centers of Excellence (COE) facilities and provide them with case management. A Covered Person seeking coverage for surgery should notify Optum as soon as the possibility of a surgical procedure arises (and before the time a pre-surgical evaluation is performed) at an Orthopedic Health Support Center of Excellence by calling Optum at 888-936-7246 to enroll in the program.

Benefits of this program may include:
- Spine fusion surgery
- Disc surgery
- Total hip replacement surgery
- Total knee replacement surgery

All active members age 18 and older are eligible.

Enhanced benefits are offered to Covered Persons who utilize the program and/or Optum COE facility. (Refer to the Orthopedic Health Support Schedule of Benefits.)

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not, however, apply to prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Co-pays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Foreign health care coverage.
- Medical care components of group long-term care contracts, such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies (including no-fault policies). See the order of benefit determination rules (below).
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

However, this Plan does not coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply:

- The Lubrizol CDHP will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

- The plan that has no coordination of benefits provision is considered primary.

- If an individual is covered under one plan as a dependent and another plan as an employee, member, or subscriber, the plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) is considered primary. This does not apply to COBRA participants. See continuation coverage below. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan.

- The plan that covers a person as a dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent. See continuation coverage below. Also see the section on Medicare, below, for exceptions.

- If an individual is covered under a spouse's plan and also under their parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.

- If one or more plans cover the same person as a dependent child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

    If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated (whether or not they have ever been married), the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or dependent of an active employee), and is also covered under another plan as a retired or laid-off employee (or dependent of a retired or laid-off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See the exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that has covered the person as an employee, member, subscriber, or retiree the longest is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the plan under which the person has been covered for the longer period of time will be considered to pay its benefits before the other.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including through Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Co-pays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance.

When Medicare is primary to this Plan and a Covered Person has not elected Medicare, this Plan will coordinate benefits using an estimate of what Medicare would have paid.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:

  - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.

  - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and Your spouse is also covered under a retiree plan through their former employer. In this case, this Plan pays first for You and Your covered spouse, Medicare pays second, and the retiree plan pays last.

  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.

- Medicare generally pays first under the following circumstances:

  - You are no longer actively employed by an employer; and

  - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also has COBRA continuation coverage through the Plan; or

  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first; however, COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or

  - You or Your covered spouse has retiree coverage plus Medicare coverage; or

- Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability **before** being diagnosed with ESRD and Medicare was previously paying as the Primary Plan, the person may continue to receive Medicare benefits on a primary basis).

- Medicare is the secondary payer when no-fault insurance, Workers' Compensation, or liability insurance is available as the primary payer.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's health insurance plan.

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to “You” or “Your” in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.

- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.

- The Plan Sponsor in a Workers’ Compensation case or other matter alleging liability.

- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners’, or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.

- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.

- Any person or entity that is liable for payment to You on any equitable or legal theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan’s legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

    - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or Injuries.
    - Making court appearances.
    - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
    - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, punitive, and any other alleged damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:

  - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own negligence.

- By participating in and accepting benefits from the Plan, You agree to assign to the Plan any benefits, claims, or rights of recovery You have under any automobile policy (including no-fault benefits, Personal Injury Protection benefits, and/or medical payment benefits), under other coverage, or against any third party, to the full extent of the benefits the Plan has paid for the Illness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, You acknowledge and recognize the Plan's right to assert, pursue, and recover on any such claim, whether or not You choose to pursue the claim, and You agree to this assignment voluntarily.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

- In the case of occupational Illness or Injury, the Plan's recovery rights will apply to all sums recovered, regardless of whether the Illness or Injury is deemed compensable under any Workers' Compensation or other coverage. Any award or compromise Workers' Compensation settlement,

including any lump-sum settlement, will be deemed to include the Plan's interest and the Plan will be reimbursed in first priority from any such award or settlement.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items, are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below or as otherwise required to be covered by the No Surprises Act. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of an Injury if the Plan has information that the Injury is due to a medical condition (including physical and mental health conditions and Emergencies) or domestic violence.

1. **3D Mammograms,** unless covered elsewhere in this SPD.

2. **Abdominoplasty.**

3. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

4. **Alternative / Complementary Treatment** including treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.

5. **Appointment Missed:** An appointment the Covered Person did not attend.

6. **Assistance with Activities of Daily Living.**

7. **Assistant Surgeon, Co-Surgeons, or Surgical Team Services,** unless determined to be Medically Necessary by the Plan.

8. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins or after coverage ends under this Plan.

9. **Biofeedback Services**.

10. **Blood:** Blood donor expenses.

11. **Blood Pressure Cuffs / Monitors,** unless covered elsewhere in this SPD.

12. **Breast Pumps,** unless covered elsewhere in this SPD.

13. **Cardiac Rehabilitation** beyond Phase II, including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

14. **Claims** received later than 12 months from the date of service.

15. **Cognitive Rehabilitation Therapy,** except as short-term therapy following post-traumatic brain Injury or stroke.

16. **Contraceptive Products and Counseling,** unless covered elsewhere in this SPD.

17. **Cosmetic Treatment, Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

18. **Court-Ordered:** Any treatment or therapy that is court-ordered, or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving-while-intoxicated conviction or other classes ordered by the court.

19. **Custodial Care** as defined in the Glossary of Terms of this SPD.

20. **Dental Services,** unless covered elsewhere in this SPD.

21. **Developmental Delays:** Medical charges and occupational, physical, or speech therapy services related to Developmental Delays, intellectual disability, or behavioral therapy.

22. **Duplicate Services and Charges or Inappropriate Billing,** including the preparation of medical reports and itemized bills.

23. **Education:** Charges for education, special education, job training, music therapy, and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

24. **Environmental Devices:** Environmental items such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices.

25. **Examinations:** Examinations for employment, insurance, licensing, or litigation purposes.

26. **Excess Charges:** Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, the Negotiated Rate, or the fee schedule. This exclusion does not apply to payments that may be required under the No Surprises Act.

27. **Experimental, Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment. This exclusion does not apply to Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD.

28. **Extended Care:** Any Extended Care Facility services that exceed the appropriate level of skill required for treatment as determined by the Plan.

29. **Family Planning:** Consultations for family planning.

30. **Financial Counseling.**

31. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment, and health club memberships, or other utilization of services, supplies, equipment, or facilities in connection with weight control or bodybuilding.

32. **Foot Care (Podiatry):** Routine foot care.

33. **Genetic Testing or Genetic Counseling,** unless covered elsewhere in this SPD.

34. **Growth Hormones.**

35. **Home Modifications:** Modifications to Your home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, or ramps.

36. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

37. **Intraocular Lenses Other Than Conventional Intraocular Cataract Lenses.**

38. **Lamaze Classes** or other childbirth classes.

39. **Learning Disability:** Non-medical treatment, including, but not limited to, special education, remedial reading, school system testing, and other habilitation (such as therapies)/rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

40. **Liposuction,** unless covered elsewhere in this SPD.

41. **Maintenance Therapy** if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve a condition, or if clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

42. **Mammoplasty or Breast Augmentation,** unless covered elsewhere in this SPD.

43. **Marriage Counseling.**

44. **Massage Therapy.**

45. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

46. **Military:** A military-related Illness of or Injury to a Covered Person on active military duty, unless payment is legally required.

47. **Nocturnal Enuresis Alarm** (Bed wetting).

48. **Non-Custom-Molded Shoe Inserts.**

49. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of their license.

50. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities, or equipment that reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy above.

51. **Nursery and Newborn Expenses** for a grandchild of a covered Employee or spouse.

52. **Nutrition Counseling,** unless covered elsewhere in this SPD.

53. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** unless covered elsewhere in this SPD.

54. **Over-the-Counter Medication, Products, Supplies, or Devices,** unless covered elsewhere in this SPD.

55. **Palliative Foot Care.**

56. **Panniculectomy,** unless determined by the Plan to be Medically Necessary.

57. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as, but not limited to, private rooms, televisions, telephones, and guest trays.

58. **Pharmacy Consultations.** Charges for or related to consultative information provided by a pharmacist regarding a Prescription order, including, but not limited to, information related to dosage instruction, drug interactions, side effects, and the like.

59. **Prescription Medication Written by a Physician:** A Covered Person with a written Physician's Prescription who obtains medication from a pharmacy should refer to the Prescription Drug Benefits section of this SPD for coverage.

60. **Preventive / Routine Care Services,** unless covered elsewhere in this SPD.

61. **Private Duty Nursing Services.**

62. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

63. **Respite Care.**

64. **Return to Work / School:** Telephone or Internet consultations, or the completion of claim forms or forms necessary for a return to work or school.

65. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization, unless covered by the Plan in connection with Infertility Treatment.

66. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

67. **Self-Administered Services** or procedures, including self-administered or self-infused medications, that can be performed by the Covered Person without the presence of medical supervision. This exclusion does not apply to medications that, due to their characteristics (as determined by the claims administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an Outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to members for self-infusion.

68. **Services at No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

69. **Services Provided By a Close Relative.** See the Glossary of Terms section of this SPD for a definition of Close Relative.

70. **Services Provided By a School.**

71. **Sex Therapy.**

72. **Sexual Function:** Non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Drug Benefits section of this SPD) in connection with treatment for male or female impotence.

73. **Standby Surgeon Charges.**

74. **Subrogation.** Charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Right of Subrogation, Reimbursement, and Offset section. See the Right of Subrogation, Reimbursement, and Offset section for more information.

75. **Surrogate Parenting and Gestational Carrier Services:** Any services or supplies provided in connection with a surrogate parent, not including pregnancy and maternity charges Incurred by a covered Employee or covered spouse acting as a surrogate parent.

76. **Taxes:** Sales taxes and shipping and handling charges, unless covered elsewhere in this SPD.

77. **Telehealth.** Consultations made by a Covered Person's treating Physician to another Physician.

78. **Tobacco Addiction:** Diagnoses, services, treatment, or supplies related to addiction to or dependency on nicotine, unless covered elsewhere in this SPD.

79. **Transportation:** Transportation services that are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

80. **Travel:** Travel costs, unless covered elsewhere in this SPD.

81. **Vision Care,** unless covered elsewhere in this SPD.

82. **Vitamins, Minerals, and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

83. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning, and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

84. **Weight Control:** Treatment, services, or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling.

85. **Wigs (Cranial Prostheses), Toupees, Hairpieces, Hair Implants or Transplants, or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss, unless covered elsewhere in this SPD.

86. **Workers' Compensation:** An Illness or Injury arising out of, or in the course of, any employment for wage or profit not including self-employment, for which the Covered Person was entitled to benefits under any Workers' Compensation, U.S. Longshoremen and Harbor Workers' or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force. If You are an Employee with a second job or if You are covered as a Dependent under this Plan and You are self-employed or employed by an employer that does not provide health benefits, Your claims may not be covered by the health plan. You will need to have other medical benefits to provide for Your medical care in the event that You are hurt on the job. In most cases, Workers' Compensation insurance will cover Your costs, but if You do not have such coverage You may end up with no coverage at all.

87. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

The Plan does not limit a Covered Person's right to choose their own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the claims administrator, on behalf of the Plan, prior to services being provided. Although Pre-Determinations are not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals of whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. A Covered Person or provider may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore may not be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as <u>required</u> by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person or provider, when applicable, is required to obtain approval from the Plan ***before*** obtaining medical care, such as in the case of prior authorization of health care items or services that the Plan requires. If a Covered Person or provider calls the Plan for the sole purpose of learning whether or not a claim will be covered, that call is not considered a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization. (See "Pre-Determination" above.) The fact that the Plan may grant prior authorization does not guarantee that the Plan will ultimately pay the claim.

  Note that this Plan does not require prior authorization for urgent or Emergency care claims; however, Covered Persons may be required to notify the Plan following stabilization. Please refer to the UMR CARE section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if a sudden and serious condition occurs such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of the patient's bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant their Personal Representative access to their Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Person for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services, or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient's account number (if applicable)
- Total billed charges
- Provider's billing name, address, and telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto Accident, or another Accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veterans Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly, follow the Plan's procedures for requesting prior authorization, the Plan will notify the person and explain the proper procedures within five calendar days following receipt of a Pre-Service Claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If the service is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to the billed charges, a Negotiated Rate, or the Protection from Balance Billing allowed amount, or based on the Usual and Customary amounts, minus any Deductible, Plan Participation rate, Co-pay, or penalties that the Covered Person is responsible for paying. Refer to the Protection from Balance Billing section of this SPD for covered benefits that are payable in accordance with the Protection from Balance Billing allowed amount.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service, such as transplant services, Durable Medical Equipment, Extended Care Facility treatment, or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate, or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Modifiers or Reducing Modifiers, if Medically Necessary. These terms apply to services and procedures performed on the same day and may be applied to surgical, radiological, and other diagnostic procedures. For a provider participating with a primary or secondary network, claims will be paid according to the network contract. For a provider who is not participating with a network, where no discount is applied, the industry guidelines are to allow the Usual and Customary fee allowance for the primary procedure and a percentage of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

The specific reimbursement formula used will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

Reimbursement for Covered Expenses received from providers, including Physicians or health care facilities, who are not part of Your network are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility; or
- The amount that is usually accepted by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or materials; or
- Current publicly available data reflecting the costs for health care providers providing the same or similar services, adjusted for geographical differences plus a margin factor; or
- 140 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.
  - A gap methodology may be utilized when CMS does not have rates published for certain procedural codes; or
  - 50 percent of the provider's billed charges when unable to obtain a rate published by CMS and/or gap methodology does not apply.

When covered health services are received from a non-network provider as a result of an Emergency or as arranged by Your Plan Administrator, eligible expenses are amounts negotiated by Your claims administrator or amounts permitted by law. Refer to the Protection from Balance Billing section of this SPD for more information. Please contact Your Plan Administrator if You are billed for amounts in excess of Your applicable Plan Participation, Co-pays, or Deductibles. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

See "Surgery and Assistant Surgeon Services" in the Covered Medical Benefits section for exceptions related to multiple procedures. A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

For services received from a non-network provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. Covered Persons are responsible for paying the balance of these claims after the Plan pays its portion, if any.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB form or on the back of the group health identification card. The provider will receive a similar form for each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

- Pre-Service Claims: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may have an extra 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the treatment ending or being reduced.
- Emergency and/or Urgent Care claims as defined by the Affordable Care Act: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan and deference will be made to the treating Physician.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person's loss of eligibility for coverage under the health Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group health Plan.
- Termination of the group health Plan.
- The Employee, Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Protection from Balance Billing allowed amount, the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered Experimental, Investigational, or Unproven.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or their Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this SPD.

Second Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or their Personal Representative must submit a written request for a second review within 60 calendar days following the date they received the Plan's decision regarding the first appeal. The Plan will assume the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.

- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this SPD.

If You have any questions regarding the appeal process, including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative), or other details, please contact the Plan. Refer to the Statement of ERISA Rights section of this SPD for details on a Covered Person's additional rights to challenge the benefit decision under Section 502(a) of ERISA.

Appeals should be sent within the prescribed time period as stated above to the following address(es).

Note: Post-Service Appeal Request forms are available at www.umr.com to assist You in providing all the recommended information to ensure a full and fair review of Your Adverse Benefit Determination. You are not required to use this form.

Send Post-Service Claim Medical appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

This Plan contracts with various companies to administer different parts of this Plan. A Covered Person who wants to appeal a decision or a claim determination that one of these companies made, should send appeals directly to the company that made the decision being appealed. This includes the RIGHT TO EXTERNAL REVIEW.

Send Pharmacy appeals to:
CVS CAREMARK
APPEALS DEPARTMENT
MC109
PO BOX 52084
PHOENIX AZ 85072-2084

Fax number: 1-866-689-3092

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

URGENT CLAIM APPEALS THAT REQUIRE IMMEDIATE ACTION

A request by a Covered Person or their authorized representative for the review and reconsideration of coverage that requires notification or approval prior to receiving medical care may be considered an urgent claim appeal. Urgent claim appeals must meet one or both of the following criteria in order to be considered urgent in nature:

- A delay in treatment could seriously jeopardize life or health or the ability to regain maximum functionality.
- In the opinion of a Physician with knowledge of the medical condition, a delay in treatment could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

UMR must respond to the urgent claim appeal request as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receiving the request for review.

The timelines below will apply only to the mandatory appeal levels.

- Pre-Service Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claims: Within a reasonable period of time, but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:
  - Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
  - Whether a claim for items and services was furnished by a non-network provider at a network facility;
  - Whether an individual gave informed consent to waive the protections under the No Surprises Act;

  - Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
  - Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fails to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR nor Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request as indicated below.

Notice of the right to external review for Pre-Service appeals should be sent to:

UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

Alternatively, You may fax Your request to 888-615-6584, ATTN: UMR Appeals

Notice of the right to external review for Post-Service appeals should be sent to:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to UMR or Your employer.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the claims administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, a Covered Person has the right to further appeal an Adverse Benefit Determination by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section of this SPD for more details. **No such action may be filed against the Plan later than the earlier of (i) one year from the date of the final appeal denial (or the final denial by an Independent Review Organization, if applicable) or (ii) three years from the date of the services giving rise to the claim.**

OTHER LEGAL ACTIONS

All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else, such as the Covered Person's spouse or another family member, files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on their knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under their identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. They should answer all questions to the best of their knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), their employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Employee has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the FMLA and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- Americans With Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Employee Retirement Income Security Act regarding coverage of Dependent Children in cases of adoption or Placement for Adoption.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- Genetic Information Non-discrimination Act (GINA).

HIPAA NOTICE REGARDING PRIVACY OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) require that the plan provide you with this Notice Regarding Privacy of Protected Health Information. This notice describes (1) how the plan may use and disclose your protected health information, (2) your rights to access and control your protected health information and (3) the plan's duties and contact information.

Protected Health Information
"Protected health information" is health information created or received by the plan that contains information that may be used to identify you, such as your name or address. It includes written or verbal health information that relates to your past, present or future physical or mental health; the provision of health care to you; and your past, present or future payment for health care.

The Use and Disclosure of Protected Health Information in Treatment, Payment and Health Care Operations

Your protected health information may be used and disclosed by the plan in the course of providing payment for treatment and conducting medical, prescription, vision and dental claims operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The plan may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

Treatment. The plan may use or disclose your protected health information in connection with your treatment, which includes the provision, coordination or management of health care and related services. The plan itself does not engage directly in "treatment" under the HIPAA privacy rules. However, the plan may interact with a health care provider in treatment transactions. For example, the plan may disclose information to a treating specialist the name of your regular doctor so that the specialist may request the transfer of your test results from your doctor.

Payment. The plan may use or disclose your protected health information to provide payment to you or your health care providers for services rendered to you by your health care providers. These uses or disclosures may include disclosures to your health care provider or to another group health care plan or insurer to obtain the information needed to process your claim for benefits. For example, the plan may tell your doctor whether you are eligible for coverage and the percentage of the bill that is covered.

Operations. The plan may use or disclose your protected health information when needed for the plan's medical, prescription, and dental claims operations for the purposes of management and administration of the plan. For example, the plan may use your information for utilization management; disease management program administration; administration of the plan's subrogation provisions; coordination of benefits; claims management; reviewing provider performance and plan performance; activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits; conducting or arranging for medical review, legal services, actuarial services and auditing functions, including fraud and abuse detection and compliance programs; business planning and development; systems maintenance; and management activities.

Other Uses and Disclosures. The plan may also use or disclose your protected health information to provide appointment reminders; to describe or recommend treatment alternatives; or to provide information about other health-related benefits and services that may be of interest to you.

The plan may use or disclose protected health information for underwriting purposes as permitted by law, but the plan cannot use or disclose your genetic information for that purpose. Underwriting purposes include eligibility rules or determinations, including eligibility for enrollment or continued enrollment and for benefits under the plan; calculating premium or contribution amounts under the plan; applying pre-existing condition exclusions, if any; or activities related to creating, renewing or replacing any health insurance contract or health benefits.

The plan may also disclose protected health information to The Lubrizol Corporation, the sponsor of the plan. Any disclosure to The Lubrizol Corporation will be in accordance with the HIPAA privacy regulations.

Additional Uses and Disclosures Permitted without Authorization or An Opportunity to Object
In addition to payment and health care operations, the plan may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

When Legally Required. The plan will comply with any federal, state or local law that requires it to disclose your protected health information.

For Judicial and Administrative Proceedings. The plan may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal as expressly authorized by the order or a signed authorization is provided.

For Workers Compensation. The plan may disclose your protected health information to comply with workers compensation laws or similar Programs.

Uses and Disclosures Permitted with an Opportunity to Object
Subject to your objection, the plan may disclose your protected health information to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care. The plan will inform you orally or in writing of these uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not respond to these disclosures, the plan is able to infer from the circumstances that you do not object, or the plan determines that it is in your best interests for the plan to disclose information that is directly relevant to the person's involvement with your care, then the plan may disclose your protected health information. If you are incapacitated or in an emergency situation, the plan may determine if the disclosure is in your best interests and, if that determination is made, may only disclose information directly relevant to your health care.

Uses and Disclosures Authorized by You
Other than the circumstances described above, the plan will not disclose your health information unless you provide written authorization. In particular, without your authorization, the plan will not use or disclose your health information that consists of psychotherapy notes, except to defend itself in a legal action or other proceeding brought by you or as otherwise permitted by law. The plan must also obtain your authorization to use or disclose information for most marketing purposes or to sell your information.

You may revoke your authorization in writing at any time except to the extent that the plan has taken action in reliance upon the authorization.

Your Rights
You have certain rights regarding your protected health information under the HIPAA privacy regulations. These rights include:

The right to inspect and copy your protected health information. For as long as the plan holds your protected health information, you may inspect and obtain a copy of the information included in a designated record set. A "designated record set" contains enrollment, payment, claims adjudication and case or medical management records systems maintained by or for the plan, as well as any other records the plan uses to make decisions regarding health care benefits provided to you. The plan may deny your request to inspect or copy your protected health information if the plan determines that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information. You have the right to request a review of this decision.

In addition, you may not inspect or copy certain records by law, including: (1) psychotherapy notes; (2) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and (3) protected health information that is subject to a law that prohibits access to protected health information. You have the right to have a decision to deny access reviewed in some situations.

You must submit a written request to the plan's Privacy Officer to inspect and copy your health information. The plan may charge you a fee for the costs of copying, mailing, or other costs incurred by the plan in complying with your request. Please contact the Privacy Officer at the number given at the end of this notice if you have any questions about access to your medical information.

The right to request a restriction on uses and disclosures of your protected health information. You may request that the plan not use or disclose specific sections of your protected health information for the purposes of payment or health care operations. Additionally, you may request that the plan not disclose your health information to family members or friends who may be involved in your care or for notification purposes described in this notice. In your request, you must specify the scope of restriction requested as well as the individuals for whom you want the restriction to apply. Your request should be directed to the Privacy Officer.

The plan may choose to deny your request for a restriction, in which case the plan will notify you of its decision. Once the plan agrees to the requested restriction, the plan may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The plan may terminate the agreement to a restriction in some cases.

The right to request to receive confidential communications from the plan by alternative means or at an alternative location. You have the right to request to receive communications of protected health information from the plan through alternative means or at an alternative location if you clearly state that the disclosure of all or part of that information could endanger you. The plan will make every effort to comply with reasonable requests. However, the plan may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact. You are not required to provide an explanation for your request. Requests should be made in writing to the Privacy Officer.

The right to request an amendment of your protected health information. During the time that the plan holds your protected health information, you may request an amendment of your information in a designated record set. The plan may deny your request in some instances. However, should the plan deny your request for amendment, you have the right to file a statement of disagreement with the plan. In turn, the plan may develop a rebuttal to your statement. If it does so, the plan will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the Privacy Officer. Your written request must supply a reason to support the requested amendments.

The right to request an accounting of certain disclosures. You have the right to request an accounting of the plan's disclosures of your protected health information made for the purposes other than payment or health care operations as described in this notice. The plan is not required to account for (1) disclosures you requested, (2) disclosures you authorized by signing an authorization form, (3) disclosures to friends or family members involved in your care and (4) certain other disclosures the plan is permitted to make without your authorization. The request for an accounting must be made in writing to the Privacy Officer and should state the time period that you wish the accounting to include, up to a six year period. The plan is not required to provide an accounting for disclosures that took place prior to April 14, 2003. The plan will not charge you for the first accounting you request in any 12-month period. Subsequent accountings may require a fee based on the plan's reasonable costs for compliance of the request.

The right to receive a paper copy of this notice. The plan will provide a separate paper copy of this notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

The Plan's Duties

The plan is required by law to ensure the privacy of your protected health information, to provide you with this notice of your rights and the plan's legal duties and privacy practices, and to notify you in the event of a breach of your unsecured protected health information. The plan must abide by the terms of this notice, as may be amended periodically. The plan reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that the plan collects and maintains. If the plan alters its notice, the plan will provide a copy of the revised notice through regular mail or in person, and the revised notice will be posted on the plan sponsor's internal website.

Complaints

If you believe that your privacy rights have been violated, you have the right to relay complaints to the plan and to the Secretary of the Department of Health and Human Services. You may provide complaints to the plan verbally or in writing. These complaints should be directed to the Privacy Officer. The plan encourages you to relay any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The plan's contact person regarding the plan's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this notice by request. Complaints to the plan should be directed to the Privacy Officer at the following address:

HR Director– Employee Benefits
The Lubrizol Corporation
29400 Lakeland Boulevard
Wickliffe OH 44092

STATEMENT OF ERISA RIGHTS

Under the Employee Retirement Income Security Act of 1974 (ERISA), all Covered Persons will have the right to:

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls), all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, 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. No charge will be made for examining the documents at the Plan Administrator's principal office.

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

CONTINUE GROUP HEALTH COVERAGE

Covered Persons have the right to continue health care coverage if they experience a loss of coverage under the Plan as a result of a COBRA qualifying event. You or Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "fiduciaries" of this Plan, have a duty to do so prudently and in the interest of all Plan participants.

NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

ENFORCING COVERED PERSONS' RIGHTS

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

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within 30 days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 per day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting their rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

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

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post-tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as, a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

ABA / IBI / Autism Spectrum Disorder Therapy means intensive behavioral therapy programs used to treat Autism Spectrum Disorder. These programs are often referred to as Intensive Behavioral Intervention (IBI), Early Intensive Behavioral Intervention (EIBI), or Applied Behavior Analysis (ABA). These interventions aim to reduce problem behaviors and develop alternative behaviors and skills in those with Autism Spectrum Disorder. In a typical therapy session, the Child is directed to perform an action. Successful performance of the task is rewarded with a positive reinforcer, while noncompliance or no response receives a neutral reaction from the therapist. For Children with maladaptive behaviors, plans are created to utilize the use of reinforcers to decrease problem behavior and increase more appropriate responses. Although once a component of the original Lovaas methodology, aversive consequences are no longer used. Parental involvement is considered essential to long-term treatment success; parents are taught to continue behavioral modification training when the Child is at home, and may sometimes act as the primary therapist.

Accident means an unexpected, unforeseen, and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, or to treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Advanced Imaging means the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology such as MRA, MRI, CT, or PET scans and nuclear medicine.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation, or when deemed Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Refer to the Protection from Balance Billing section of this SPD for the No Surprises Act requirements specific to air ambulance.

Ancillary Services means services rendered in connection with care provided to treat a medical condition whether scheduled or unscheduled, including, but not limited to: surgery, anesthesia,

diagnostic testing, and imaging or therapy services. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency. With respect to the Protection from Balance Billing section, Ancillary Services means items and services provided by out-of-network Physicians at network facilities that are related to Emergency medicine, anesthesiology, pathology, radiology, neonatology, laboratory services, or diagnostic services; provided by assistant surgeons, hospitalists, and intensivists; or provided by an out-of-network Physician when a network Physician is not available.

Birthing Center means a legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's or Domestic Partner's Legal Guardianship; a Child of a Domestic Partner, a foster Child; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes the Employee, spouse, Domestic Partner, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, Domestic Partner's Children, stepchildren, and grandchildren.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to qualifying events.

Common-Law Marriage means a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

Cosmetic Treatment means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expense means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan. Details regarding Covered Expenses that are health care services subject to the federal No Surprises Act protections are provided in the Protection from Balance Billing section of this SPD.

Covered Person means an Employee or Dependent who is enrolled under this Plan.

Custodial Care means non-medical care given to a Covered Person, such as administering medication and assisting with personal hygiene or other Activities of Daily Living, rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve the condition of a Covered Person.

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see the Eligibility and Enrollment section of this SPD.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills. Developmental Delay may not necessarily have a history of birth trauma or other Illness that could be causing the impairment, such as a hearing problem, mental Illness, or other neurological symptoms or Illness.

Domestic Partner / Domestic Partnership means an unmarried person of the same or opposite sex with whom the covered Employee shares a committed relationship, who is jointly responsible for the other's welfare and financial obligations, who is at least 18 years of age, who is not related by blood, who maintains the same residence, and who is not married to or legally separated from anyone else.

In order for Your Domestic Partner to qualify as a Dependent, You and Your partner must complete a certification declaring that You and Your partner:

- Are in a relationship of mutual support, care, and commitment, and are responsible for each other's welfare;
- Have maintained this relationship for the past six months and intend to do so indefinitely;
- Have shared a primary residence for the past six months and intend to do so indefinitely;
- Are not married to anyone else and do not have other Domestic Partners;
- Are financially interdependent.

Durable Medical Equipment means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It is generally not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

A cochlear implant is not considered Durable Medical Equipment.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as their Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency means a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and applicable regulations.

Experimental, Investigational, or Unproven means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™, or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility means a facility including, but not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: provide 24-hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; require compensation from its patients; admit patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintain adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provide the services to which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Gender Dysphoria means a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Health Savings Account (HSA) means a tax-exempt account administered by a qualified HSA trustee or custodian, established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a Qualified High Deductible Health Plan (QHDHP), has no other impermissible coverage under IRS rules, is not entitled to benefits under Medicare, and is not claimed as a Dependent on another person's tax return. See Qualified High Deductible Health Plan (QHDHP).

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Home Health Care means a formal program of care and intermittent treatment that is: performed in the home; prescribed by a Physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician that is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours per day, 7 days per week; is certified by Medicare as a Hospice Care Agency; and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services, medical social worker services, psychological and dietary counseling, Physician services, physical or occupational therapy, home health aide services, pharmacy services, and Durable Medical Equipment.

Hospital means a facility that:

- Is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, the term "Hospital" also includes Surgical Centers and Birthing Centers licensed by the states in which they operate.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer, and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital. A person is not Inpatient on any day on which they are on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas, including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Manipulation means the act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

Maximum Benefit means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

Medical Specialty Medications (including gene therapy and CAR-T therapy) means Prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Medical Specialty Medications often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, substance use disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and

- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, disease, or symptoms; and
- Clinical factors used when reviewing Medical Necessity for specialty drugs may include review of the progress in use or therapy as compared to other similar products or services, Site of Care, relative safety or effectiveness of specialty drugs, and any applicable prior authorization requirements.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

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

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Mental Health Disorder means a syndrome that is present in an individual and that involves clinically significant disturbance in behavior, emotion regulation, or cognitive functioning. These disturbances are thought to reflect a dysfunction in biological, psychological, or developmental processes that are necessary for mental functioning.

Multiple Surgical Procedures means that more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliance means a brace, splint, cast, or other appliance that is used to support or restrain a weak or deformed part of the body, that is designed for repeated use, that is intended to treat or stabilize a Covered Person's Illness or Injury or improve function, and that is generally not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services, or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who performs services payable under this Plan: a doctor of medicine (MD); doctor of medical dentistry, including an oral surgeon (DMD); doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); doctor of optometry (OPT). Subject to the limitations below, the term "Physician" also includes the following practitioner types: physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which they practice, the services being provided are within their scope of practice, and the services are payable under this Plan.

Placed for Adoption / Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means LUBRIZOL CORPORATION Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom it is prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive / Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive / Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive / Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

For a Qualified High Deductible Health Plan (QHDHP), Preventive / Routine Care means care consistent with IRS Code §223(c)(2)(c) and as listed in the Schedule of Benefits, that may be paid by a QHDHP without the Covered Person satisfying the minimum Deductible under the Plan.

Primary Care Physician means a Physician engaged in family practice, general practice, non-specialized internal medicine (i.e., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology, or the treatment of mental health/substance use disorders, or a Physician assistant / nurse practitioner regardless of specialty or practice type. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat Children.

Private Duty Nursing (PDN) means continuous and skilled care by a registered nurse (RN) or licensed practical nurse (LPN) under the direction of a qualified practitioner for a medical condition that requires more than four continuous hours of skilled care that can be provided safely outside of an institution. It does not include care provided while confined at a Hospital, Extended Care Facility, or other Inpatient facility; care to help with Activities of Daily Living, including, but not limited to, dressing, feeding, bathing, or transferring from a bed to a chair; or Custodial Care.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified High Deductible Health Plan (QHDHP) means a health plan that meets the IRS requirements of a High Deductible Health Plan with respect to Deductibles and out-of-pocket amounts for the purpose of being able to contribute to a Health Savings Account (HSA). See Health Savings Account (HSA).

Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which they are practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

Recognized Amount means, in the Plan's determination of the allowed amount payable for covered services subject to Protection from Balance Bills, the amount on which Co-pays, Plan Participation, and applicable Deductibles are based for the below covered health services when provided by non-network providers:

- Non-network Emergency health services.
- Non-Emergency covered health services received at certain network facilities by non-network Physicians, when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, the term "certain network facility" is limited to a Hospital (as defined in section 1861(e) of the Social Security Act), a Hospital Outpatient department, a critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act), and any other facility specified by the Secretary of Health and Human Services.

The amount is based on either:

- an All Payer Model Agreement if adopted,
- state law, or
- the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for air ambulance services provided by a non-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered health services that use the Recognized Amount to determine Your cost-sharing may be higher or lower than if cost-sharing for these covered health services was determined based upon a Covered Expense.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

Site of Care means the treatment location where services are rendered, for example, Outpatient Hospital, community office, ambulatory infusion site, or home-based settings.

Specialist means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians who are not considered Specialists include, but are not limited to, those specified in the definition of Primary Care Physician above.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.

Telemedicine means the clinical services provided to patients through electronic communications utilizing a vendor.

Temporomandibular Joint Disorder (TMJ) means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means, as determined by the Plan in its sole discretion:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is qualified by education, training, or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

Waiting Period means the period of time that must pass before coverage becomes effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan. Refer to the Eligibility and Enrollment section of this Plan to determine if a Waiting Period applies.

Walk-In Retail Health Clinics means health clinics located in retail stores, supermarkets, or pharmacies that provide a limited scope of preventive and/or clinical services to treat routine family Illnesses. Such a clinic must be operating under applicable state and local regulations and overseen by a Physician where required by law.

You / Your means the Employee.