Emory Health Care Plan
Summary Plan Description
Health Savings Account
(HSA) Health Plan



Effective as of January 1, 2026

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The purpose of this Summary Plan Description ("SPD") is to provide you with a summary of your Benefits and other important information under the Health Savings Account (HSA) Health Plan. Claims under this plan are administered by Aetna for the medical and behavioral health benefits and CVS/caremark for the pharmacy benefits. The plan qualifies as a High Deductible Health Plan and once enrolled you may participate in a Health Savings Account (HSA), provided you meet the IRS eligibility rules, and make payroll contributions to your HSA to an account administered by Aetna/PayFlex. This is one of the health plan options available in the Emory University Health Care Plan (the "Plan").

Aetna will administer the Plan in accordance with this SPD and apply policies and procedures which Aetna has developed to administer this Plan.

Important Notice

The HSA Health Plan is established by Emory voluntarily and may be amended or terminated at any time by Emory, in its sole discretion. Amendments may, among other things, affect eligibility, contribution rates, benefits coverage, reimbursement rates, procedures, participation, etc., at any time, regardless of whether the individual is participating in the benefit plans at the time of amendment. The Plan Administrator has the discretionary authority to interpret the provisions of the Plan and SPD, and its decisions are final and binding. Nothing in the SPD or the Plan gives, or is intended to give any person the right to be retained in Emory's employment or to interfere with Emory's right to terminate the employment of any person.

Each health plan option under the Plan, including this HSA Health Plan, also has a Summary of Benefits and Coverage (SBC). The SBCs are based on templates required by the Affordable Care Act ("ACA") which are intended to standardize the description of medical options so individuals can easily compare medical options. While the SBCs are concise "snapshots" of the options, they are not intended to take the place of your Summary Plan Description (SPD) or the official plan document. Nothing in an SBC makes you eligible for a health plan option or any medical benefits unless the official plan document and SPD provide for such eligibility or benefits. Your eligibility and benefits will only be determined in accordance with and subject to the official plan documents and the applicable SPD.

Due to a federal law (ACA), you also will be able to purchase health coverage for yourself and your family members through the Health Insurance Marketplace (otherwise known as an Exchange). If you purchase coverage through the Marketplace, you may be eligible for a premium tax credit to help pay for that coverage, but in most cases the tax credit is only available if your employer does not offer you coverage under a health plan that is "affordable" and provides "minimum value." Additional information about the coverage offered through the Marketplace and the tax credit that may be available to you is available in Emory's Marketplace notice which is available online. You may request a copy of this notice from Emory at any time, and one will be provided free of charge.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. The notice will describe how the Plan may use or disclose your health information and under what circumstances it may share your health information without your authorization (generally, to carry out treatment, payment, or health care operations). In addition, the notice will describe your rights with respect to your health information. Refer to the Plan's privacy notice for more information. You can obtain a copy of the notice by contacting the Emory University Benefits Department at 404-727-7613.

It is Emory's policy and intent to comply with all applicable provisions of ACA and HIPAA and the related regulations. Emory will investigate fully any complaint that it or the Plan has not complied with such laws and regulations and will take steps to remedy any violations should they occur. If you believe that the Plan has violated a provision of HIPAA or ACA, you are encouraged to share your complaint

with Emory by contacting the Emory University Benefits Department at 404-727-7613. Emory will not retaliate or otherwise discriminate against you if you assert a complaint or take any other action which is protected under HIPAA or ACA.

Effective Date: January 1, 2026

Eligibility

Employees

Your eligibility date, if you are then in an Eligible Class, is the effective date of this Plan. Otherwise, it is the date you start working for Emory or, if later, the date you enter the eligible class. You are in an Eligible Class for coverage under this Plan if you are:

- A regular full-time or half-time (at least 20 hours per week) employee of Emory.
- A temporary full-time employee on an assignment at Emory University scheduled for at least six consecutive months.
- An Emory retiree who has returned to work at least half-time (at least 20 hours per week).

Individuals classified in Emory's sole discretion as part-time temporary employees or full-time temporary employees scheduled to work less than six consecutive months, are not in an Eligible Class and are not eligible to participate in the Plan.

Dependents

If you elect coverage, your dependents may also be eligible for coverage. Eligible dependents include:

Your Legal Spouse
Spouse includes your opposite sex or same sex spouse to whom you are legally married. This does not include registered domestic partnerships, civil unions or similar formal relationships recognized under state law.

Your Child
Child includes your natural or adopted child. Also a child in the process of being adopted, step-child or any child for whom you have legal custody.

A child is eligible:

- Up to age 26; or
- Regardless of age, if fully disabled and unmarried, provided he or she became fully disabled either:
  - Prior to age 19; or
  - Between the ages of 19 and 26, if that child was covered by the Plan when the disability occurred.

Your child is fully disabled if:

- He or she is not able to earn his or her own living because of mental or physical disability which started prior to the date he or she reached the maximum age for dependent children; and
- He or she depends chiefly on you for financial support and maintenance

Proof that your child is fully disabled must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age for eligibility (or within 31 days of your employment, if later).

Coverage for a fully disabled child will cease on the first to occur of:

- Cessation of the disability;
- Failure to provide proof to the Plan Administrator that the disability continues;
- Failure to have any exam required by the Plan Administrator; or
- Termination of dependent child coverage for any reason other than reaching the maximum age for eligibility.

Emory will have the right to require proof of the continuation of the disability. Emory also has the right to have your child examined as often as needed while the disability continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age for dependent coverage.

Your Surviving Spouse and/or Child(ren)

Emory University
The spouse may continue to participate in the medical plan at the active employee rate to age 65, if an employee dies and has at least 10 years of service and is at least 55 years old. If the employee was eligible to retire with medical benefits, the spouse may remain on the active employee plan until age 65 and then move to the Post-65 Retiree Health Reimbursement Arrangement (HRA) plan. Children may remain on the plan until age 26. Only eligible dependents covered prior to the employee's death may continue coverage.

If upon death, an employee does not meet the 10 years of service and 55 years of age eligibility criteria, the spouse and/or child(ren) may continue to participate in the medical plan under COBRA. Emory will subsidize the COBRA premium for six months.

Emory Healthcare
If an employee dies and at time of death met the grandfathered retiree benefits eligibility rules listed below, the covered spouse and child(ren) may enroll for the retiree Pre-65 POS plan or Post-65 Retiree HRA plan. If covered spouse is under age 65 at time of employee's death & enrolls for the Pre-65 POS plan, then they would move to the Post-65 Retiree HRA plan until his/her death. Children may remain on the plan until age 26 unless disabled (see eligibility for Children). If upon death, an employee does not meet the grandfathered retiree benefits eligibility rules the spouse and/or child(ren) may continue to participate in the medical plan under COBRA.

Retiree Coverage

Retiree Medical Coverage for Emory University Employees
To be eligible for the grandfathered retiree medical plan, an employee must be employed at Emory University on the payroll, in a benefits eligible position prior to January 1, 2003. In addition, an employee (and covered dependents) must be covered by the Emory University Health Care Plan on the date of his/her retirement and satisfy the applicable age and service requirements.

Retiree Medical Eligibility Rules for Emory Healthcare Employees
To be eligible for the grandfathered retiree medical plan an employee (and covered dependents) must be enrolled at the time of retirement and meet the following criteria:

- Employed at Emory University Hospital or Emory University Hospital Midtown on the payroll in a benefits eligible position prior to December 21, 2002;

- Have been covered by the Emory Healthcare Medical Plan at time of retirement;
- Minimum 55 years of age;
- 10 or more years of consecutive benefits eligible service;
- Meet "Rule of 75", defined as current age + years of service equals at least 75; and
- No breaks in benefits eligible service since December 21, 2002.

If a retiree medical eligible employee moves to a PRN, Registry or part-time position that is non–benefits eligible, the employee will lose his/her eligibility for the EHC retiree medical plan.

Retiree Medical Coverage for Emory Clinic Staff

To be eligible for Pre-65 retiree medical coverage, you (and covered dependents) must be enrolled at the time of retirement and meet the following criteria:

- Employed at Emory Clinic on the payroll in a benefits eligible position prior to July 1, 1983;
- Have been covered by the Emory Healthcare Medical Plan at time of retirement;
- Minimum 55 years of age;
- 20 or more years of consecutive benefits eligible service, or at least 60 years of age with 15 or more consecutive years of benefits eligible service;
- Meet "Rule of 75," defined as current age + years of service equals at least 75; and
- No breaks in benefits eligible service since July 1, 1983.

If a retiree medical eligible employee moves to a PRN, Registry or part-time position that is non–benefits eligible, the employee will lose his/her eligibility for the Emory Healthcare retiree medical plan.

Retiree Medical Coverage for Grandfathered Dekalb Retiree

To be eligible for retiree medical coverage, you (and covered dependents) must be enrolled in the Emory Healthcare Medical Plan at the time of retirement and meet the following criteria:

- Employed by DeKalb Medical on the payroll in a benefits eligible position prior to January 1, 2003;
- Have been covered by a medical plan at the time of retirement;
- Minimum 55 years of age AND minimum 10 years of service;
- Must be a participant in the Pension Plan;
- Age and credited years of service must equal 70; and
- May not have any breaks in benefits eligible service since January 1, 2003.

You will also be eligible if you retired from DeKalb Medical prior to September 9, 2018, and you were receiving retiree medical benefits from DeKalb Medical on September 8, 2018, and you have maintained retiree medical benefits as required by the terms of the plan.

Note: Wesley Woods Center, Emory Johns Creek Hospital, Emory Saint Joseph's Hospital, and Emory Specialty Associates retirees are not eligible for retiree medical benefits.

Retiree and Covered Participants

Enrollees who are in an eligible retiree class and are age Pre-65 [including their child(ren) and/or Pre-65 spouses] will have a ***one-time opportunity*** to elect continuation of health coverage under the POS Health Care Plan. The retiree and/or spouse/surviving spouse of such retirees, may not add any new dependents. Only those dependents enrolled at the time of retirement are eligible for coverage under this or any Emory plan. **If retiree medical coverage is waived, coverage cannot be elected at a later date.**

At age 65, **eligible** retirees and/or spouses who elected to continue coverage under the POS Health Care Plan, will transition to the Emory Post-65 Retiree Health Reimbursement Arrangement (HRA) Plan. Eligible child(ren) may remain covered under the POS Health Care Plan. See Retiree HRA Plan Document for more detailed information.

Important Note: No person may be covered both as an employee and dependent of another employee and no person may be covered as a dependent of more than one employee of Emory.

Enrolling Ineligible Individuals

It is your responsibility to report a change in a spouse's or dependent's eligibility. Premiums paid in error due to your delay in reporting a change in eligibility will not be refunded. If the wrong birth date of a child is entered on an application, the child has no coverage for the period for which he or she is not legally eligible. Your and your dependents' Plan coverage may also be terminated or suspended for engaging in misrepresentation or fraud against the Plan, including filing or participating in filing a false, misleading or fraudulent claim for benefits, allowing your ID card to be used by an individual who is not enrolled in the Plan, providing false or misleading information regarding a spouse or dependent, enrolling an individual who does not satisfy the eligibility criteria or failing to timely drop an enrolled individual when he/she no longer satisfies the eligibility criteria.

Emory reserves the right to audit at any time the status of your enrolled spouse and dependent children to determine if they meet the eligibility criteria. During an audit, you may be required to provide proof of eligibility. If you cannot provide sufficient proof that an enrolled individual meets the eligibility criteria, he/she will be dis-enrolled from the Plan, possibly retroactively.

If Emory determines that misrepresentation has occurred, it may also terminate or suspend your coverage, require repayment of the ineligible individual's prior claims, require payment of the total value of the ineligible individual's coverage or take other corrective action.

If you or a dependent has been classified by Emory as ineligible and you or your dependent are reclassified into an eligible class, either by an action of the employer, Plan Administrator, or a governmental or judicial authority, you or your dependent will be eligible to participate only prospectively following such reclassification, assuming all other eligibility requirements are met.

Enrollment Procedure

Enrolling is easy and available 24 hours a day via Employee Self-Service or e-Vantage through your employer's homepage. You must enroll within 31 days of your eligibility date. If you miss the enrollment period, you will not be able to enroll in the plan until the next annual enrollment period, unless you qualify under a Family Status Change or a Special Enrollment Period, as described below. Elections made during annual enrollment are effective the following January 1.

Newborns are automatically covered for 31 days after birth, if the mother is covered under the plan. To continue coverage after 31 days, you must enroll the child under the Family Status Change or Special Enrollment right provisions.

You and Emory share the cost of your health care coverage. By electing coverage under the Plan, you are also electing to have your contributions deducted from your pay on a pre-tax basis through the cafeteria plan. If the cost of coverage changes, your deductions will be automatically adjusted accordingly. Contributions depend on the coverage you choose. You will receive information on your contributions when you enroll via Employee Self Service or e-Vantage.

Annual Enrollment

Once you enroll for coverage under this Plan, the coverage will remain in effect unless you make a change during annual enrollment or you have a family status change or other special enrollment right which would allow you to change your coverage as described below. Changes made during annual enrollment will be effective January 1 of the year following the enrollment.

Family Status Changes

A family status change is an event that may allow you to change your election for this Plan during the middle of the year. If one of the situations below applies, you may enroll or change your election within 31 days of the event. To be allowed, the event must affect eligibility for the type of coverage that you wish to change, and your election change must be consistent (under IRS rules) with the event that has occurred. If you do not enroll or make a change within 31 days of the event, you will not be able to enroll or make a change until the next annual enrollment period.

> **Extenuating Extreme Circumstances:** If the Plan Administrator determines that you failed to enroll your new dependent(s) within this 31-day period on account of extreme and compelling circumstances, such as the death or serious medical condition of an immediate family member which occurs during this 31-day period, you may be given additional time to enroll your new dependent(s), but no more than an additional forty-four (44) days. If you are allowed to enroll your new dependents (or yourself and your new dependents) during this special late enrollment event (after 31 days), coverage will be effective only prospectively from the date the election change request is submitted (it will not be retroactive). For additional information, you should contact the Benefits and Work Life Department at 404-727-7613 or via email at hrbenef@emory.edu. Submission of pertinent documentation will be required.

Family status changes include:

- Your marriage, divorce, or annulment;
- Birth of your child;
- Placement with you of a foster child or child for adoption;
- A change in the employment of your spouse or dependent, which affects his or her benefits eligibility, including termination or commencement of employment or a change in worksite;
- An event that would make a dependent child no longer eligible for coverage, such as his or her 26th birthday; or
- The death of your dependent.

Special Enrollment

If one of the situations below applies, you may enroll yourself and/or your eligible dependents within 31 days of the event. If you do not enroll within 31 days of the event, you will be not able to enroll until the next annual enrollment period. When you have a special enrollment right, if you are already enrolled and are adding a dependent, you may also change medical options at that time.

Loss of Other Health Care Coverage

You or your dependents may qualify for a special enrollment period if you did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time you or your dependents were covered under other creditable coverage. You may enroll within 31 days of losing other creditable coverage because of one of the following:

- Termination of the other plan;
- Loss of eligibility under the other plan (such as due to termination of employment);
- Death, divorce or legal separation;
- The contributions by another employer for the coverage terminated;
- COBRA coverage period ends (this does not include voluntarily dropping COBRA coverage before the maximum COBRA period ends); or
- For other reasons identified by the Department of Labor in its regulations relating to special enrollment rights.

If you or your dependent lost the other coverage because of a failure to pay the required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan), there is no special enrollment right.

Marriage or Acquisition of a New Dependent

Your marriage or your acquisition of a new dependent through birth, adoption or placement for adoption also triggers a special enrollment right, which allows you to enroll yourself, your spouse, and your eligible dependents in the Plan within 31 days of that event. Election changes requested within 31 days due to birth, adoption or placement for adoption are effective on the date of the birth, adoption, or placement for adoption. See above for a special rule relating to Extenuating Extreme Circumstances.

Medicaid and SCHIP

If you or your eligible dependent (1) becomes eligible for state-granted health premium assistance or (2) loses health coverage under Medicaid or the State Children's Health Insurance Plan (known as SCHIP or CHIP), you will have a separate enrollment right. You can request coverage within 60 days of either of these two events (instead of the 31-day rule that applies for the other events).

Other Events Which May Entitle You to Mid-Year Changes

In addition to the family status changes and special enrollment rights mentioned above you may also have the right to change your coverage within 31 days of the event if one of the following events occurs:

- The employer sponsored cafeteria plan or benefit plan in which your spouse or dependent participates has a different period of coverage than this Plan and your spouse or dependent makes coverage changes under his or her plan based on that coverage period; in this case, you will be allowed to make changes under this Plan consistent with the election of your spouse or dependents effective when their new coverage election takes effect.

- There is a significant increase in the cost of coverage for the option you have selected, and you wish to switch to another option for the remainder of the year. Special rules (discussed in the Transfers between Entities section on page 14) apply to election changes when you transfer your employment between entities.

Making a Mid-Year Change

If you have a family status change, special enrollment right or another event that entitles you to make mid-year changes, you have 31 days from the date of the event to change your coverage (except for the special rule that applies for SCHIP, as explained above). Your changes must be consistent with your changes in family status or special enrollment right or other event, and must be approved by the Plan Administrator. Permitted changes may include changing your coverage tier and, if the event is marriage, birth, adoption/placement for adoption or divorce, changing your medical plan option. You may also change your medical plan option if you are adding a dependent on account of a special enrollment event. As you decide what change is right for you, keep in mind that, even if you change your medical plan option, you are not allowed to change the type of health care spending account that you have (e.g., general purpose or limited purpose).

> For example, if you are married and elect family coverage that covers your spouse and your only child, and your child turns 26 and no longer qualifies as a dependent, you may change your coverage to employee and spouse, but not to employee only or no coverage. You could also move from the POS Plan or the Kaiser Permanente Plan to the high deductible/HSA Plan, but you will not be able to move from a general-purpose health flexible spending account to a limited purpose health flexible spending account plan. This means that you will not be eligible to contribute to a health savings account until the following year (assuming you are eligible at that time).
>
> For example, if you are married and elect family coverage that covers your spouse and your only child and you divorce, you may change your coverage to employee plus child, but not to employee-only or no coverage. You could also move from the high deductible/HSA Plan to the POS Plan or the Kaiser Permanente Plan, but you will not be able to move from a limited purpose health flexible spending account to a general-purpose health flexible spending account plan until the beginning of the following plan year.

For additional information regarding making changes to your health flexible spending account election mid-year, you should refer to the summary plan description for the Emory University Beneflex Plan.

Transfers between Entities

Employees who transfer employment between companies (e.g., Emory University to Emory Healthcare, or vice versa) cannot change their election to participate in the HSA Health Plan, the POS Health Plan, or the Kaiser Permanente Plan on account of the transfer even if the cost of coverage increases or decreases. This means that if you transfer your employment you may not (1.) move from the HSA Health Plan, to the POS Health Plan or the Kaiser Permanente Plan (or vice versa), (2.) change your coverage tier (e.g., move from family to single), or (3.) enroll in the HSA Health Plan, the POS Health Plan or the Kaiser Permanente Plan if you declined to enroll previously.

Health Savings Account Contributions

If you are a participant in the HSA Health Plan and you qualify as an eligible individual under rules that apply under federal tax law, you may elect to make pre-tax salary reduction contributions to a Health Savings Account (HSA) established in your name.

An HSA is a special type of savings account that you can use to pay your eligible medical expenses on a pre-tax basis, including amounts that are counted towards the deductible for the HSA Health Plan. An HSA account is established at a financial institution in your name and is portable if your employment changes. Emory does not set up this HSA account for you. You must complete the required process for setting up an HSA account within the required time period. Your HSA grows through the contributions you make to this account. Any remaining balance at the end of the year rolls over to be available in the

next calendar year. If you want to contribute to an HSA, it is important to enroll in your HSA as soon as you enroll in the HSA Health Plan. Expenses incurred prior to the date on which the financial institution opens your HSA cannot be reimbursed tax-free from your HSA account.

You may change your election to contribute pre-tax to an HSA at any time by submitting a new election in the time and manner directed by Emory. Your election change must be prospective and shall take effect with the first payroll period following the date that it is approved.

If you have enrolled in the HSA Health Plan and you have established an HSA, Emory may make contributions to your HSA each year. These amounts, if any, are described in the enrollment materials. Any limits on the amount that you may contribute to your Health Savings Account will be determined by Emory and announced to participants from time to time. Health Savings Account contributions also are subject to limits that apply under the Internal Revenue Code and Emory may limit the amount you may contribute to your Health Savings Account through the Plan if it appears that contributions to the HSA exceed any limit that applies to you. However, you are responsible for making sure you do not exceed the annual limit on HSA contributions that applies to you.

To be an "eligible individual" for purposes of HSA contributions, you must meet the following criteria:

- Must be covered under a qualifying HDHP, such as the HSA Health Plan.
- May not be covered under any other non-HDHP "disqualifying" health coverage. Examples of disqualifying coverage include:
    - Coverage under a spouse's or parent's health insurance coverage unless it is a qualifying HDHP coverage;
    - Access to your spouse's full-purpose flexible spending account (FSA) (even if you do not request reimbursement);
    - Access to your spouse's health reimbursement arrangement (HRA) which covers pre-deductible medical expenses (even if you do not request reimbursement); and
    - Medicare and TRICARE coverage.
- May not be claimed as a dependent on someone else's tax return.

If you are covered under Medicare, you are not an eligible individual and you may not receive or make HSA contributions through the Plan. If you plan to retire this year, you should talk to your advisor about how your retirement will affect your eligibility to contribute to an HSA. Whether you are an eligible individual is determined on a monthly basis. If you have any questions about whether any other coverage you have disqualifies you from being an "eligible individual," please contact the Emory University Benefits Department at 404-727-7613. However, keep in mind that Emory cannot give you legal or tax advice, and it is your responsibility to determine if you are eligible.

Your HSA is considered your property and is not an employer-sponsored plan. Payments provided through your HSA are not provided under this Plan and are not subject to the federal law known as ERISA or to the claims procedures described in this SPD. The ERISA Rights section of this SPD does not apply to these benefits.

Effective Date of Coverage

Employees

Your coverage will take effect on the later to occur of:

- Your date of hire (if you are eligible right away); or

- The date you became eligible (for example, if you worked fewer than 20 hours per week and transfer to a position in which you work at least 20 hours per week).

If you do not elect coverage within 31 days of your eligibility date, you will not be eligible to enroll in coverage until the next annual enrollment period unless you have a family status change or another event that entitles you to make a mid-year change.

Dependents

Coverage for your dependents will take effect on your eligibility date if you have properly enrolled each such dependent within 31 days from your eligibility event. You must report any new dependents, and provide the required information in a timely manner, for that dependent to be covered, even if it does not affect your required contributions for coverage. If you do not enroll dependents within 31 days of any dependent's eligibility date, you will not be able to enroll them until the next annual enrollment period unless there is a family status change or other event that entitles you to make a mid-year change (or unless you apply under the Extenuating Extreme Circumstances provision described above).

Child Who Must Be Covered Due to a Qualified Medical Child Support Order (QMCSO)

Emory will extend group health benefits to an employee's non-custodial child(ren) as required by a qualified medical child support order. Dependent coverage will become effective as soon as administratively possible. Important Note: As legally defined, upon receipt of a qualified order, Emory will enroll a non-custodial child(ren) and the employee (if not enrolled) without employee consent.

A QMCSO is an order or judgment from a court or administrative body that directs a health plan to cover a child of a participant under the plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Plan's procedure for determining if the order is valid. Coverage under the Plan pursuant to a medical child support order will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or would like to receive a copy of the written procedure for determining whether a QMCSO is valid, you should contact the Plan Administrator.

Termination of Coverage

Your current coverage under the Plan will end on the last day of the month in which one of the following events occurs:

- You are no longer employed by Emory (unless you qualify and enroll as a retiree, and make the required payments);
- You lose your eligibility under the Plan; including on account of a reduction in hours;
- You revoke your election for coverage (which generally must be made prospectively) provided such revocation is otherwise permitted under the terms of the Plan; or
- You stop paying for your coverage.

Your coverage will also terminate on the date on which the Plan is terminated or amended to exclude coverage for you or the class in which you are a member.

Your dependent's coverage will end on the last day of the month that:

- Your coverage ends;
- You die;
- Your dependent loses his or her eligibility under the Plan, including on account of a divorce or your Dependent child aging out of the Plan; or
- The effective date of any election you make to revoke your Dependent's coverage (which generally must be made prospectively) provided such revocation is otherwise permitted under the terms of the Plan.

Note: If you stop making contributions, your coverage will end on the last day of the month for which a full contribution was credited.

In certain situations, you and/or your Dependent may be eligible to elect to continue your coverage under the Plan when it is lost for one or more of the reasons described above. For additional information, you should review the section of this SPD titled "Continuation of Group Health Plan Coverage."

Rescission of Medical Coverage

Once your Plan coverage is effective, your medical coverage cannot be rescinded unless you or a covered dependent performs an act, practice or omission that constitutes fraud or unless you or a covered dependent makes an intentional misrepresentation of a material fact. A rescission is a cancellation, discontinuance or termination of medical coverage that has a retroactive effect. The Plan will provide you at least 30 days' advance written notice if your medical coverage will be rescinded. Any rescission of medical coverage is subject to the Claims and Appeals procedures. For this purpose, the following are treated as intentional misrepresentation or fraud (unless prohibited by applicable law):

- Providing Emory, the Plan Administrator or the Plan with false or misleading information regarding a spouse or dependent child (e.g., incorrect name or social security number);
- Enrolling an individual who does not satisfy the eligibility criteria;
- Failing to timely drop an enrolled individual when he/she no longer satisfies the eligibility criteria (e.g., following divorce);
- Filing or participating in filing a false or misleading claim for benefits;
- Allowing your ID card to be used by an individual who is not enrolled in the Plan; or
- Any other act, practice or omission that constitutes intentional misrepresentation or fraud as determined by the Plan Administrator (unless prohibited by applicable law).

However, the rescission rules described above do not apply in the following situations:

- If you fail to timely pay required contributions towards the cost of your coverage, your coverage can be terminated retroactively; or
- If your coverage is terminated prospectively; or
- As otherwise permitted by law.

Plan Summary

2026 HSA Medical Plan Summary	Tier 1	Tier 2	Tier 3*
Deductible	***The amounts in this chart represent the member's responsibility***		
Single	$1,700	$1,950	$2,900
Family[2]	$3,400	$3,850	$5,800
Out-of-Pocket Maximum[1]			
Single	$3,750	$5,500	$11,500
Family	$7,500	$11,000	$23,000
Aggregate	Yes	Yes	Yes
Physician Fees (Primary Care Office or Telemedicine Visits) Includes services of an internist, general physician, family practitioner, dermatologist, and/or allergist	15% after deductible	25% after deductible	50% after deductible
Pediatrician and Behavioral Mental Health Office Visits	15% after deductible	25% after deductible	50% after deductible
Physician Fees (Specialist)	15% after deductible	25% after deductible	50% after deductible
Routine Preventive Care[3]			
Routine Adult Physical Exams including immunizations (One exam per calendar year age 18 and over)	Plan Pays 100%	Plan Pays 100%	50% after deductible
Routine Preventive GYN Exams (one visit per calendar year; includes pap smear and related lab fees)	Plan Pays 100%	Plan Pays 100%	50% after deductible
Routine Preventive Child Exams including immunizations	Plan Pays 100%	Plan Pays 100%	50% after deductible
Routine Cancer Screening Expenses (includes routine rectal exam/prostate-specific antigen test for covered males)	Plan Pays 100%	Plan Pays 100%	50% after deductible
Routine Mammogram Expenses for covered females	Plan Pays 100%	Plan Pays 100%	50% after deductible
Flu Shots	Plan Pays 100%	Plan Pays 100%	50% after deductible
Urgent Care	15% after deductible	25% after deductible	50% after deductible
Emergency Room Treatment – Emergency Care	15% after deductible	25% after deductible	25% after deductible
Ambulance Services	15% after deductible	25% after deductible	50% after deductible
Outpatient Hospital Expenses (includes facility fee and ambulatory surgery center)	15% after deductible	25% after deductible	50% after deductible
Physician/Surgeon Fees for Outpatient Surgery	15% after deductible	25% after deductible	50% after deductible
Hospital Expenses – Inpatient Coverage (i.e. hospital room, facility fee, physician/surgeon fee)	15% after deductible	25% after deductible	50% after deductible
Pre-Admission Testing Office Visit	15% after deductible	25% after deductible	50% after deductible
Physician Fees for Routine Eye Exam Expenses (1 exam per 12 months) Non-surgical Office[3]	Plan Pays 100%	Plan Pays 100%	50% after deductible
Physician Fees for Routine Hearing Exams (1 exam per 24 months)[3]	Plan Pays 100%	Plan Pays 100%	50% after deductible

*Amounts applied to the deductible and out-of-pocket maximum will be limited to the Reasonable and Customary Charge (also referred to as recognized charge) or the Facility Charge Review Rate.

[1]Out-of-pocket maximum includes the deductible and most coinsurance amounts. When covering more than one person, the ***Individual*** out-of-pocket maximum applies for the first member. Once the entire ***Family*** out-of-pocket maximum is met by the remaining members, the plan begins to pay 100% of the allowed amount for covered services for all other members.
[2]Family deductible applies when Employee+Spouse, Employee+Children or Family level coverage is elected.
[3]**ONLY** Routine Preventive Care services at the Tier 1 or Tier 2 level are covered at 100% under the plan. Diagnostic services are subject to the deductible and coinsurance.

2026 HSA Medical Plan Summary	Tier 1	Tier 2	Tier 3*
Other Covered Medical Expenses			
Convalescent / Skilled Nursing Facility Expenses (120-day maximum, prior hospital confinement not required)	15% after deductible	25% after deductible	50% after Deductible
Home Health Care Expenses (up to 120 visits per calendar year)	15% after deductible	25% after deductible	50% after Deductible
Hospice Care Expenses (Inpatient or Outpatient, no limit or dollar maximum)	Plan Pays 100% after deductible	Plan Pays 100% after deductible	50% after Deductible
Gene Based, Cellular and Other Innovative Therapies (GCIT)	75% after deductible	75% after deductible	No Coverage
Short-Term Rehabilitation / Outpatient Therapy (Coverage is limited to 90 visits combined for Speech, Physical or Occupational therapies, including Outpatient Hospital Facility Services.)	15% after deductible	25% after deductible	50% after Deductible
Habilitation Services	15% after deductible	25% after deductible	50% after deductible
Chiropractic Care / Spinal Manipulation (Limited to 20 visits per calendar year)	15% after deductible	25% after deductible	50% after Deductible
Durable Medical and Surgical Equipment (includes hearing aids for children up to age 26, when medically necessary; one per ear, per 24 month maximum)	15% after deductible	25% after deductible	50% after Deductible
Acupuncture	15% after deductible	25% after deductible	50% after deductible
Allergy Testing	15% after deductible	25% after deductible	50% after deductible
Allergy Serum and Injections	15% after deductible	25% after deductible	50% after deductible
Family Planning			
Maternity - Initial Visit and Post Natal Care (except as covered as preventive care) Inpatient Care (including physician's cost for delivery)	15% after deductible	25% after deductible	50% after deductible
Vasectomy, Tubal Ligation and Voluntary Abortion**	15% after deductible	25% after deductible	50% after deductible
Infertility Expenses, Therapy, and Treatment (includes both Comprehensive and Advanced Reproductive Technology services)	15% after deductible	25% after deductible	50% after deductible
Combined medical and pharmacy lifetime maximum up to $25,000	Coverage based on type of service and where services are rendered***		
Labs and Imaging			
Non-preventive independent or outpatient labs*:* Diagnostic test (blood work)	15% after deductible	25% after deductible	50% after deductible
Complex Imaging (X-rays, MRI, CAT and PET scan) Outpatient or free-standing facility	15% after deductible	25% after deductible	50% after deductible
Behavioral Health Benefits			
Outpatient Treatment Includes telemedicine visits, psychiatry, psychology, and other licensed behavioral health providers; out-of-network is covered at the in-network level	15% after deductible	25% after deductible	25% after deductible
Inpatient Treatment (precertification required for Tier 3 or $750 penalty applies)	15% after deductible	25% after deductible	50% after deductible

*Amounts applied to the deductible and out-of-pocket maximum will be limited to the Reasonable and Customary Charge (also referred to as recognized charge) or the Facility Charge Review Rate.

**Voluntary abortions are excluded for the following groups: Emory/Saint Joseph's, Inc., Saint Joseph's Hospital of Atlanta, Inc., and The Medical Group of Saint Joseph's, LLC.

***Infertility services performed at an Emory Healthcare facility are covered at **Tier 1**; Services performed at Institute of Excellence facilities (Aetna designated IOE facilities) are covered at **Tier 2**; and All other non-IOE Aetna contracted facilities and out-of-network are paid at **Tier 3**.

Prescription Drug Expense Coverage

The Prescription Drug benefit is administered by CVS/caremark. To locate a Preferred Pharmacy, visit https://www.caremark.com/wps/portal or call CVS/caremark at 1-866-601-6935.

This Plan uses a drug formulary, which is a list of medications that are covered under this Plan. The drug formulary is reviewed to ensure it includes medications for most medical conditions and includes many:

- Federal Legend Drugs
- State Restricted Drugs
- Insulin
- Needles, syringes and over-the counter-diabetic supplies
- Weight Loss Drugs

All covered medications are categorized into five tiers, and each tier has a different coinsurance amount. Your cost (up to the retail maximum) depends on which coverage tier your medication is located in.

Tier Zero – Select generic medications used to treat diabetes, congestive heart failure, high blood pressure, and high cholesterol; Select brand-name medications and generic smoking deterrents; and single source brand and generic forms of birth control.

Tier One – Generic drugs not included in Tier Zero; brand-name medications; all preferred brand medications used to treat diabetes, congestive heart failure, high blood pressure and high cholesterol; and all insulin drugs.

Tier Two – Non-preferred brand drugs used to treat diabetes, congestive heart failure, high blood pressure, and high cholesterol; brand-name medications used to treat other health conditions; and all other preferred brand drugs for other conditions.

Tier Three – Non-Formulary brands; and other non-preferred brand-name medications.

Tier Four – Personal choice brand-name medications.

Type of Drugs	Tier	Coinsurance*	30-Day Retail Maximum
Preventive Prescriptions Drugs (Not subject to deductible) and **Non-Preventive Prescription Drugs** (After meeting deductible)	Tier Zero	-0-	-0-
	Tier One	10%	$25
	Tier Two	20%	$75
	Tier Three	30%	$120
	Tier Four	40%	$150

*90-Day mail order prescriptions are subject to the coinsurance amount. The cost, depending on the coverage tier, is up to 2.5 times the retail maximum amount.

Maintenance Prescriptions

Maintenance medications are commonly used to treat a chronic or long-term condition and require regular, daily use. Examples include drugs used to treat high blood pressure, heart disease, asthma, and diabetes. Some birth control and tobacco cessation medications are also considered maintenance drugs.

Under the Plan, all maintenance prescription drugs must be filled in one of five ways:

- Through CVS/caremark's mail-order service:

- At a CVS retail pharmacy location (at the mail-service cost);
- At a Target retail pharmacy location (at the mail-service cost);
- At an Emory pharmacy (at the mail-service cost); or
- At a Costco, Kroger, and several independent pharmacies (effective April 1, 2024)

After the 2nd fill, participants will be charged the full retail cost if a 90-day prescription is not filled at a CVS/caremark, Target, or Emory pharmacy. Note: To locate other in-network pharmacies online, you may access https://www.caremark.com/pharmacylocator.

Preventive Care Medications under the Affordable Care Act (ACA)

To the extent required by federal law, some preventive care drugs (as determined by CVS/caremark) are covered and are not subject to a copay. Preventive care drugs include, in certain circumstances, drugs that can be purchased over-the-counter, like aspirin and iron supplements, but only if they are prescribed by a healthcare provider. It also includes certain types of contraceptives, such as barrier methods (e.g., diaphragms and sponges), hormonal methods (e.g., birth control pills and vaginal rings), implanted devices and emergency contraception. To be covered without a copay, the contraceptive must be a generic contraceptive (or brand-name contraceptive if a generic is not available or if the brand name is medically necessary).

For a list of current preventive care drugs, contact CVS/caremark.

Limitations

No Benefits are paid under this section for:

- Any drug entirely consumed at the time and place it is prescribed;
- Any drug provided by or while the person is a patient in any health care facility or for any drug provided on an outpatient basis in any health care facility to the extent Benefits are paid for it under any other part of this Plan or under any other medical or Prescription Drug expense benefit Plan carried or sponsored by Emory;
- Any drugs which do not, by federal or state law, require a prescription order (i.e. an over-the-counter (OTC) drug), even if a prescription is written (except as required as preventive care under federal law);
- Any Prescription Drug for which there is an over-the-counter (OTC) product which has the same active ingredient and strength;
- Biological sera; or
- Nutritional supplements.

Your Health Benefits

This Plan will pay Benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no Benefits are payable for expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by the Claims Administrator. Only the pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Although a specific service may be listed as a covered expense, it may not be covered unless it is Medically Necessary for the prevention, diagnosis or treatment of an illness or condition. There are exclusions, deductible and coinsurance features, and stated maximum benefit amounts.

All maximums included in this Plan are combined maximums between Tier 1, Tier 2 and Tier 3, where applicable, unless specifically stated otherwise.

Provider Networks

Aetna's provider network is available to give you the care you need. You can find network providers and see important information about them by logging in to your member website (see below). There you will find the online provider directory. You may also contact Aetna Member Services to ask for a copy of the directory. The online directory is updated regularly, but the listings can change. Before you get care, call for current information or to make sure that your provider, their office location, or their provider group is in the network. See below for more information.

To obtain a listing of network providers:

- Call Aetna Member Services at 1-800-847-9026
- Log-on to Aetna Navigator at http://www.aetna.com/docfind/custom/emory

Tier 1 gives you the maximum benefit available under the Plan, with lower deductible and coinsurance.

Tier 2 coinsurance and deductibles are higher than Tier 1.

Tier 3 providers are not contracted with the network; therefore, your out-of-pocket cost will be the highest. Your out-of-pocket costs are the highest because the Plan does not have a negotiated rate with the provider and benefits are based on what is Reasonable and Customary or the Facility Charge Review Rate. If the charge by a Tier 3 Provider is more than what is Reasonable and Customary or the Facility Charge Review Rate, you pay the amount that exceeds that amount, in addition to any applicable deductible and coinsurance amounts (which are also higher).

Continuity of Care

Keeping a provider or facility you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider or facility** you have now is not in the network
- You are already an Aetna member, and your **provider or facility** stops being in our network

However, in some cases, you may be able to keep going to your current **provider or facility** to complete a treatment or to have treatment that was already scheduled at the in-network cost sharing levels (for up to 90 days) of the provider or facility ceasing to be in Aetna's network. This is called continuity of care. If Aetna is aware that you are under an active treatment plan, you will be notified of the provider's or facility's contract termination and how you can submit a request to keep going to your current provider or facility. Contact Aetna for additional information.

Covered Medical Expenses

Precertification for Certain Procedures and Treatments

Certain procedures and treatments require precertification by Aetna. Precertification is a process that helps you and your physician determine whether the recommended services are covered expenses under the plan.

You do not need to precertify services provided by a Tier 1 or Tier 2 Provider. Network providers will be responsible for obtaining necessary precertification for you. Since precertification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a network provider's failure to precertify services.

When you go to a Tier 3 provider, it is your responsibility to obtain precertification from Aetna for any services or supplies on the precertification list below. If you do not precertify, your benefits may be reduced, or the plan may not pay any benefits.

When any of the procedures or treatments shown below are to be performed on an inpatient or outpatient basis, covered medical expenses incurred in connection with the performance of the procedure or treatment will be payable as follows:

If the procedure or treatment is not medically necessary: No Benefits will be payable whether or not certification has been requested.

If certification has been requested and the procedure or treatment is medically necessary: Benefits will be payable at the applicable deductible and coinsurance based on the place of service.

If certification has not been requested and the procedure or treatment is medically necessary: Expenses incurred in connection with its performance, up to the Excluded Amount, will not be considered to be Covered Medical Expenses.

Benefits for Covered Medical Expenses in excess of the Excluded Amount will be payable at the applicable deductible and coinsurance based on the place of service.

List of Procedures and Treatments Which Require Precertification

The following procedures or treatments require precertification, unless prescribed by a Tier 1 or Tier 2 provider, before the procedure or treatment is performed. Even though the procedures or treatments are most often done on an outpatient basis, certification is required whether the procedure or treatment will be performed on an inpatient basis or on an outpatient basis.

- Allergy Immunotherapy
- Athletic Pubalgia Surgery
- Bunionectomy
- Carpal Tunnel Surgery
- Colonoscopy
- Computerized Axial Tomography (CAT Scan)-Spine
- Coronary Angiography
- Dilation/Curettage
- Hemorrhoidectomy
- Knee Arthroscopy
- Laparoscopy (pelvic)

- Magnetic Resonance Imaging (MRI)-Knee
- Magnetic Resonance Imaging (MRI)-Spine
- Septorhinoplasty
- Tympanostomy Tube
- Upper GI Endoscopy
- Cataract Removal
- Septoplasty
- Strabismus Repair
- Hammertoe Repair

You or the provider performing the procedure or treatment must call the number shown on your ID card to request precertification.

If the procedure or treatment is performed due to an emergency condition, the call must be made before the procedure or treatment is performed or not later than 48 hours after the procedure or treatment is performed unless the call cannot be made within that time. In that case, the call must be made as soon as it is reasonably possible. In the event the procedure or treatment is performed on a Friday or Saturday, the 48-hour requirement will be extended to 72 hours.

If the procedure or treatment is performed for any condition other than an emergency condition, the call must be made at least 14 days before the date the procedure is to be performed or the treatment is to start. If it is not possible to make the call during the specified time, it must be made as soon as reasonably possible before the date the procedure or treatment is to be performed.

Written notice of the certification decision will be sent promptly to you and the provider performing the procedure or treatment. This decision will be valid for 60 days from the date you receive the notice. If the procedure or treatment is to be performed after this 60-day period, certification must again be requested, as described above.

Hospital Care

Covered services include inpatient and outpatient hospital care. This includes:

- Semi-private room and board (your plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services and supplies provided by the outpatient department of a hospital including the facility charge
- Services of physicians employed by the hospital
- Administration of blood and blood products

The following are not covered services:

- All services and supplies provided in:
    - Rest homes
    - Any place considered a person’s main residence or providing mainly custodial or rest care
    - Health resorts
    - Spas
    - Schools or camps

Inpatient Hospital Expenses

Inpatient hospital expenses include charges made by a hospital for giving room and board and other hospital services and supplies to a person who is confined as a full-time inpatient.

For Tier 1 or Tier 2 care, if a private room is used, the daily Room and Board Charge will be covered if the person's Tier 1 or Tier 2 provider requests the private room, and the request is approved by the Claims Administrator. If these procedures are not met, any part of the daily Board and Room Charge that is more than the Semi-private room rate is not covered.

For Tier 3 care, any charge for daily room and board in a private room over the Semi-private room rate is not covered.

Precertification for Hospital Admissions

This precertification section applies to hospital admissions other than those for the treatment of alcoholism, drug abuse, or Mental Disorders.

If a person becomes (a) confined in a hospital as a full-time inpatient and it has not been precertified that such confinement (or any day of such confinement) is medically necessary and (b) the confinement has not been ordered and prescribed by a Tier or Tier 2 care provider, the covered medical expenses incurred on any day not precertified during the confinement will be paid as follows:

- As to hospital expenses incurred during the confinement if precertification has been requested and denied, no Benefits will be paid for hospital expenses incurred for room and board. If precertification has not been received, but the stay is determined to be medically necessary, the first $750 will be an Excluded Amount therefore not a covered expense. Charges after the first $750 will be paid as any other Hospital Expense.

- Whether or not a day of confinement is pre-certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan.

- Precertification of days of confinement can be obtained as follows: If the admission is a non-urgent admission, you must get the number of days precertified by calling the number shown on your ID card for precertification. This phone call must be made at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an emergency admission or an urgent admission, you, the person's physician, or the hospital must get the number of days precertified by calling the number shown on your ID card.

This must be done:

- Before the start of a confinement as a full-time inpatient that requires an urgent admission; or

- Not later than 48 hours following the start of a confinement as a full-time inpatient that requires an emergency admission; unless it is not possible for the physician to request certification within that time. In that case, it must be done as soon as reasonably possible. In the event the confinement starts on a Friday or Saturday, the 48-hour requirement will be extended to 72 hours.

If, in the opinion of the person's physician, it is necessary for the person to be confined for a longer time than already precertified, you, the person's physician or the hospital may request that more days be precertified by calling the number shown on your ID card. This call must be made no later than on the last day that has already been precertified.

Written notice of the number of days precertified will be sent promptly to the hospital by Aetna. A copy will be sent to you and to the physician.

Endoscopic Spine Surgery

Endoscopic Spine Surgery is covered when performed by a Tier 1 provider at a Tier 1 facility only.

Transgender Surgery Expenses

Medically-necessary transgender surgery is a covered benefit. Extensive guidelines outlined by Aetna apply.

Transgender Surgery Allowable Expenses are excluded for the following groups: Emory/Saint Joseph's, Inc., Saint Joseph's Hospital of Atlanta, Inc., The Medical Group of Saint Joseph's, LLC.

Outpatient Hospital Expenses

Outpatient Hospital expenses include charges made by a hospital for hospital services and supplies that are given to a person who is not confined as a full-time inpatient.

Outpatient Surgical Expenses

Outpatient surgical expenses that are covered under the Plan include charges made in its own behalf by a Surgery Center, the outpatient department of a hospital or an office-based surgical facility of a physician or a dentist.

Skilled Nursing Facility Expenses

Covered medical expenses include charges made by a Skilled Nursing Facility during your stay for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury.

- Room and Board. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any charge for daily room and board in a private room over the Semi-private rate;
- Use of special treatment rooms;
- X-ray and lab work;
- Physical, occupational or speech therapy;
- Oxygen and other gas therapy;
- Other medical services usually given by a Skilled Nursing Facility. This does not include private or special nursing or physician's services; or
- Medical Supplies.

Benefits will be paid for no longer than the Skilled Nursing Facility days' maximum during any one calendar year.

Limitations to Skilled Nursing Facility Expenses

This section does not cover charges made for treatment of:

- Drug addiction;
- Chronic brain syndrome;
- Alcoholism;
- Senility;
- Mental retardation; or

- Any other Mental Disorder.
- Daily room and board charges over the semi-private rate.

Home Health Care Expenses

Home health care expenses are covered for:

- The charge is made by a Home Health Care Agency;
- The care is given under a Home Health Care Plan; and
- The care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by a R.N. or by a L.P.N. if a R.N. is not available;
- Part-time or intermittent home health aide services for patient care; and
- Physical, occupational, and speech therapy.

The following to the extent they would have been covered under this Plan if the person had been confined in a Hospital or Skilled Nursing Facility:

- Medical supplies;
- Drugs and medicines prescribed by a physician; and
- Lab services provided by or for a home health care agency.

There is a maximum number of visits covered in a plan year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Limitations to Home Health Care Expenses

This section does not cover charges made for:

- Services or supplies that are not a part of the Home Health Care Plan;
- Services of a person who usually lives with you or who is a member of your or your spouse's family;
- Services of a certified or licensed social worker;
- Services for Infusion Therapy;
- Transportation;
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present; or
- Services that are custodial care.

Preventive Care

Preventive care can help you identify potential health risks before they become real health problems. Preventive care benefits such as screenings, well woman visits, routine physical, eye, and hearing examinations, well child visits and immunizations are covered services under the Plan. Routine preventive care services, as defined under federal law, are covered at 100% when administered by a Tier 1 or Tier 2 provider and the main purpose of the visit is preventive in nature. Services provided as part of a diagnostic or treatment plan are not covered at 100% and are subject to the deductible and coinsurance.

Screenings

Certain routine preventive care screenings are included as covered medical expenses under the Plan; contact Aetna if you have questions. The Plan covers all the preventive care services as required under the Affordable Care Act.

Examples of Covered Screenings
Alcohol misuse (covered benefit during pregnancy only)
Blood pressure
Cervical cancer
Cholesterol (for adults of certain ages or at higher risk)
Colorectal
Depression
HIV
Obesity
Osteoporosis
Preventive mammogram
Routine digital rectal exam/prostate-specific antigen test (PSA) for males
Syphilis
Tobacco use
Type 2 diabetes (for adults with high blood pressure)

Immunizations

Immunizations (single-antigen or combination vaccines) for children and adults are covered benefits under the Plan. The doses, recommended ages and populations vary for adults and for children, birth to 18 years of age.

Covered immunizations for adults*

COVID-19
Diphtheria, pertussis, tetanus (DPT)
Hepatitis A and/or B
Herpes Zoster (shingles)
Human papillomavirus (HPV)
Influenza (Flu Shot)
Measles, mumps, rubella (MMR)
Meningococcal (meningitis)
Pneumococcal (pneumonia)
RSV (respiratory syncytial virus), age 60 and older
Varicella (chicken pox)

Covered immunizations for children (from birth to age 18)*

COVID-19 (eligible participants only)
Diphtheria, pertussis, tetanus (DPT)
Haemophilus influenzae type b
Human papillomavirus (HPV)
Inactivated poliovirus
Measles, mumps, rubella (MMR)
Meningococcal (meningitis)
Pneumococcal (pneumonia)
Rotavirus Influenza (Flu Shot)

*The listed single-antigen/combination vaccines do not represent a complete list of covered immunizations. You may contact Aetna to obtain more detailed information.

Routine Physical Exam Expenses

The charges for a routine physical exam given to a Covered Person may be included as covered medical expenses. A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified injury or disease.

Some preventive care services are covered as part of routine physical exams. These include regular checkups, routine gynecological (well woman) visits, and well-child exams.

For a dependent child

To qualify as a covered physical exam, the physician's exam must include at least:

- A review and written record of the patient's complete medical history;
- A check of all body systems; and
- A review and discussion of the exam results with the patient or with the parent or guardian.

For all exams given to your child under age 7, covered medical expenses will not include charges for:

- More than 7 exams in the first twelve months of the child's life.
- More than 3 exams between the 13th and 24th month of the child's life;
- More than 3 exams between the 25th and 36th month of the child's life; and thereafter
- More than one exam per 12 months through their 17th year.

Routine Eye Exam Expenses

- Covered Medical Expenses include charges for a complete eye exam, including refraction, which is furnished by a legally qualified ophthalmologist or optometrist.
- Covered Medical Expenses will not include charges for more than one eye exam per 12 months.

Routine Hearing Exam Expenses

- Covered Medical Expenses include charges for an audiometric exam.
- Covered Medical Expenses will not include charges for more than one hearing exam per 24 months.

Hospice Care Expenses

Charges made for the following when given as a part of a Hospice Care Program are included as Covered Medical Expenses.

Facility Expenses

The charges made in its own behalf by a Hospice, Hospital or a Skilled Nursing Facility which are for:

- Room and Board and other services and supplies furnished to a person while a full-time inpatient for pain control and other acute and chronic symptom management.
- Services and Supplies furnished to you on an outpatient basis.

Not included is any charge for daily room and board in a private room over the semi-private room rate.

Outpatient Care

Covered expenses include charges made on an outpatient basis by a Hospice Care Agency for:

- Part-time or intermittent nursing care by a R.N. or L.P.N. for up to 8 hours in any one day;
- Medical social services under the direction of a physician. These services include assessment of the person's social, emotional, and medical needs; the home and family situation; identification of the community resources which are available to the person and assisting the person to obtain those resources needed to meet the person's assessed needs;
- Psychological and dietary counseling;
- Consultation or case management services by a physician;
- Physical and occupational therapy;
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person;
- Medical supplies; and
- Drugs and medicines prescribed by a physician.

Charges made by the providers below for outpatient care, but only if the provider is not an employee of a Hospice Care Agency and such agency retains responsibility for the care of the person.

A physician for consultation or case management.

A physical or occupational therapist
.
A Home Health Care Agency for:

- Physical and occupational therapy;
- Part-time or intermittent home health aid services for up to 8 hours in any one day (these consist mainly of caring for the person);
- Medical supplies;
- Drugs and medicines prescribed by a physician; and
- Psychological and dietary counseling.

Not included are charges made for:

- Daily room and board in a private room over the semi-private room rate.
- Bereavement counseling;
- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling - this includes estate planning and the drafting of a will;
- Homemaker or caretaker services - these are services that are not solely related to care of the Covered Person. Including but not limited to, sitter or companion services for either the person who is ill or other members of the family, transportation, house cleaning, or maintenance of the house; and

Respite Care: This is care furnished during a period of time when the Covered Person's family or usual caretaker cannot, or will not, attend to the Covered Person's needs.

Infertility Services Expenses

Even though not incurred for treatment of a disease or injury, covered medical expenses will include expenses incurred by a covered female for infertility.

The following infertility services expenses will be covered medical expenses:

- Ovulation induction with ovulatory stimulant drugs, subject to a maximum of six courses of treatment in a covered person's lifetime;
- Advanced Reproductive Therapy (ART); and
- Cryopreservation (freezing), storage and thawing of eggs, embryos, and sperm (effective May 1, 2023).

These expenses will be covered on the same basis as for disease.

A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.

Infertility expenses, therapy, and treatment are covered at a combined medical and pharmacy lifetime maximum up to $25,000 (includes both Comprehensive and Advanced Reproductive Technology services).

Not covered are charges for:

- Purchase of donor sperm or storage of sperm;
- Care of donor egg retrievals or transfers;
- The use of a gestational carrier for the female acting as the gestational carrier; and
- Home ovulation prediction kits.

Infertility services performed at an Emory Healthcare facility are covered at **Tier 1**; Infertility services performed at Institute of Excellence facilities (Aetna designated IOE facilities) are covered at **Tier 2**; and All non-IOE Aetna contracted facilities and out-of-network facilities are paid at **Tier 3**.

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of a Covered Person on the same basis as for a disease (except as otherwise required to be covered as preventive care).

In the Event of an Inpatient Confinement

Such Benefits will be payable for inpatient care of the covered person and any newborn child for (a) a minimum of 48 hours following a vaginal delivery; and (b) a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, Benefits will be payable for two post-delivery home visits by a health care provider.

Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling Aetna at the number shown on your ID card for certification.

Prior Plans

Any pregnancy Benefits payable by previous group medical coverage will be subtracted from medical Benefits payable for the same expenses under this Plan.

Family Planning

The charges made by a physician or a hospital for the following services even though they are not incurred in connection with the diagnosis or treatment of a disease or injury, are Covered Medical Expenses.

Benefits will be payable for a:

- Vasectomy for voluntary sterilization;
- Tubal ligation for voluntary sterilization; and
- Voluntary abortion*

Not covered are charges for the reversal of a sterilization procedure.

* Voluntary abortions are excluded for the following groups: Emory/Saint Joseph's, Inc., Saint Joseph's Hospital of Atlanta, Inc., and The Medical Group of Saint Joseph's, LLC.

Travel and Lodging for Voluntary Abortion Services

There may be occasions when travel and lodging services may be available for voluntary abortion services.

The following travel and lodging expenses are covered under the plan if abortion services are not available from a network provider within 100 miles of your home:

- Maximum lodging benefit, $50 per person, per night (up to $100)

- Total maximum travel and lodging benefit, $10,000 per occurrence

To confirm availability, specific requirements, and any limitations, contact Aetna Health Concierge at 1-800-847-9026.

Short-Term Rehabilitation

Short-term rehabilitation is therapy that is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to an injury, a disease, or Congenital Anomaly.

Short-term rehabilitation services include physical therapy, occupational therapy, and speech therapy, furnished to a person who is not confined as an inpatient in a hospital or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 visits from the date the therapy begins.

Not covered are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Any services which are covered expenses in whole or in part under any other group Plan sponsored by Emory;
- Services received while the person is confined in a hospital or other facility for medical care;
- Services not performed by a physician or under his or her direct supervision;
- Services rendered by a physical, occupational, or speech therapist who resides in the Covered Person's home or who is a part of the family of either the Covered Person or the Covered Person's spouse;

- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired. This includes lessons in how to function without that ability; and
- Treatment for which a benefit is or would be provided under the Spinal Manipulation Expenses section, whether or not Benefits for the maximum number of visits under that section have been paid.

Also not covered are any services unless they are provided in accordance with a specific treatment plan that details the treatment to be rendered and the frequency and duration of the treatment and provides for ongoing reviews and is renewed only if therapy is still medically necessary.

Habilitation Services and Applied Behavioral Analysis (ABA)

Applied Behavioral Analysis and other habilitative treatments (including speech therapy for autism) which meet medically-necessary guidelines. Coverage includes speech, physical and occupational therapies for developmental delays.

Spinal Manipulation Expenses

Covered Medical Expenses include charges for treatment of spinal subluxation or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the spinal manipulation maximum visits will be payable in any one calendar year.

The maximum does not apply to expenses incurred:

- While the person is a full-time inpatient in a hospital
- For surgery - this includes pre- and post-surgical care given or ordered by the operating physician

Durable Medical and Surgical Equipment Expenses

Covered medical expenses include the following:

- Hearing aids for children up to age 26, when medically necessary. One hearing aid per ear is allowed, per 24 month maximum;
- The rental of Durable Medical and Surgical Equipment;
- The initial purchase of Durable Medical and Surgical Equipment and accessories needed to operate it only if the Claims Administrator is shown that long term use is planned, and the equipment cannot be rented, or it is likely to cost less to buy it than to rent it;
- The repair or replacement of purchased Durable Medical and Surgical Equipment and accessories. Replacement will be covered only if the Claims Administrator is shown that it is needed due to a change in the covered person's physical condition or it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment; and
- Charges for oxygen.

The following are not covered medical expenses:

- More than one item of equipment for the same or similar purpose;
- Equipment that is normally of use to persons who do not have a disease or injury;
- Equipment for use in altering air quality or temperature; and
- Equipment for exercise or training.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a physician, a dentist and hospital for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves) for surgery needed to:

- Treat a fracture, dislocation or wound;
- Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into the bone; the roots of a tooth without removing the entire tooth; cysts, tumors or other diseased tissues;
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement, or repair of teeth;
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a stay required because of your condition.

Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:

- Natural teeth damaged, lost or removed; or
- Other body tissues of the mouth fractured or cut due to injury.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jawbone at the time of the injury.

The treatment must be completed in the Calendar Year of the accident or in the next Calendar Year.

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

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

Complex Imaging Services

Covered Medical Expenses include charges for complex imaging services received by a Covered Person on an outpatient basis when performed in a physician’s office, a hospital outpatient department, emergency room; or a licensed radiological facility.

Complex Imaging Services include:

- Computed Axial Tomography (CAT) Scans;
- Magnetic Resonance Imaging (MRIs);
- Positron Emission Tomography (PET Scans); and
- Any other outpatient diagnostic imaging service costing over $500.

Other Medical Expenses

These include:

Charges made by a physician.

Charges for the following:

- Drugs and medicines which by law need a physician's prescription and for which no coverage is provided under the Prescription Drug Expense Coverage
- Diagnostic lab work and X-rays
- Gene based, Cellular and other Innovative Therapies (GCIT) Services
- X-rays, radium, and radioactive isotope therapy
- Anesthetics and oxygen
- Artificial limbs and eyes

Not included are charges for:

- Eyeglasses;
- Vision aids;
- Adult hearing aids;
- Communication aids; and
- Orthopedic shoes unless necessary to prevent complications of diabetes.

Acupuncture

Charges made by a physician for acupuncture services. Covered services include manual or electro acupuncture.

The following are not covered services:

- Acupressure

Ambulance services

Professional ambulance service to transport a Covered Person from the place where he or she is injured or stricken by disease to the first Hospital where treatment is given.

- An ambulance is a vehicle staffed by medical personnel and is equipped to transport an ill or injured person by ground, air or water.

Emergency

Covered services include emergency transportation when your condition is unstable and requires medical supervision and rapid transport. These emergency ambulance services are limited to transportation by a licensed ambulance:

- To the first facility to provide emergency services

- From one facility to another if the first can't provide the emergency services you need

Non-emergency

Covered services also include non-emergency transportation when an ambulance is the only safe way to transport you. These non-emergency ambulance services are limited to transportation by a licensed ambulance:

- To the nearest facility able to treat your condition
- From a facility to your home by ground ambulance

The following are not covered services:

• Ambulance services for routine transportation to receive outpatient or inpatient services

Transplant Services

Eligible health services include organ transplant services provided by a physician and hospital.

Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T-cell receptor therapy for FDA-approved treatments

Network of Transplant Specialist Facilities

The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from:

- An **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need
- A Non-IOE facility

Your cost share will be lower when you get transplant services from the IOE facility we designate to perform the transplant you need. You may also get transplant services at a non-IOE facility, but your cost share will be higher.

The National Medical Excellence (NME) Program® will coordinate all solid organ, bone marrow and CAR-T and T-cell therapy services, and other specialized care you need.

Many pre- and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the NME Program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the covered service is not directly related to your transplant.

Travel Expenses

These are expenses incurred by an IOE Patient for transportation between his or her home and the medical facility to receive services in connection with a procedure or treatment. Also included are expenses incurred by a Companion for transportation when traveling to and from an IOE Patient's home and the medical facility to receive such services.

All Travel Expenses must be approved in advance by the Claims Administrator.

Lodging Expenses

These are expenses incurred by an IOE Patient for lodging away from home while traveling between his or her home and the medical facility to receive services in connection with a procedure or treatment.

Also included as covered medical expenses are expenses incurred by a Companion for lodging away from home:

- While traveling with an IOE Patient between the IOE Patient's home and the medical facility to receive services in connection with any listed procedure or treatment; or
- When the Companion's presence is required to enable an IOE Patient to receive such services from the medical facility on an inpatient or outpatient basis.

All Lodging Expenses must be approved in advance by the Claims Administrator.

Limitations

Travel Expenses and Lodging Expenses do not include, and no Benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one Companion who is traveling with the IOE Patient.

Approved Clinical Trials

The Plan covers "routine patient costs" for items and services incurred by a "qualified individual" in connection with participation in an "approved clinical trial." The Plan may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for any items or services furnished in connection with participation in an approved clinical trial.

"Routine patient costs" include all items and services that would be covered typically under the Plan for individuals who are not otherwise participating in a clinical trial. Routine patient costs for items and services to diagnose or treat complications or adverse events arising from participation in an approved clinical trial are items and services furnished in connection with participation in an approved clinical trial, and accordingly, are required to be covered in accordance with Federal law if the plan typically covers such items or services for a qualified individual who is not enrolled in a clinical trial.

Routine patient costs do not include any of the following:

- The investigational items, devices, or services themselves;

- Items and services that are provided solely to satisfy clinical trial data collection and analysis needs and that are not used in the direct clinical management of the patient; and

- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If the approved clinical trial is only offered outside the patient's state of residence, the Plan will cover routine patient costs of services and items which are provided by out-of-network providers. Otherwise, the Plan will not provide benefits for routine patient costs if the services are provided by an out-of-network provider unless the Plan otherwise covers services by out-of-network providers.

To be a "qualified individual," you must meet two requirements. First, you must be eligible to participate in an approved clinical trial (defined below) according to the trial protocol. Second, your attending

physician must determine that your participation in the trial is appropriate, or you must provide medical and scientific information establishing that you meet the eligibility standards of the trial protocol and that your participation in the trial is appropriate.

An "approved clinical trial" is a phase I, II, III or IV clinical trial that is (1) conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition (i.e., likely to lead to death unless the course of the disease or condition is interrupted), and (2) is any one of the following:

- Federally funded by one or more government agencies or entities designated in Section 2709(d)(1)(a) of the Public Health Service Act;
- Conducted under an investigational new drug application reviewed by the FDA; or
- Is a drug trial that is exempt from the investigational new drug application requirements.

Note: If one or more network providers are participating in the approved clinical trial, you must use the network provider for the approved clinical trial provided he or she will accept you as a patient.

Behavioral Health Coverage (Mental Disorders and Substance Abuse)

The care you receive through your Behavioral Health Benefit is confidential. Aetna shall not disclose confidential information to anyone without your consent, except where required by federal and state laws.

Behavioral Health Care includes services and supplies, which are:

Covered services, for mental disorders and substance abuse treatment;

Given while the Covered Person is covered under this Plan;
Given by one of the following:

Psychologist
Licensed Behavioral Health Counselor
Provider Hospital
Treatment Center
Social Worker

Behavioral Health Services includes but is not limited to the following:

Assessment
Diagnosis
Treatment Planning
Medication Management
Individual, family, and group psychotherapy
Psychological testing

Services and supplies will not automatically be considered Covered Health Services solely because they were prescribed by a Provider.

Benefit Maximums

Description	Plan Limit
Skilled Nursing Facility	120 days per calendar year
Home Health Care Maximum Visits	120 visits per calendar year
Short-Term Rehabilitation Maximum Visits	90 visits per calendar year
Habilitation Services	Unlimited
Spinal Manipulation	20 visits per calendar year
Private Room Limit	The institution's semi-private rate
Child Hearing Aids (covered under Durable Medical and Surgical Equipment)	One hearing aid per year, per 24-month maximum, up to age 26

General Exclusions

Coverage is not provided for the following charges:

- Services and supplies not medically necessary, as determined by the Claims Administrator, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending physician or dentist;
- Care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending physician or dentist;
- In connection with, services or supplies that are, as determined by the Claims Administrator, experimental or investigational, except as provided otherwise in this SPD. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or if required by the FDA, approval has not been granted for marketing; or a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

  However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease if the Claims Administrator determines that the disease can be expected to cause death within one year, in the absence of effective treatment; and the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the Claims Administrator will take into account the results of a review by a panel of independent medical professionals. They will be selected by the Claims Administrator. This panel will include professionals who treat the type of disease involved. Also, this exclusion will not apply with respect to drugs that have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute if the Claims Administrator

determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury;

- The following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy;

- Treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field;

- Services of a resident physician or intern rendered in that capacity;

- Those that are made only because there is health coverage;

- Those that a covered person is not legally obliged to pay;

- Custodial Care as determined by the Claims Administrator;

- Services and supplies furnished, paid for, or for which Benefits are provided or required by reason of the past or present service of any person in the armed forces of a government. Furnished, paid for, or for which Benefits are provided or required under any law of a government (this exclusion will not apply to "no fault" auto insurance if it is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to a Plan established by government for its own employees or their dependents or Medicaid);

- City of Hope (formerly known as Cancer Treatment Centers of America) will not be paid In- or Out-of-Network levels. The centers are excluded from payment.

- Rio Acupuncture and associated providers will not be paid In or Out-of-Network levels. The providers are excluded from payment.

- Eye surgery mainly to correct refractive errors;

- Education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment;

- Therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis;

- Artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided in this Summary Plan Description;

- Routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in this Summary Plan Description;

- Career, social adjustment, pastoral, or financial counseling;

- Speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury. The exclusion also does not apply to speech therapy charges when there is an Autism diagnosis.

- Weight control services including: weight control/loss programs; dietary regimens and supplements; appetite suppressants and other medications (when medically necessary and/or meets program criteria); food or food supplements; exercise programs; exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity. Under certain criteria Morbid Obesity surgical procedures may be covered if provided by a Tier 1 or Tier 2 provider, but only with a Body Mass Index (BMI) exceeding 40; or a BMI greater than 35 with one of the following co-morbidities which is aggravated by obesity: coronary heart disease or Type 2 diabetes mellitus;

- Dental services related to an injury must be performed in the calendar year of the accident which causes the injury or in the next calendar year;

- Those to the extent they are not Reasonable Charges or Facility Charge Review Rates, as determined by the Claims Administrator;

- Reversal of a sterilization procedure;

- Service or supply furnished by a Tier 1 or Tier 2 provider in excess of such provider's Negotiated Charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the Benefits of the group contract are paid;

- Treatment of services, except for the initial diagnoses, for a primary diagnoses of Mental Retardation (317, 318, 319), Learning, Motor Skills, and Communication Disorders (315), Conduct Disorder (312), Dementia (290, 294), and Personality Disorders (301), as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by Aetna;

- Neuropsychological testing when used for the diagnosis of attention deficit disorder, unless medically necessary; or

- Blood, blood products, and related services which are supplied by your provider free of charge (blood, blood plasma, synthetic blood, blood derivatives or substitutes).

<u>Cosmetic Services and Plastic Surgery</u>
Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, except where described in the General Exclusions section.

- Plastic surgery, reconstructive surgery, Cosmetic Procedures, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to improve the function of a part of the body that is not a tooth or structure that supports the teeth; and is malformed as a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or as a direct result of disease; or surgery performed to treat a disease or injury.

Foot Care

Routine services and supplies for the following:

- Routine pedicure services, such as routine cutting of nails, where there is no illness or injury in the nails;
- Supplies (including orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies;
- Treatment of calluses, bunions, toenails, hammertoes or fallen arches; or
- Treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working, or wearing shoes.

Transplant Services

- Services and supplies furnished to a donor when the recipient is not a covered person.
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness.
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness.

Voluntary Abortion Services

- Some state or local laws restrict the scope of health care services that a provider may render. In such cases, the Plan will not cover such health care services.
- In some cases the plan may provide travel benefits for services affected by this exclusion.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage provided under this Plan.

These Excluded Amounts will not be used when figuring Benefits.

Effect of Benefits under Other Plans

Coordination of Benefits - Other Plans Not Including Medicare

This Coordination of Benefits (COB) provision applies to this Plan when an employee (or former employee or eligible retiree) or the employee's (or former employee's or eligible retiree's) covered dependent has medical and/or dental coverage under more than one Plan. "Plan" is defined herein.

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 under this Plan and other Plans. This Plan has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Right of Recovery

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

The order of benefit determination rules as discussed below determines which Plan will pay as the primary Plan. The primary Plan pays first without regard to the possibility that another Plan may cover some expenses. A secondary Plan pays after the primary Plan and may reduce the Benefits it pays so that payments from all group Plans do not exceed 100% of the total Allowable Expense. When two or more Plans pay Benefits, the rules for determining the order of payment are as follows:

- The primary Plan pays or provides its Benefits as if the secondary Plan or Plans did not exist.

- A Plan that does not contain a coordination of Benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide Tier 3 benefits.

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

- The first of the following rules that describes which Plan pays its Benefits before another Plan is the rule to use:

  Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber, or retiree is primary and the Plan that covers the person as a dependent is secondary.

  However, if the person is a Medicare beneficiary, and as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee) then the order of Benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber, or retiree is secondary and the other Plan is primary.

  Child Covered Under More Than One Plan. The order of Benefits when a child is covered by more than one Plan is:

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

    - The parents are married;
    - The parents are not separated (whether or not they ever 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 covered either of the parents longer 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 commencing after the Plan is given notice of the court decree.

- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, 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; and then
    - The Plan of the spouse of the non-Custodial Parent.

  Active or Inactive Employee. The Plan that covers a person as an employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the above rule.

  Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Benefits, this rule is ignored.

  Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member or subscriber longer is primary.

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

Effect of Medicare

Medical Coverage under this Plan will be changed for any person while eligible for Medicare unless they are in current employment status.

A person is "eligible for Medicare" if he or she is covered under it or is not covered under it because of having refused it; having dropped it; or having failed to make proper request for it.

These are the charges this Plan will pay:

- The amount this Plan will pay will be figured so that this amount, plus the benefits under Medicare, will equal 100% of the amount that would have been paid under the Emory plan alone. For example, if the Emory plan would have paid 90%, the amount paid by Medicare and the Emory plan together will not exceed 90%. "Plan Expenses" means any necessary and reasonable health expenses, part, or all of which is covered under this Plan.

- Charges used to satisfy a person's Part B Deductible under Medicare will be applied under this Plan in the order received by the Claims Administrator. Two or more charges received at the same time will be applied starting with the largest first.

- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.

- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's Benefits have been figured under the above rules.

- Any benefits under Medicare will not be deemed to be an Allowable Expense.

If it is necessary in order to administer this provision, the Claims Administrator has the right to release or obtain data and make or recover any payments.

Coverage will not be changed for any Covered Person at any time when Emory's compliance with federal law requires this Plan's Benefits for a person to be determined before Benefits are available under Medicare.

Medicare Allowed Rates

Medicare Allowed Rates are rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have rate, we use one or more of the items below to determine the rate:

- The method CMS uses to set Medicare rates
- What other providers charge or accept as payment
- How much work it takes to perform a service
- Other things as needed to decide what rate is reasonable for a particular service or supply

We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
- Our rate may also exclude other payments that CMS may make directly to hospitals or other providers. It also may exclude any backdated adjustments made by CMS.
- For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.
- For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
- For DME, our rate is 75% of the rates CMS establishes for those services or supplies.

For medications payable/covered as medical benefits rather than prescription drug benefits, our rate is 100% of the rates CMS establishes for those medications.

Additional Provisions

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the plan document on file with Emory. If you have any questions about the terms of this Plan or about the proper payment of Benefits, you may obtain more information from Emory.

Emory hopes to continue this Plan indefinitely, but as with all group Plans; this Plan may be changed or discontinued as to all or any class of employees.

Aetna's Authority as Claim Administrator

Aetna has been designated as claim administrator for benefits under the Plan with full discretion and authority to make claim and appeal determinations. The claims administrator is the appropriate named fiduciary of the plan for purposes of reviewing denied claims for benefits. In exercising this fiduciary responsibility, Aetna has full discretionary authority to make factual determinations; to determine eligibility for benefits; to determine the amount of benefits for each claim received; and to construe terms of the Plan with respect to benefits. Aetna's decisions are final and binding upon you and any person making a claim on your behalf. Your employer retains sole and complete authority to determine eligibility of persons to participate in the Plan.

Assignments

Your rights and benefits under the Plan cannot be assigned, sold, or transferred to any person, including your healthcare provider. The only exception is under a qualified medical child support order ("QMCSO"). Any purported assignments of benefits or rights under the Plan that a healthcare provider or any other person or entity requests that you execute (and/or has you execute) are void and will not apply to the Plan.

At its option, the Plan may accept claims filed by a healthcare provider and may make payments for covered services directly to a healthcare provider. However, these activities will not constitute an assignment of health benefits or rights under the Plan or a waiver of the Plan's anti-assignment rules. Further, a direct payment to a healthcare provider will not constitute an assignment of health benefits or rights under the Plan. Any purported assignments of benefits or rights under the Plan are void and will not apply to the Plan.

The Plan may also make payments directly to you. Payments, as well as notice regarding the receipt and/or adjudication of claims, may also be made to an alternate recipient or that person's custodial parent or authorized representative under a qualified medical child support order. If the Plan makes a payment, this will fulfill the Plan's obligation to pay for covered services. The Plan is not responsible for paying healthcare provider invoices that are balance-billed to you.

Reimbursement Provision

If a Covered Person suffers a loss or an injury caused by the act or omission of a third party, the Benefits in this Plan for such loss or injury will be paid only if the Covered Person, or his or her legally authorized representative, agrees in writing to:

- Pay the Claims Administrator up to the amount of the Benefits received under this Plan subject to applicable law if damages are collected. Damages may be collected by action at law; settlement; or otherwise; and

- Provide the Claims Administrator a lien in the amount of the benefit paid. This lien may be filed with the third party; his or her agent; or a court which has jurisdiction in the matter. The payment and the lien referred to above shall be made or provided to the Claims Administrator in its capacity as the provider of administrative services to this Plan.

Our Reimbursement Policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the recognized charge.

These policies consider:

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required.
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided.
- The educational level, licensure, or length of training of the provider

Our reimbursement policies may consider:

- The Centers of Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in the relevant clinical areas
- Aetna's own data and/or databases and methodologies maintained by third parties.

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Subrogation and Right of Recovery Provision

As used throughout this provision, the term Responsible Party means any party actually, possibly, or potentially responsible for damages or compensation due to a Covered Person as a result of a Covered Person's injuries, illness, or condition, including the liability insurer of such Responsible Party, or any insurance carrier providing medical expense or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The Plan's subrogation right is a first priority right and must be satisfied in full prior to any of your or your representative's other claims, regardless of whether you are fully compensated for your damages. The Plan expressly rejects and overrides any default rule that the plan does not have a right of subrogation until you or your dependent have been fully compensated. Neither the make-whole doctrine nor the common fund doctrine apply to the Plan.

The Plan shall be subrogated to all rights of recovery a Covered Person has against any Responsible Party with respect to any damages collected from a Responsible Party whether by action at law, settlement, or compromise, by a Covered Person or his/her legal representative as a result of a Covered Person's injuries or illness, to the full extent of Benefits provided or to be provided by the Plan.

In addition, if a Covered Person receives any payment from any Responsible Party as a result of an injury, illness, or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from all Responsible Parties. Further, the Plan will automatically have a first priority equitable lien, to the extent of Benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a Covered Person receives from any Responsible Party as a result of the Covered Person's injuries, illness, or condition. The amount of the lien is equal to the amount of prior and future benefits paid by the Plan. The Plan also has a right to impose a constructive

trust on the process awarded, transferred, or paid by or on behalf of a third party to you, your dependents and any other person or entity holding the proceeds, including a legal representative or trust.

The Plan Administrator, or its delegate, has the sole authority and discretion to decide whether to pursue any right of recovery in favor of the Plan.

By accepting Benefits (whether the payment of such Benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that this Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim.

The terms of this entire subrogation and right of recovery provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical Benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The Covered Person shall fully cooperate with the Plan's efforts to recover its Benefits paid. It is the duty of the Covered Person to notify the Plan within thirty (30) days of the date when any notice is given to any party, including an attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the Covered Person. The Covered Person shall provide all information requested by the Plan, the Claim Administrator or its representative including, but not limited to, completing, and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health Benefits for the Covered Person or the institution of court proceedings against the Covered Person. The Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all Benefits provided by the Plan.

In the event that any claim is made that any part of this right of recovery provision is ambiguous, or if questions arise concerning the meaning or intent of any of its terms, the Plan Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

By accepting Benefits (whether the payment of such Benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such Benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Recovery of Overpayment

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator -- Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the plan may have with respect to overpayments.

Reporting of Claims

A claim must be submitted to the Claims Administrator in writing. It must give proof of the nature and extent of the loss. Emory has claim forms.

All claims should be reported promptly. The deadline for filing a claim for any Benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. But unless you are legally incapacitated, no later than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. All Benefits are payable to Tier 1 providers or Tier 2 providers or to you. However, this Plan has the right to pay any health Benefits to the service provider. This Plan may pay up to $1,000 of any benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you, and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses

Keep complete records of the expenses of each Covered Person. They will be required when a claim is made. In particular, make sure to keep the following:

- Names of physicians, dentists and others who furnish services;
- Dates expenses are incurred; and
- Copies of all bills and receipts.

Legal Action

No legal action can be brought against the Plan to recover under any benefit after three (3) years from the deadline for filing claims or, if the claim does not relate to a claim for benefits subject to a deadline for filing claims under the Plan, within two years of the date when you knew or should have known of the actions or events giving rise to your claim.

Filing an Appeal

Eligibility for Coverage, Participation and Contributions

The Plan Administrator has the discretionary authority to make all determinations relating to eligibility for coverage, participation, contributions, or other administrative aspects of the Plan. You may file a claim with regard to any of these administrative issues with the Plan Administrator and appeal adverse claim decisions to the Plan Administrator.

How to File Your Appeal?

To appeal an adverse administrative decision, submit your letter of appeal and any pertinent documents via regular mail to:

Emory University
Benefits and Work Life Department
Official Appeal
1599-001-1AP
1599 Clifton Road NE
Atlanta, Georgia 30322

or by fax to:

Emory University
Benefits and Work Life Department
Official Appeal
(404) 727-7145

or as an attachment by email to: hrbenef@emory.edu

Your appeal request should include your name, employee number and any other comments, documents, records and/or other information you would like to have considered, whether or not submitted originally. You will have 180 days from receiving notification of a denial of eligibility for coverage, participation and/or contributions to file an appeal with the Plan Administrator. Your appeal will be acknowledged within 15 working days of receipt. You will be notified of a decision with regard to your appeal not later than 30 days after the appeal is received. This period may be extended up to 15 days and a representative of the Plan Administrator will contact you to indicate a delay with regard to a determination of your appeal.

If you are dissatisfied with an appeal decision, you may file a second-level appeal with the Plan Administrator within 60 days of receipt of the decision with regard to your first appeal. The Plan Administrator will notify you of the decision with regard to your second appeal not later than 45 days after the appeal is received.

Health Plan Appeals for Claims Payment

You may file claims for Plan Benefits with the Claims Administrator and appeal adverse claim decisions, either yourself or through an authorized representative. To file a claim and/or appeal:

For Medical and Behavioral Health claims: Aetna
Attn: National Account CRT
P. O. Box 14463
Lexington, KY 40512
Fax (859) 455-8650

For Pharmacy Claims:
Prescription Claim Appeals MC 109 – CVS/caremark
P. O. Box 52084
Phoenix, AZ 85072
Fax (866) 443-1172

If your claim (or appeal) is denied in whole or in part, you will receive a written notice of the denial from the Claims Administrator. The notice will include:

- Information that enables you to identify the claim involved (including, if applicable, the date of service, the provider, and the claim amount), and a statement describing the availability, upon request, of the diagnosis and treatment codes (and their meanings);

- The specific reason(s) for the adverse determination, including the denial code (and its meaning), and a description of any standard that was used in the denial;

- Reference to the specific plan provisions on which the determination was based;

- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

- A description of the plan's review procedures (except for notices on appeals) and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA, following an adverse benefit determination on review;

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;

- If the adverse benefit determination was based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge, or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request;

- If the adverse benefit determination is based on the medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided, or a statement will be included that such explanation will be provided free of charge, upon request;
- A description of available external review processes, including information on how to initiate the appeal;

- The availability of, and contact information for, an applicable health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is a claim involving urgent care, you will be notified of the decision not later than 72 hours after the claim is received.

"A claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, the time permitted may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims that name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre- service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce Benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

You may file an appeal in writing. The denial notice will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call the toll-free phone number on the front of your ID card. Your request should include the group name (that is, Emory), your name, Social Security Number or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records, and other information you would like to have considered, whether or not submitted in connection with the initial claim.

Your appeal will be acknowledged within five working days of receipt.

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to the Claims Administrator. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

If your claim is a claim involving urgent care, an expedited appeal may be initiated by a telephone call to Member Services. The Claims Administrator's Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on a claim involving urgent care, you may file a second level appeal with the Claims Administrator. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with the Claims Administrator within 60 days of receipt of the level one appeal decision. The Claims Administrator will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

Full and Fair Review Rules

The Plan will provide you with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, such evidence to be provided as soon as possible and sufficiently in advance of the date on which the notice of the appeal determination is required to be provided as set forth above so that you have a reasonable opportunity to respond prior to that date.

Before the Plan can issue a final determination on an appeal based on a new or additional rationale, you must be provided with the rationale, and the rationale must be provided as soon as possible and sufficiently in advance of the date on which the appeal determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Plan Administrator, or its delegate, has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. If any exercise of this discretionary authority is reviewed by a court, arbitrator, or any other tribunal, it will be reviewed under the arbitrary and capricious standard (i.e., the abuse of discretion standard). Benefits under the Plan will be paid only if the Plan Administrator or Claims Administrator decides in its discretion that the applicant is entitled to them.

External Review of Medical Procedures

Note: This provision applies only to the extent required by federal law.

The external review process discussed in this section does not apply to eligibility appeals. It also does not apply to appeals for dental or vision benefits. External review is available for adverse benefit determinations that involve medical judgments (including those based on medical necessity, appropriateness, health care setting, level of care or experimental or investigational determinations). They also apply to rescissions of coverage and whether a rescission has any effect on a particular benefit at the time of the rescission.

When You Can Request an External Review

If your internal claim for benefits is denied and you have properly completed all of the levels of the internal appeals process for that benefit claim which are also denied, an additional external voluntary review may be available.

If you would like your claim reviewed through the external review process, you must file the request in writing with the Claims Administrator within 123 calendar days of the date you received the final denied internal appeal. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Procedures after an External Appeal Request is Filed

Within five business days following the date of receipt of the external appeal request, the Claims Administrator will complete a preliminary review of the request to determine whether:

- You are or were covered under the medical benefit option at the time the item or service was requested or, in the case of a retrospective review, were covered at the time the health care item or service was provided;
- The denied appeal does not relate to your failure to meet the requirements for eligibility;
- You have exhausted the internal appeal process; and
- You have provided all the information and forms required to process an external appeal.

Within one business day after completing the preliminary review, the Claims Administrator will notify you in writing of its decision. If the claim is not eligible for external review, the notice will include the reasons for its ineligibility. If the request is not complete, the notice will describe the information or materials needed to complete the request, and you will have until the later of the remaining time within the four-month filing period (described above) or 48 hours following the receipt of the notice to complete your request for an external review.

Procedures after your Request is Approved

If your request for an external appeal is approved, the Claims Administrator will assign it to an independent review organization (IRO). These IRO procedures are intended to comply with applicable law. The following is a general description of those procedures, but they may be updated or revised as additional guidance is issued with respect to the external appeal process, as provided under federal law.

The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of the receipt of the notice and additional information that the IRO must consider when conducting the external appeal. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days. Any additional information received by the IRO

from you will be shared with the Claims Administrator and the Medical Plan. If, upon receipt of this information, the Claims Administrator decides to review its decision and then reverses its prior decision and fully approves the internal appeal, then your claim will be paid accordingly, and the external appeal will be terminated.

If the external appeal is not terminated as noted above, the IRO will review all information and documents related to your denied internal appeal. The IRO is not bound by any decisions or conclusions reached by the applicable Claims Administrator during the internal claim and appeal process.

The IRO will provide written notice to you and the applicable Claims Administrator of the final external review decision within 45 days after it receives the request for review. Such notice will contain:

- A general description of the reason for the request for the review and information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rational for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding, except to the extent that other remedies may be available under state or federal law to either the Plan or to you;
- A statement that judicial review may be available to you; and
- Current contact information, including a telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act.

If the IRO reverses the internal decision, the Claims Administrator will provide the applicable coverage or payment for the claim.

Expedited External Appeal Requests

You may also make an expedited external appeal request to the Claims Administrator at the time you receive:

- A denied urgent care internal claim if you have also filed at the same time an internal appeal
- A denied urgent care internal appeal, or
- A denied internal appeal, which concerns an admission, availability of care, conducted stay or medical care item or service for which you have received emergency services and have not been discharged from the facility.

Upon receipt of the request for expedited external review, the Claims Administrator will conduct a preliminary review to determine whether the request meets the requirements for an expedited review. If it does, you will be notified within 72 hours that your request is eligible for an expedited external review. Upon a determination that a request is eligible for expedited external appeal, the IRO will follow the procedures discussed above with respect to standard external appeals, except that the IRO will provide notice of the external appeal decision, as expeditiously as the circumstances require, but in no event more than 72 hours after the IRO receives the request for the expedited external appeal.

Exhaustion of Process Required

Before filing any claim or action in court or in another tribunal with respect to the Plan, you must first fully exhaust all of your actual or potential rights under the claims procedures provided above by filing an

initial claim and then seeking a timely appeal (and second appeal, when available) of any denial. You are not required to follow the voluntary review process, however. This relates to claims for benefits under the Plan and to any other issue, matter, or dispute with respect to the Plan (including any Plan eligibility, interpretation, or amendment issue).

This exhaustion requirement applies even if the Plan Administrator has not previously defined or established specific claims procedures that directly apply to the submission and consideration of a particular issue, matter, or dispute. After you have filed your initial claim, the Plan Administrator will inform you of any specific claims procedures that will apply to your particular issue, matter, or dispute, or it will apply the claims procedures above that apply to claims for benefits.

Restriction of Venue

Any claim, suit or action filed in court or any other tribunal in connection with the Plan by or on behalf of a Claimant shall only be brought or filed in the United States District Court for the Northern District of Georgia.

Foreign Language Assistance

If you reside in a county where 10% or more of the population is literate in a non-English language (as determined in accordance with data provided by the United States Census Bureau and the United States Department of Labor), the Plan must provide the following language assistance:

- Oral language services in the applicable non-English language for claims, appeals and external review;

- Upon request, an explanation of benefits (EOB) or other adverse benefit determination in the applicable non-English language; and
- Provide in English versions of EOBs and other adverse benefit determinations a statement in any applicable non-English language indicating how to access the language services.

If you have any questions regarding this foreign language assistance, please see the statements on your EOBs or otherwise contact the Claims Administrator or the Service Center.

Retrospective Record Review

The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of healthcare services. The Claims Administrators' effort to manage the services provided to the Covered Persons includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

Concurrent Review and Discharge Planning

The following items apply if the Plan requires certification of any confinement, services, supplies, procedures, or treatments:

Concurrent Review

The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for the Covered Person receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.

Discharge Planning

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.

Legal Notices

Newborns' and Mothers' Health Protection Act

Under federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, Plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceeds 48 hours (or 96 hours). For information on precertification, contact the Claims Administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this Plan, coverage will be provided to a Covered Person who is receiving Benefits for a Medically Necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymph edemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual Deductibles and Coinsurance provisions that apply for the mastectomy.

If you have any questions about the coverage of mastectomies and reconstructive surgery under the Plan, please call the Member Services number on your ID card.

Surprise Billing

The surprise billing provisions of the No Surprises Act provides protections from surprise medical bills (unexpected balance bills) for:

- Coverage of emergency services;
- Coverage of non-emergency services performed by non-par providers at par facilities;
- Prohibits balance billing; and
- Applies external review requirements for surprise billing

Emergency Services

When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an emergency medical condition in a hospital emergency room. You can get emergency services from network or out-of-network providers.

Your coverage for emergency services will continue until the following conditions are met:

- You are evaluated and your condition is stabilized; and
- Your attending physician determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another provider if you need more care.

If your physician decides you need to stay in the hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. See the Covered Medical Expenses and General Exclusions sections that fit your situation (for example, Hospital care). You can also contact Aetna or your network physician or primary care physician (PCP).

Non-emergency Services

If you go to an emergency room for what is not an emergency medical condition, the plan may not cover your expenses. See the schedule of benefits for more information.

Voluntary Services

The amount of an out-of-network provider's charge that is eligible for coverage. You may be responsible for all amounts above what is eligible for coverage. However, there are some types of claims for which a provider may not bill you for amounts above what is eligible for coverage (see Involuntary Services and Surprise Bills for more information).

If your ID card displays the National Advantage Program (NAP) logo, your cost may be lower when you get care from a NAP provider. Through NAP, the recognized charge is determined as follows:

- If your service was received from a NAP provider, a pre-negotiated charge will be paid. NAP providers are out-of-network providers that have contracts with Aetna, directly or through third-party vendors, that include a pre-negotiated charge for services. NAP providers are not network providers. (At times Aetna may choose to terminate specific providers from NAP and will notify the provider of such a decision.)
- If your service was not received from a NAP provider, a claim specific rate or discount may be negotiated by Aetna or a third-party vendor.

If your claim is not paid as outlined above, the recognized charge for specific services or supplies will be the out-of-network plan rate, calculated in accordance with the following:

Service or Supply	Out-of-Network Plan Rate
Professional services*	There is no change to your out-of-network plan rate. Please refer to your current SPD language for the plan rate that applies to each of these services.
Inpatient and outpatient charges of hospitals*	
Inpatient and outpatient charges of facilities other than hospitals*	
Prescription drugs	

* Involuntary services are not paid as outlined above. See Surprise Bill for information on how these claims are paid under the plan.

Important Note: If the provider bills less than the amount calculated using the out-of-network plan rate, the recognized charge is what the provider bills.

In the event you receive a balance bill from a provider for your out-of-network service, Patient Advocacy Services may be available to assist you in certain circumstances. If Patient Advocacy Services are available for your claim, additional information will be provided to you.

If NAP does not apply to you, the recognized charge for specific services or supplies will be the out-of-network plan rate set forth in the above chart.

The out-of-network plan rate does not apply to involuntary services. See Surprise Bill for more information.

Special terms used:

- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility provider's estimated costs for the service and leave the provider with a reasonable profit. This means for:
  - Hospitals and other facilities that report costs or cost to charge ratios to The Centers for Medicare & Medicaid Services (CMS), the FCR rate is based on what the facilities report to CMS
  - Facilities that don't report costs or cost to charge ratios to CMS, the FCR rate is based on a statewide average of these facilities

We may adjust the formula as needed to maintain the reasonableness of the recognized charge. For example, we may make an adjustment if we determine that in a state the charges of a specific type of facility are much higher than charges of facilities that report to CMS.

- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Our reimbursement policies

We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the recognized charge. When we do this, we consider:

- The length and difficulty of a service
- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow-up care is included
- Whether other conditions change or make a service unique

- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the provider

We base our reimbursement policies on our review of:

- CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren't appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in relevant clinical areas

Surprise Bill

There may be times when you unknowingly receive services or do not consent to receive services from an out-of-network provider, even where you try to stay in the network for your covered services. You may then get a bill at a rate that you didn't expect. This is called a surprise bill.

An out-of-network provider can't balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirement, such as deductibles, copayments and payment percentage for the following services:

- Emergency services provided by an out-of-network provider and ancillary services initiated from your emergency services
- Non-emergency services provided by an out-of-network provider at an in-network facility, except when the out-of-network provider has given you the following:
    - The out-of-network notice for your signature
    - The estimated charges for the items and services
    - Notice that the provider is an out-of-network provider
- Out-of-network air ambulance services

The out-of-network provider must get your consent to be treated and balance billed by them.

Ancillary services mean any professional services including:

- Items and services related to emergency medicine
- Anesthesiology
- Hospitalist services
- Laboratory services
- Neonatology
- Pathology
- Radiology
- Services provided by an out-of-network provider because there was no network provider available to perform the service

A facility in this instance means an institution providing health care related services, or a health care setting. This includes the following:

- Hospitals and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- Skilled nursing facilities
- Residential treatment facilities

- Diagnostic, laboratory, and imaging centers
- Rehabilitation facilities
- Other therapeutic health settings

A surprise bill claim is paid based on the median contracted rate for all plans offered by us in the same insurance market for the same or similar item or service that is all of the following:

- Provided by a provider in the same or similar specialty or facility of the same or similar facility type
- Provided in the geographic region in which the item or service is furnished

The median contracted rate is subject to additional adjustments as specified in federal regulations.

Any cost share paid with respect to the items and services will apply toward your in-network deductible and maximum out-of-pocket limit if you have one.

It is not a surprise bill when you knowingly choose to go out-of-network and have signed a consent notice for these services. In this case, you are responsible for all charges.

You may request external review if you want to know if the federal surprise bill law applies to your situation.

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

Summary of ERISA Information

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Name:	Emory University Health Care Plan
Plan Sponsor:	Emory University Attn: Sr. VP & Chief HR Officer 1599 Clifton Road NE, First Floor Atlanta, GA 30322
Employer Identification Number:	58-0566256
Plan Number:	502
Type of Plan:	Welfare (health care benefits)
Type of Administration:	Administrative Services Contract with the following claims administrators: Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156 CVS Health One CVS Drive Woonsocket, Rhode Island 02895
Plan Administrator:	Emory University Attn: Sr. VP & Chief HR Officer 1599 Clifton Road NE, First Floor Atlanta, GA 30322
Agent for Service of Legal Process:	Emory University Office of the General Counsel 201 Dowman Drive 101 Administration Building Atlanta, GA 30322
Plan Year:	January 1 - December 31
Source of Contributions:	Participants and Emory share in the cost of this Plan.
Procedure for Amending the Plan:	Emory may amend the Plan at any time, even after retirement, by a written instrument signed by a senior officer of Emory University. Some terms are described only in the SPD and the SPD can be revised at any time (without a formal amendment to the Plan).
Trustee:	Emory University Attn: Sr. VP & Chief HR Officer 1599 Clifton Road NE, First Floor Atlanta, GA 30322

Continuation of Group Health Plan Coverage

You may be able to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.

In accordance with federal law (PL 99-272) as amended, Covered Persons have the right to continue their health expense coverage under certain circumstances. You or your dependents may continue any health expense coverage then in effect, if coverage would terminate for the reasons specified in sections A or B below. You and your dependents may be required to pay up to 102% of the full cost to the Plan of this continued coverage or as to a disabled individual whose coverage is being continued for 29 months in accordance with section A, up to 150% of the full cost to the Plan of this continued coverage for any month after the 18th month. Subject to the payment of any required contribution, health expense coverage may also be provided for any dependents you acquire while the coverage is being continued. Coverage for these dependents will be subject to the terms of this Plan regarding the addition of new dependents.

When making the decision of whether to elect COBRA continuation coverage, you should consider that there may be other coverage options for you and your family. For example, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away. Being eligible for COBRA does not limit your eligibility for this coverage or a tax credit through the Marketplace. However, once you elect COBRA, these options are affected. Before you make a decision to enroll in coverage offered through the Marketplace, you can see what premiums, deductibles and out-of-pocket costs will be.

You should compare plans so that you can see which coverage is right for you. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. You can learn more about many of these options at www.healthcare.gov.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out-of-pocket than you would under COBRA because the new coverage may impose a new deductible. When you lose job-based health coverage, it is important that you choose carefully between COBRA continuation coverage and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact 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

Continuation shall be available as follows:

A. Continuation of Coverage on Termination of Employment or Loss of Eligibility. If your coverage terminates due to termination of your employment for any reason other than gross misconduct or your loss of eligibility under this Plan due to a reduction in the number of hours you work, you may elect to continue coverage for yourself and your dependents or your dependents may each elect to continue their own coverage. This election must include an agreement to pay any required contribution. You or your dependents must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date Emory informs you or your eligible dependents of any rights under this section.

Coverage will terminate on whichever of the following is the earliest to occur:

- The end of an 18-month period after the date of the event that caused coverage to terminate.
- The end of a 29-month period after the date of the event that caused coverage to terminate, but only if prior to the end of the above 18-month period, you or your dependent provides notice to Emory, in accordance with section D below, that you or your dependent has been determined to have been disabled under Title II or XVI of the Social Security Act on the date of, or within 60 days of, the event that caused coverage to terminate. Coverage may be continued for the individual determined to be disabled and for any family member (employee or dependent) of the disabled individual for whom coverage is already being continued and for your newborn or newly adopted child who was added after the date continued coverage began.
- The date Emory no longer provides a group health plan.
- The date any required contributions are not made.
- The first day after the date of the election that the individual becomes covered under another group health Plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health Plan.
- The first day after the date of the election that the individual becomes enrolled in benefits under Medicare.

If the employee became entitled to (i.e., enrolled in) Medicare benefits less than 18 months before the event described in Section A, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the employee's Medicare entitlement. For example, if the employee becomes entitled to Medicare eight months before the date on which employment terminates, COBRA continuation coverage for the employee's covered spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

As to all individuals whose coverage is being continued in accordance with the terms of the second bulleted item above, the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled individual whose coverage is being so continued is no longer disabled but in no event shall such coverage terminate prior to the end of the 18-month period described in the first bulleted item above.

B. Continuation of Coverage under Other Circumstances. If coverage for a dependent terminates due to:

- Your death;
- Your divorce;
- The dependent's ceasing to be a dependent child as defined under this Plan; or
- The dependent's loss of eligibility under this Plan because you become entitled to benefits under Medicare.

The dependent may elect to continue his or her own coverage. The election to continue coverage must be made within 60 days of the later to occur of the date coverage terminates and the date Emory informs your dependents, subject to any notice requirements in section D below, of their continuation rights under this section. The election must include an agreement to pay any required contribution.

C. Coverage for a dependent who experiences an event described in Section B will terminate on the first to occur of:

- The end of a 36-month period after the date of the event that caused coverage to terminate.
- The date Emory no longer provides a group health plan.

- The date any required contributions are not made.
- The first day after the date of the election that the dependent becomes covered under another group health Plan. However, continued coverage will not terminate until such time that the dependent is no longer affected by a preexisting condition exclusion or limitation under such other group health Plan.
- The first day after the date of the election that the dependent becomes enrolled in benefits under Medicare.

D. Multiple Qualifying Events - If coverage for you or your dependents is being continued for a period specified under section A, and during this period one of the qualifying events under the above section B occurs, this period may be increased. In no event will the total period of continuation provided under this provision for any dependent be more than 36 months. Such a qualifying event, however, will not act to extend coverage beyond the original 18-month period for any dependents (other than a newborn or newly adopted child) who were added after the date continued coverage began.

E. Notice Requirements

If coverage for you or your dependents:

- Is being continued for 18 months in accordance with section A; and
- It is determined under Title II or XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of, the event in section A that caused coverage to terminate you or your dependent must notify Emory of such determination within 60 days after the date of the determination and within 30 days after the date of any final determination that you or your dependent is no longer disabled.

If coverage for a dependent terminates due to:

- Your divorce; or
- Your dependent ceasing to be a dependent as defined under this Plan, you or your dependent must provide notice to Emory of the occurrence of the event. This notice must be given within 60 days after the later of the occurrence of the event and the date coverage terminates due to the occurrence of the event. If notice is not provided within the above specified time periods, continuation under this section will not be available to you or your dependents.

F. Continuation of Coverage During an Approved Leave of Absence Granted to Comply with Federal Law – If you cease active employment due to an approved leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for the length of the approved leave under the same terms and conditions which would have applied had you continued in active employment provided you make the required contributions.

Coverage will not continue beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date Emory determines your approved FMLA leave is terminated if you do not return to work.
- The date the coverage involved discontinues as to your eligible class.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate. If coverage terminates because your approved FMLA leave is deemed terminated by Emory, you may, on the date of such termination, be eligible for COBRA continuation beginning on such date.

If you return to work for Emory following the date Emory determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave. If your coverage had terminated during the leave, you can again enroll upon returning to work when your FMLA leave terminates, provided you make request for such coverage within 31 days of the date Emory determines the approved FMLA leave to be terminated. If you do not enroll within 31 days, you cannot later enroll until you have an enrollment period or a mid-year enrollment event.

If the employee chooses to continue coverage during the leave, the employee will be given the same health care benefits that would have been provided if the employee were working, with the same premium contribution ratio. If the employee's premium for continued membership in the Plan is more than 30 days late, the Employer will send written notice to the employee. It will tell the employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

USERRA Continuation Coverage

If you or your dependents lose coverage under the Plan due to your qualifying service in the uniformed services, you have the right to elect to continue such coverage under Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). To be entitled to USERRA rights, you must give advance notice of your service unless it is impossible or unreasonable under the circumstances to give such notice or giving such notice is precluded by military necessity. Service in the uniformed services includes duty on a voluntary or involuntary basis in the Armed Forces (including the Coast Guard and the Reserves), the Army National Guard, the Air National Guard, and the commissioned corps of the Public Health Service.

Your right to continued health coverage under USERRA is very similar, but not identical, to your right to continued health coverage under COBRA. In those instances, where your rights under COBRA and USERRA are not the same, whichever law gives you the greater benefit will apply. The administrative policies and procedures, which govern your right to COBRA continuation coverage, also apply to your right to USERRA continuation coverage, with a few limited exceptions.

Any election that you make under COBRA will also be an election to continue your health coverage under USERRA. If, however, you are unable to elect COBRA within the required period because of military necessity or because it is impossible or unreasonable for you to do so, the period for electing USERRA coverage will be tolled until the military necessity is abated or it is no longer impossible or unreasonable for you to make the required election. The period for electing COBRA coverage, however, will not be tolled in this situation.

You are the only one that has the right to make an election under USERRA to continue health coverage for yourself and any covered dependents. Your covered dependents do not have an independent right to make an election for USERRA continuation coverage. As a result, if you do not elect USERRA / COBRA coverage on behalf of your covered dependents, your covered dependents will still have a right to elect to continue their health coverage under COBRA, but they will not be entitled to receive any additional benefits provided under USERRA.

If you elect to continue health coverage for yourself (or your covered dependents) under USERRA, you must pay the required premium, which will be the same amount charged to active employees for the same coverage.

USERRA continuation coverage will generally continue for up to 24 months following the date your leave of absence begins. However, this coverage will terminate earlier if any one of the following events occurs:

- A premium payment is not made within the required time;
- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Although COBRA coverage and USERRA coverage begin at the same time, they do not end at the same time. COBRA coverage continues for up to 18 months (although, if certain events occur, it can be extended), while USERRA coverage continues for to 24 months as described above. On the other hand, there are certain events, like your failure to return to work at the end of your service or a dishonorable discharge, which cause your USERRA coverage to terminate early but which do not cause COBRA coverage to terminate. In that situation, even if your USERRA coverage terminates, you may still be entitled to continued health coverage under COBRA.

ERISA Rights

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

Receive Information about Your Plan Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may be able to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan for the rules governing your COBRA continuation rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact:

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Definitions

When used in this SPD, the following words and phrases have the meaning explained herein.

Acupuncture Services - Services for pain therapy when both of the following are true:

- The service is performed by a provider in the provider's office; and
- The provider is a licensed acupuncturist.

Aggregate Out-Of-Pocket Maximum - The combination of each family member's out-of-pocket expense is accumulated toward the maximum

Allowable Expense - means a health care service or expense, including deductibles and coinsurance that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid to the extent provided in this SPD. An expense or service that is not covered by any of the Plans is not an allowable expense.

The following are examples of expenses and services that are not allowable expenses:

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in the private hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the Plans routinely provides coverage of hospital private rooms) is not an allowable expense.

- If a person is covered by two or more Plans that compute their benefit payments on the basis of Reasonable and Customary Charges or Facility Charge Review Rates, any amount in excess of the highest of the Reasonable and Customary Charges or Facility Charge Review Rates for a specific benefit is not an allowable expense.

- If a person is covered by two or more Plans that provide benefits or services on the basis of Negotiated Charges, an amount in excess of the highest of the Negotiated Charges is not an allowable expense, unless the secondary Plan's provider's contract prohibits any billing in excess of the provider's agreed upon rates.

- If a person is covered by one Plan that calculates its benefits or services on the basis of Reasonable and Customary Charges or Facility Charge Review Rates and another Plan that provides its benefits or services on the basis of Negotiated Charges, the primary Plan's payment arrangements shall be the allowable expense for all the Plans.

- The amount a benefit is reduced by the primary Plan because a Covered Person does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

Ambulance Services – An ambulance is a vehicle staffed by medical personnel and is equipped to transport an ill or injured person by ground, air, or water.

Behavioral Health Care - Treatment of Mental Disorders and/or substance abuse disorders. Services include assessment, diagnosis, treatment planning, medication management, psychotherapy, and psychological testing.

Benefits - Your right to payment for Covered Health Services that are available under the Plan. Your right to benefits is subject to the terms, conditions, limitations, and exclusions of the Plan.

Body Mass Index - This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand Name Medication - A Prescription Drug that is protected by trademark registration.

Claim Determination Period - The calendar year.

Claims Administrator - The companies (including affiliates) that provide certain claim administration services for the Plan including Aetna and CVS/caremark.

Coinsurance - A percentage of the charge that you are responsible for, after deductibles.

Companion - A person whose presence as a companion or caregiver is necessary to enable an NME Patient:

- To receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- To travel to and from the facility where treatment is given.

Congenital Anomaly - A physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Cosmetic Procedures - Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator on behalf of this Plan.

Covered Health Service(s) - Those health services provided for the purpose of preventing, diagnosing, or treating a sickness, injury, Mental Disorders, substance abuse, or symptoms thereof.

Covered Medical Expense(s) - The cost of Covered Health Services(s) that are included in this Plan when calculating Benefits payable.

Covered Person - This is either the employee, retired employee, or an enrolled dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care - Services and supplies furnished to a Covered Person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The Covered Person does not have to be disabled. Such services and supplies are Custodial Care without regard to:

- By whom they are prescribed;
- By whom they are recommended; or
- By whom or by which they are performed.

Custodial Parent - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

Deductible - The amount of Covered Expense you must pay each year before any Plan Benefits begin.

Dentist - A legally qualified dentist. Also, a physician who is licensed to do the dental work he or she performs.

Detoxification – The process of getting alcohol or other drugs out of an addicted person's system and getting them physically stable.

Durable Medical and Surgical Equipment - No more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is: made to withstand prolonged use; made for and mainly used in the treatment of a disease or injury; suited for use in the home; not normally of use to persons who do not have a disease or injury; not for use in altering air quality or temperature; and not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; over-bed tables; elevators; communication aids; vision aids; and telephone alert systems.

Emergency Services – Treatment given in a hospital's emergency room or an independent freestanding emergency department. This includes evaluation of and treatment to stabilize the emergency medical condition. An independent freestanding emergency department means a health care facility that is geographically separate, distinct, and licensed separately from a hospital and provides emergency services.

Emory - Shall mean Emory University and its schools, operating divisions and affiliates and any/all entities controlled by Emory University either directly or indirectly, including but not limited to, the Carter Center, Inc., Emory + Children's Pediatric Institute, Emory Decatur Hospital, Emory Hillandale Hospital, Emory Long Term Acute Care, Emory Healthcare Inc.,The Emory Clinic Inc., Emory Specialty Associates, LLC, Emory /Saint Joseph's, Inc., Saint Joseph's Hospital of Atlanta, Inc., The Medical Group of Saint Joseph's, LLC, EHCA Johns Creek, LLC d/b/a Emory Johns Creek Hospital.

Excluded Amount - A charge made by a provider that is not covered under the Plan.

Facility Charge Review Rate (FCR) – A determined amount that is enough to cover the provider's estimated costs for the service and that leaves the provider with a reasonable profit. For hospitals and other facilities which report costs (or cost-to-charge ratios) to Centers for Medicare and Medicaid Services (CMS), the FCR rate is based on what the facilities report to CMS. For facilities which do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. The formula may be adjusted as needed to maintain the reasonableness of the recognized charge. Example: An adjustment may be made if it is determined that in a particular state, the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.

Federal Legend Drug - Any drug that requires a prescription.

Generic Medication - A Prescription Drug that is not protected by trademark registration but is produced and sold under the chemical formulation name.

Home Health Care Agency - This is an agency that:

- Mainly provides skilled nursing and other therapeutic services; and
- Is associated with a professional group that makes policy (this group must have at least one physician and one R.N.); and
- Has full-time supervision by a physician or a R.N.; and
- Keeps complete medical records on each person; and

- Has a full-time administrator; and
- Meets licensing standards.

Home Health Care Plan - This is a plan that provides for care and treatment of a disease or injury. The care and treatment must be prescribed in writing by the attending physician and an alternative to confinement in a hospital or Skilled Nursing Facility.

Hospice Care - This is care given to a terminally ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

Hospice Care Agency - This is an agency or organization that has Hospice Care available 24 hours a day and meets any licensing or certification standards set forth by the jurisdiction where it is located and which:

- Provides skilled nursing services, medical social services, and psychological and dietary counseling.
- Provides or arranges for other services, including services of a physician; physical and occupational therapy; part-time home health aide services that mainly consist of caring for terminally ill persons; and inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel including at least: (a) one physician; (b) one R.N. and (c) one licensed or certified social worker employed by the Hospice Care Agency.
- Establishes policies governing the provision of Hospice Care.
- Assesses the patient's medical and social needs and develops a Hospice Care Program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the Hospice Care Agency. Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program - This is a written plan of Hospice Care that is established by and reviewed from time to time by a physician attending the Covered Person; and appropriate personnel of a Hospice Care Agency. It is designed to provide palliative and supportive care to terminally ill persons and supportive care to their families. A Hospice Care Program includes an assessment of the person's medical and social needs and a description of the care to be given to meet those needs.

Hospice Facility - This is a facility, or distinct part of one, which:

- Mainly provides inpatient Hospice Care to terminally ill persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians. At least one of them must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a R.N.
- Has a full-time administrator.

Hospital - This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of physicians.
- Provides 24-hour a day R.N. service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

L.P.N. - This means a licensed practical nurse.

Mail Order Pharmacy - An establishment where Prescription Drugs are legally dispensed by mail.

Medically necessary, medical necessity – Health care services or supplies that prevent, evaluate, diagnose, or treat an illness, injury, disease, or its symptoms, and that are all of the following, as determined by us within our discretion:

- In accordance with "generally accepted standards of medical practice"
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease.
- Not primarily for your convenience, the convenience of your physician or other health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, or disease.

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, and
- Following the standards set forth in our clinical policies and applying clinical judgment.

Important note:
We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **experimental or investigational**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact Aetna.

Mental Disorder - A sickness that is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). A disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist, or a psychiatric social worker. A mental disorder includes, but is not limited to:

- Alcoholism and drug abuse
- Schizophrenia
- Bipolar disorder
- Pervasive Mental Developmental Disorder (Autism)
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive compulsive disorder

Morbid Obesity - This means a certain Body Mass Index that is calculated by the Claim Administrator to determine eligibility of certain supplies and services.

Negotiated Charge - This is the maximum charge a Tier 1 or Tier 2 provider has agreed to make as to any service or supply for the purpose of the Benefits under this Plan.

Orthodontic Treatment - This is any medical service or supply or dental service or supply that is furnished to prevent, diagnose or to correct a misalignment of the teeth, bite or of the jaws or jaw joint relationship, whether or not for the purpose of relieving pain. Not included is the installation of a space maintainer or a surgical procedure to correct malocclusion.

Out-of-Core Network Facilities – For Emory Healthcare employees and their covered dependents only: While the HSA medical plans do allow for flexibility in selecting providers for care, many of the facilities in the Atlanta metropolitan area are considered out-of-core-network. Contact Aetna to obtain a list of out-of-core-facilities.

Out-of-Pocket Maximum - The most you will have to pay per person, per year for certain covered expenses. It includes the deductible and most coinsurance amounts. Once you have paid the out-of-pocket maximum expense amount, the Plan pays 100% of the Covered Person's covered expenses for the rest of the calendar year.

Pharmacy - An establishment where Prescription Drugs are legally dispensed.

Physician - A health professional trained and licensed to practice and prescribe medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy. Under some plans, a physician can also be a primary care provider (PCP).

Plan - Any Plan providing benefits or services by reason of medical or dental care or treatment, which benefits, or services are provided by one of the following:

- Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trusted Plans, labor organization Plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the contract includes both medical and dental coverage, those coverages will be considered separate Plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy Plans. In turn, the dental coverage will be coordinated with other dental Plans. The Plan described in this summary is the Emory Health Savings Account (HSA) Health Care Plan, the "Plan".

Plan Administrator - Emory University, c/o Human Resources Department.

Preferred Pharmacy - A pharmacy, including a Mail Order Pharmacy that is party to a contract with CVS/caremark to dispense drugs to a Covered Person while the contract remains in effect and while such a pharmacy dispenses a Prescription Drug under the terms of its contract with CVS/caremark.

Prescription Drugs - Any of the following:

- A drug, biological, compounded prescription, or contraceptive device that, by Federal Law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".

- An injectable contraceptive drug prescribed to be administered by a paid healthcare professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes that are purchased to administer a covered injectable Prescription Drug.
- Disposable diabetic supplies.

Primary Care Provider - This is a person who is responsible for coordinating all of a covered participant's medical care.

A provider who:
- The directory lists as a PCP
- Is selected by you from the list of PCPs in the directory
- Supervises, coordinates and provides initial care and basic medical services to you
- Shows in our records as your PCP

A PCP can be any of the following providers:
- General practitioner
- Family physician
- Internist
- Nurse Practitioner
- Physician Assistant
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group (primary care office)

Psychologist - This is a person who specializes in clinical psychology and fulfills one of the following requirements: A person licensed or certified as a psychologist or a member or fellow of the American Psychological Association, if there is not government licensure or certification required.

R.N. – This means a registered nurse.

Reasonable and Customary Charge (also referred to as recognized charge) - This only applies to Tier 3 claims. Only that part of a charge that is reasonable is covered. The reasonable charge for a service or supply is the lowest of the provider's usual charge for furnishing it, and the charge the Claims Administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and the charge the Claims Administrator determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply, the complexity; the degree of skill needed; the type of specialty of the provider; the range of services or supplies provided by a facility; and the prevailing charge in other areas will be taken into consideration.

In some circumstances, the Claims Administrator may have an agreement with a provider (either directly, or indirectly through a third party) that sets the rate that will be paid for a service or supply. In these instances, in spite of the methodology described above, the reasonable charge is the rate established in such agreement.

Important Note: For inpatient and outpatient charges of non-participating hospitals and facilities other than hospitals, the Facility Charge Review Rate will apply.

Recognized Charge (Voluntary Services) – The amount of an out-of-network provider's charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

If your ID card displays the National Advantage Program (NAP) logo, your cost may be lower when you get care from a NAP provider. Through NAP, the recognized charge is determined as follows:

- If your service was received from a NAP provider, a pre-negotiated charge will be paid. NAP providers are out-of-network providers that have contracts with Aetna, directly or through third-party vendors, that include a pre-negotiated charge for services. NAP providers are not network providers.
- If your service was not received from a NAP provider, a claim specific rate or discount may be negotiated by Aetna or a third-party vendor.

Important Note: If the provider bills less than the amount calculated using the out-of-network plan rate, the recognized charge is what the provider bills.

In the event you receive a balance bill from a provider for your out-of-network service, Patient Advocacy Services may be available to assist you in certain circumstances.

If NAP does not apply to you, the recognized charge for specific services or supplies will be the out-of-network plan rate.

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by an out-of-network provider, unless that out-of-network provider is an assistant surgeon for your surgery
- Not available from a network provider
- Emergency services

We will calculate your cost share for involuntary services in the same way as we would if you received the services from a network provider.

Special term used:

- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Residential Treatment Facility – A facility that provides mental health disorder services or substance related disorder services and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed physician for the level of care provided
- Maintains a written treatment plan prepared by a licensed behavioral health provider (RN or master's level) requiring full-time residence and participation
- Has a licensed **behavioral health provider**, (RN or master's level) on-site 24 hours per day 7 days per week, and is:
    - Credentialed by us, or
    - Certified by Medicare, or

- Accredited by The Joint Commission (TJC); The Committee on Accreditation of Rehabilitation Facilities (CARF); The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP); or The Council on Accreditation (COA)

Room and Board Charges - Charges made by an institution for room and board and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

Semi-private Rate - This is the charge for room and board that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, the Claims Administrator will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Facility – A facility that provides skilled nursing care and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed physician for the level of care provided
- Maintains a written treatment plan prepared by a licensed provider (RN or master's level) requiring full-time residence and participation
- Has a licensed provider (RN or master's level) on-site 24 hours per day 7 days per week, and is:
  - Credentialed by us, or
  - Certified by Medicare, or
  - Accredited by The Joint Commission (TJC) or The Committee on Accreditation of Rehabilitation Facilities (CARF)

Skilled nursing facilities also include rehabilitation hospitals, and portions of a rehabilitation hospital and a hospital designated for skilled or rehabilitation services.

Skilled nursing facility does not include institutions that provide only:
- Minimal care
- Custodial care services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of mental health disorders or substance related disorders.

Specialist - A physician who practices in any generally accepted medical or surgical sub-specialty and is providing other than routine medical care.

Surgery Center - This is a freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped, and run to provide general surgery.
- Makes charges.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery that requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to physicians who practice surgery in an area hospital and dentists who perform oral surgery.

- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a R.N.
- Is equipped and has trained staff to handle medical emergencies.
- Has a physician trained in cardiopulmonary resuscitation; and
- Has a defibrillator, a tracheotomy set and a blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

Surprise Billing – Unexpected balance billing (except when you have consented) for emergency services and non-emergency services performed by non-par providers at par facilities.

Terminally Ill - This is a medical prognosis of 6 months or less to live.

Tier 1 Providers - Providers and facilities that are owned by or affiliated with Emory.

Tier 2 Providers - Providers that are part of, or who have contracts with the Claim Administrators. To locate a participating physician or facility, visit http://www.aetna.com/docfind/custom/emory or call 1-800-847-9026.

Tier 3 Providers – Includes providers who are not participating/contracted with the Claims Administrator and also Out-of-Core Network Facilities. Out-of-pocket will be higher when seeking care from these providers. Please refer to the Out-of-Core Network Facilities definition.

Treatment Center (Mental Disorder) - A facility that provides a program of effective mental health and substance abuse treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It is staffed by psychiatric physicians involved in care and treatment.
- Is not mainly a school or a custodial, recreational, or training institution
- It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
    - Room and Board;
    - Evaluation, diagnosis; counseling;
    - Referral and orientation to specialized community resources;
    - Infirmary-level medical services;
    - Provides, or arranges with a hospital in the area for, any other medical service that may be required;
    - Full-time supervision by a psychiatrist who is responsible for patient care and is there regularly;
    - Psychiatric social work and nursing services at all times; and
    - Skilled nursing care by licensed nurses who are supervised by a full-time R.N. at all times.

Treatment Facility (Alcoholism or Drug Abuse) - This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse;
- Makes charges;
- Meets licensing standards;
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological, and social needs. It must be supervised by a physician;
- Provides, on the premises, 24 hours a day:
    - Detoxification services needed with its effective treatment program.
    - Infirmary-level medical services.
- Provides, or arranges with a hospital in the area for, any other medical services that may be required; and
- Provides supervision by a staff of physicians; and provides skilled nursing care by licensed nurses who are directed by a full-time R.N.

Urgent Care Provider – This is a freestanding medical facility that provides unscheduled medical services to treat an urgent condition if the Covered Person's physician is not reasonably available. It is not emergency room or outpatient department of a hospital.