2024

Curative EPO Benefit Booklet

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Welcome
Building a Healthy Tomorrow Together

Benefit Booklet

This Benefit Booklet is a guide to your Health Plan benefits. It includes definitions of terms you should know and detailed information about your Health Plan. Included in the booklet will be a comprehensive Table of Contents to help you locate information, but if you have any questions, please contact Curative Member Services at 855-428-7284.

You are responsible for carefully reading this Benefit Booklet so you will be aware of all the benefits and requirements in the Health Plan, including definitions, limitations and exclusions. The Summary of Benefits chart will break down the Copays, Deductible, and Coinsurance percentages for the most typical services Members utilize.

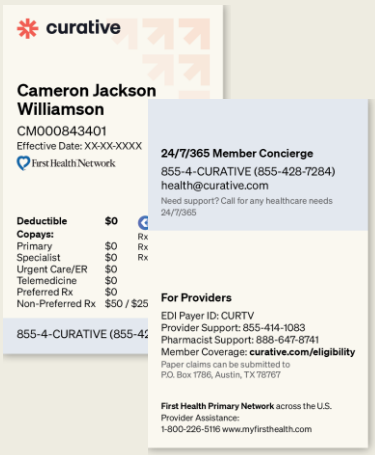
Information and forms can be found at our website www.curative.com. For specific information and forms regarding your Prescription Benefits you may also find this information at www.curative.com/drugs.

This Benefit Booklet and the Addendum to the Benefit Booklet, together, are the Summary Plan Description ("SPD") for the Health Plan.

ID Cards

The ID Card issued to you by Curative identifies you as a Member in the Health Plan offered by your Employer. This ID Card contains essential information about you, your Employer, and the benefits to which you are entitled. Always remember to carry your ID Card with you, present it when receiving health care services or supplies, and make sure your provider always has an updated copy.

You will also have access to your ID Card online at the Curative Member Portal accessible at health.curative.com. Or you can request another ID Card at any time, by requesting it online at health.curative.com or contacting Curative Member Services at 855-428-7284.



Summary of Benefits

In-Network and Out-of-Network benefits apply to Members and services are limited to the Allowable Amount as determined by the Claims Administrator. All In-Network providers have agreed to accept the Allowable Amount as payment in full. For Out-of-Network providers, any charges over the Allowable Amount for services are the patient's responsibility in addition to the Deductible and Coinsurance.

If you complete your Baseline Visit within 120 calendar days of your effective date in the Health Plan, all medical in-network Copays, Deductibles, and Coinsurances will be waived so that your cost for provider services In-Network will always be $0. If you are unable to schedule a Baseline Visit within 120 calendar days of your effective date because an appointment is not available, Curative will extend the timeframe to complete the Baseline Visit until an appointment is available. Maximum visits, limitations and tiered Pharmacy benefits will continue to apply.

In the first year, during the first 120 calendar days enrolled in the Health Plan, all Copays, Deductibles, and Coinsurance will be waived for in-network services for all members.

The Baseline Visit is a meeting with a Curative Clinician to onboard you to the Curative Health Plan, understand your health goals and how Curative can best work with you to meet your current and future healthcare needs. The Baseline Visit will also include an Evaluation of Preventive recommendations indicated by the United States Preventive Services Task Force (USPSTF) and evaluate whether your immunizations are up to date, all designed to keep you healthy.

***** NOTE – Services received from Out-of-Network providers are not covered unless Network services were not available as described in "Necessary Out-of-Network Services" in this Benefit Booklet. Necessary Out-of-Network Services will be treated the same as In-Network Services.**

Coverage	Curative In-Network	Curative In-Network
	When compliant with Baseline Visit (see above)	When non-compliant with Baseline Visit (see above)
Annual Deductible	**$0**	$5,000/person $10,000/family
Coinsurance Percentage	**0%**	20% Medical; 25% Pharmacy (with $25/mo cap on insulin)
Annual Out-of-Pocket Maximum (Medical)	**$0**	$7,500/person $15,000/family

Coverage	Curative In-Network	Curative In-Network
	When compliant with Baseline Visit (see above)	When non-compliant with Baseline Visit (see above)
	Non-Preferred Brand Name & Generics and Specialty Drugs $7,500/person $15,000/family	
Lifetime Maximum Benefit	**No Limit**	No Limit
OFFICE SERVICES		
Preventive Care	**$0 Copay**	$0 Copay
Child Immunizations for children under the age of 6 Covered at 100%	**$0 Copay**	$0 Copay
Family Practice Internal Medicine OB/GYN Pediatrics (Office/Virtual Visit)	**$0 Copay**	$25 Copay after Deductible
Specialist (Office/Virtual) Visit	**$0 Copay**	$50 Copay after Deductible
Telemedicine On Demand with a 24/7/365 Doctor Visit	**$0 Copay**	$0 Copay
Urgent Care	**$0 Copay**	20% Coinsurance after Deductible
Lab and X-Ray	**$0 Copay**	20% Coinsurance after Deductible
Other Tests	**$0 Copay**	20% Coinsurance after Deductible
Allergy Testing	**$0 Copay**	20% Coinsurance after Deductible
Allergy Serum/Injections (if no office visit billed)	**$0 Copay**	20% Coinsurance after Deductible

Coverage	Curative In-Network	Curative In-Network
	When compliant with Baseline Visit (see above)	When non-compliant with Baseline Visit (see above)
PHARMACY BENEFITS **(a $25/month cap on cost-sharing obligations applies for insulin included on the Curative Formulary)**		
Preferred Drugs (includes certain Generic, Brand Name, & Specialty drugs)	**$0 Copay**	$50 Copay after Deductible. (Mail order: $0 copay for 30-90 days supply. 90 day supply only available for certain Maintenance Medications)
Non-Preferred Brand Name & Generics Drugs (annual max out-of-pocket)	**$50 Copay**	$100 Copay after Deductible. (Mail order: $50-$150 Copay for 30-90 days supply only available for certain Maintenance Medications)
Non-Preferred Specialty Drugs (annual max out-of-pocket)	**$250 Copay**	25% Coinsurance after Deductible
EMERGENCY CARE **(limited to services in the United States)**		
Ambulance Service	**$0 Copay**	20% Coinsurance after Deductible
Hospital / Free Standing Emergency Room	**$0 Copay**	20% Coinsurance after Deductible
Emergency Room Physicians	**$0 Copay**	20% Coinsurance after Deductible
OUTPATIENT CARE		
Observation	**$0 Copay**	20% Coinsurance after Deductible
Surgery - Facility	**$0 Copay**	20% Coinsurance after Deductible
Surgery - Physician	**$0 Copay**	20% Coinsurance after Deductible
Lab and X-Ray	**$0 Copay**	20% Coinsurance after Deductible
Advanced Imaging Scans	**$0 Copay**	20% Coinsurance after Deductible

Coverage	Curative In-Network	Curative In-Network
	When compliant with Baseline Visit (see above)	When non-compliant with Baseline Visit (see above)
Other Tests	**$0 Copay**	20% Coinsurance after Deductible
Outpatient Procedures in Physician's Office	**$0 Copay**	20% Coinsurance after Deductible
INPATIENT CARE		
Hospital - Semi-private Room and Board	**$0 Copay**	20% Coinsurance after Deductible
Hospital Inpatient Surgery	**$0 Copay**	20% Coinsurance after Deductible
Physician	**$0 Copay**	20% Coinsurance after Deductible
OBSTETRICAL CARE		
Prenatal and Postnatal Care Office Visits	**$0 Copay**	$25 Copay after Deductible (first visit only)
Delivery - Facility/Inpatient Care	**$0 Copay**	20% Coinsurance after Deductible
Obstetrical Care and Delivery - Physician	**$0 Copay**	20% Coinsurance after Deductible
Newborn Care- covered for first 30 days without enrollment	**$0 Copay**	20% Coinsurance after Deductible (covered under mother's deductible first 30 days)
THERAPY		
Physical Therapy	**$0 Copay**	20% Coinsurance after Deductible
Occupational Therapy	**$0 Copay**	20% Coinsurance after Deductible
Speech and Hearing Therapy	**$0 Copay**	20% Coinsurance after Deductible

Coverage	Curative In-Network	Curative In-Network
	When compliant with Baseline Visit (see above)	When non-compliant with Baseline Visit (see above)
Applied Behavioral Analysis	**$0 Copay**	20% Coinsurance after Deductible
EXTENDED CARE		
Skilled Nursing Facility	**$0 Copay**	20% Coinsurance after Deductible
Home Health Care Services	**$0 Copay**	20% Coinsurance after Deductible
Hospice Care Services	**$0 Copay**	20% Coinsurance after Deductible
BEHAVIORAL HEALTH		
Mental Illness - Office/Virtual Visit	**$0 Copay**	$25 Copay after Deductible
Mental Illness - Intensive Outpatient and Partial Hospitalization	**$0 Copay**	20% Coinsurance after Deductible
Mental Illness - Inpatient	**$0 Copay**	20% Coinsurance after Deductible
Substance Use Disorder - Office/Virtual Visit	**$0 Copay**	$25 Copay after Deductible
Substance Use Disorder - Intensive Outpatient and Partial Hospitalization	**$0 Copay**	20% Coinsurance after Deductible
Substance Use Disorder - Inpatient Treatment	**$0 Copay**	20% Coinsurance after Deductible
OTHER SERVICES		
Durable Medical Equipment	**$0 Copay**	20% Coinsurance after Deductible
Prosthetic Devices	**$0 Copay**	20% Coinsurance after Deductible

Coverage	Curative In-Network	Curative In-Network
	When compliant with Baseline Visit (see above)	When non-compliant with Baseline Visit (see above)
Hearing Aids	**$0 Copay**	20% Coinsurance after Deductible
Bariatric Surgery (limited to one surgery per lifetime)	**$0 Copay**	20% Coinsurance after Deductible
Breastfeeding Support and Services (1 pump per pregnancy)	**$0 Copay**	$0 Copay
Acupuncture (Limited to 20 visits per plan year)	**$0 Copay**	20% Coinsurance after Deductible
Acupuncture (limited to 20 visits per plan year)	**$0 Copay**	20% Coinsurance after Deductible
Wigs (limited to $200 per plan year)	**$0 Copay**	20% Coinsurance after Deductible

*The Health Plan covers preventive care services in accordance with the requirements of the Affordable Care Act and implementing regulations and guidance thereunder (the "ACA"). To the extent any services under the Plan constitute preventive care services as defined in the ACA, coverage will be provided as required by law.

How your Health plan works

Choice of Providers and How Coverage Will Be Applied

You have freedom of choice in choosing your provider.

If you choose from the extensive list of high quality In-Network Providers who have contracted with Curative, you will receive the benefits at a higher level and will never be balance billed. **Find an In-Network Provider at** www.curative.com/get-care **or you can call or text Curative Member Services at 855-428-7284.**

You may choose any type of provider licensed to provide services covered as benefits under the plan. The type of provider you choose will not change your benefits under the plan.

In-Network

You will not be billed by In-Network providers for amounts over your applicable Copay, Deductible, and Coinsurance. If you attend a Baseline visit within the first 120 calendar days of enrollment, these amounts will always be zero. This means with the completion of the Baseline Visit you will pay $0 for access to any type of In-Network medical care.

Some benefits may be processed as an In-Network benefit when provided by Out-of-Network providers. When you are provided services by Out-of-Network providers at an In-Network Facility these services will be processed as an In-Network benefit, and you will not be balance billed by these providers over your applicable In-Network Copay, Deductible, and Coinsurance. This means as long as you go to an in-network hospital or other provider facility, you do not have to worry about surprise bills from any Out-of-Network providers who may work at the In-Network facility.

Find an In-Network Provider at www.curative.com/get-care **or you can call or text Curative Member Services at 855-428-7284.**

Necessary Out-of-Network Services

This Plan does not provide benefits for Out-of-Network services unless In-Network services are not available or for:

- Emergency services (Out-of-Network emergency care and air ambulance services are covered at the In-Network level, including with $0 copay if you are compliant with the Baseline Visit)
- Services from facility-based providers in an In-Network facility
- Laboratory service providers when services are provided in connection with a service from an In-Network Provider
- Diagnostic imaging services from an Out-of-Network provider when services are provided in connection with a service from an In-Network Provider

You are protected from balance billing or surprise billing when you receive services from an out-of-network provider in the situations described above.

The Health Plan will pay the Allowable Amount to these Out-of-Network Providers. If you receive a balance bill from a provider based on any amount greater than the Allowable Amount in these situations, please contact Curative Member Services at 855-428-7284.

The Baseline Visit

Curative has designed the Baseline Visit as the kick-off to your future health success. The Baseline Visit combines onboarding to the Health Plan with a comprehensive visit to give you a 360-degree view of your health, establish your health goals and how Curative can best support you in achieving them. The focus is to help you take action early to be healthy, happy and live your best life. The Baseline Visit is provided at no cost to you. When you complete your Baseline Visit within 120 calendar days of enrollment, and within 120 calendar days of any renewal enrollment date, your waiver on all Copays, Deductibles and Coinsurance on In-Network services will be extended for the full year. The Health Plan wants you to have access to the highest quality care when you need it. With the completion of the Baseline Visit all In-Network Medical services will have a $0 Copay, $0 Deductible and 0% Coinsurance. You can refer to the Notice Regarding Wellness Program for Employees and Dependents, Addendum to the Benefit Booklet, and Summary of Benefits for more details.

Please remember: In your first year, for the first 120 calendar days you will automatically qualify for the $0 Copay, $0 Deductible and 0% Coinsurance for In-Network medical services, but you must complete the Baseline Visit within 120 calendar days from your enrollment date to extend this cost-sharing waiver for the full plan year, otherwise you will be subject to Copays, Deductibles, and Coinsurance for In-Network services.

On Renewal

Each year when your plan renews, you will need to complete an annual Baseline Visit within 120 calendar days of your renewal effective date. If you completed your Baseline Visit in the prior year, you would continue to qualify for the $0 Copay, $0 Deductible and 0% Coinsurance for In-Network medical services so long as you complete your annual Baseline Visit within 120. If you did not complete the Baseline Visit in the prior year, you will not be eligible for the $0 Copay, $0 Deductible and 0% Coinsurance for In-Network medical services until after you complete your Baseline Visit.

If you are unable to schedule a Baseline Visit within 120 calendar days of your effective date because an appointment is not available Curative will extend the timeframe to complete your Baseline Visit until an appointment is available.

Pharmacy Benefits

The Health Plan provides a three-tiered pharmacy Benefit designed to get you access to the most clinically and cost-effective drugs with $0 Copay, $0 Deductible and 0% Coinsurance.

- Preferred Drugs: includes drugs to treat almost-all clinical conditions that have been selected by our Pharmacy and Therapeutics (P&T) committee as the most clinically and

cost effective and are available for $0 (subject to the completion of the Baseline Visit as with other In-Network Benefits) when filled at an In-Network pharmacy. The Health Plan includes many drugs on the Preferred list including brand name drugs and specialty drugs.

- Non-Preferred Drugs: includes drugs that are more expensive than Preferred drugs where a comparable drug is available on the Preferred list. These drugs are available with a $50 Copay for non-specialty drugs or a $250 Copay for select specialty-drugs. The member's Copay will never exceed 50% of the total Allowed Amount.

The Pharmacy Benefit is designed to provide an option with $0 out-of-pocket cost for most clinical conditions. Please see the Pharmacy section below for more details.

The Plan Covers Services that are Medically Necessary

The Health Plan covers services that are Medically Necessary. Throughout the descriptions of What is Covered, you will note the references to Medically Necessary or Medical Necessity. Below is an explanation of these terms.

> **Medically Necessary/Medical Necessity** means the health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider; and (d) 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 that patient's illness, injury, or disease. No service is a Covered Service unless it is Medically Necessary.

Allowable Amount

The Allowable Amount is the maximum amount that will be paid by The Health Plan for a medical service, supply, or drug, as defined in this Booklet.

Provider and Pharmaceutical Discount Cards and Plans

A Member's out-of-pocket costs that are paid by either a Provider or Pharmaceutical Discount Card or Plan are not counted towards the Member's applicable Deductible or Maximum Out-of-Pocket amount.

Statement by Members

In the absence of fraud, a statement made by a Member is considered a representation and not a warranty and may not be used in any contest under the Health Plan, unless a copy of the written instrument containing the statement is or has been provided to the person making the statement or, if the statement was made by the Member and the Member has died or become incapacitated, the Member's beneficiary or personal representative.

What your health plan covers

The following medical expenses are covered by the Health Plan. Covered services may be subject to limitations as noted in this section, the Benefit Summary or the Limitations and Exclusions section of this Benefit Booklet.

For any applicable Deductible, Copay, or Coinsurance information, please refer to the Benefit Summary for your Plan.

Acquired Brain Injury

Benefits for medically necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neurofeedback therapy, remediation, post-acute transition services and community integration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

To ensure that appropriate post-acute care treatment is provided, the Health Plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

- Has incurred an Acquired Brain Injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or prevention of, or slowing of, further deterioration.

Note: Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury. Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury. Treatment for an Acquired Brain Injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Acupuncture

The Health Plan covers the treatment of Musculoskeletal disorders. There is a limitation of 20 visits in a plan year.

Advanced Imaging (Prior Authorization recommended)

The Health Plan covers diagnostic imaging services when medically necessary including, but not limited to, MRIs, PET Scans, and CT Scans.

Allergy Care

Allergy injections (immunotherapy) and allergy tests (skin test, scratch test and RAST) are covered if administered by a physician, allergist, or specialist. Serum and Oral Drops are covered when provided directly by prescribing physicians and are not considered part of the pharmacy benefit.

Ambulance Services

The Health Plan covers Ambulance Services when medically necessary as noted below:

- The patient's condition must be such that ambulance services are the only form of transportation that would be medically acceptable; or
- The patient is transported to the nearest site when the appropriate facilities for the treatment of the injury or illness involved or in the case of organ transplant, to the approved transplant facility.

Air Ambulance Services are medically necessary as noted below:

- The time needed to transport a patient by either base or advanced life support land ambulance poses a threat to the patient's survival;
- The point of pick-up is inaccessible by land vehicle; or
- Great distances, limited time frames, or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities for treatment (i.e. transport of a critically ill patient to an approved transplant facility with a waiting organ).

The following services are not medically necessary, as they do not require ambulance transportation:

- Ambulance service when the patient has been legally pronounced dead prior to the ambulance being summoned.
- Services provided by an ambulance crew who do not transport a patient but only render aid. For instance:
    - Ambulance dispatched and patient refuses care or transport; or
    - Ambulance dispatched and only basic first aid was rendered.

Non-emergency transports between medical facilities may be considered medically necessary for a patient who has a medical condition requiring treatment in another location and is so disabled that the use of an ambulance is the only appropriate means of transfer. Disabled means the patient's physical conditions, their mobility, is unable to stand and sit unassisted or requires continuous life support systems. Non-emergency transport from a patient's home is not covered.

Transfers by medical vans or commercial transportation (such as physician owned limousines, public transportation, cab, etc.) are not covered.

Amino Acid-Based Elemental Formulas (Prior Authorization recommended)
Regardless of the formula delivery method, medically necessary Amino Acid-Based Elemental Formulas are covered under the Health plan when prescribed by a physician and medically necessary.

Anesthesia

The Health Plan covers the administration of anesthesia, other than local infiltration anesthesia, in connection with a covered surgical procedure, provided the anesthesia is administered and charged by a physician other than the operating surgeon or his assistant.

Anesthesia means the administration of spinal anesthetic, rectal anesthetic, or the administration of a drug or other anesthetic agent by injection or inhalation, if the purpose is to obtain muscular relaxation, loss of sensation or loss of consciousness.

Assistant Surgeon (Prior Authorization recommended)

The Health Plan covers the services of a physician who is actively assisting the operating surgeon when the condition of the patient or the type of surgical service requires such assistance.

Autism Spectrum Disorder

Generally recognized services prescribed for Autism Spectrum Disorder by the Member's physician or behavioral health practitioner in a treatment plan are available for a Plan Member. Generally recognized services such as:

- Evaluation and assessment services;
- Screening at 18 and 24 months;
- Applied behavior analysis (Prior Authorization recommended);
- Speech therapy;
- Occupational therapy; or
- Physical therapy.

Blood Transfusions

The Health Plan covers blood transfusions to maintain or replace blood volume, to provide deficient blood elements and improve coagulation, to maintain or improve transport of oxygen and in exchange for blood removed in the treatment of Rh incompatibility in a newborn. In addition, blood transfusion coverage is provided for liver failure in which toxins accumulate in the blood and in some other types of toxemia. Coverage includes autologous, direct donation, regular administration, and whole blood.

Breastfeeding Support and Services

Benefits will be provided for breastfeeding counseling and support services by a provider, during pregnancy and/or in the postpartum period. Benefits include the purchase of manual or electric breast pumps and supplies. In-Network providers and DME suppliers have options available with no cost-sharing requirements.

Coverage is provided for one pump per pregnancy. For assistance, please contact Curative Member Services at 855-428-7284.

Chiropractic

Curative covers the treatment of Musculoskeletal disorders. There is a limitation of 20 visits in a plan year.

Clinical Trials

Benefits will be provided for routine patient care costs in connection with a phase I, phase II, phase III, or phase IV Clinical Trial if the Clinical Trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is one of the following:

(1) Approved or funded by one or more of the following:
- the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- the National Institutes of Health;
- the Agency for Health Care Research and Quality;
- the Centers for Medicare & Medicaid Services;
- a qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
- the United States Department of Energy if certain approvals are in place;
- the United States Department of Defense if certain approvals are in place;
- the United States Department of Veterans Affairs if certain approvals are in place; or
- an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

(2) Conducted under an investigational new drug application reviewed by the Food and Drug Administration, or the trial is exempt from having an investigational new drug application.

Benefits will be paid if the research institution conducting the Clinical Trial agrees to accept reimbursement at the rates established under the Plan as payment in full for the routine patient care provided in connection with the Clinical Trial. Benefits will not be provided for:

(1) The investigational item, device, or service itself;
(2) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
(3) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Diabetic Management Services

The Health Plan covers expenses associated with the treatment of diabetes for individuals diagnosed with insulin-dependent or non-insulin-dependent diabetes, elevated blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels. Emergency refills of diabetes equipment or diabetes supplies, dispensed to the enrollee in accordance with applicable state law, will be covered in the same manner as for a

non-emergent refill of diabetes equipment or diabetes supplies. Covered Health Services will be consistent with minimum standards for coverage adopted by the Commissioner of Insurance pursuant to applicable state law and include:

Diabetic Equipment:

- Blood glucose monitors (including non-invasive glucose monitors and monitors for the blind);
- Insulin pumps and necessary accessories (infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin, and other required disposable supplies); and
- Podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes.

Insulin Pump Supplies can be obtained in 30-day amounts through this Durable Medical Supply benefit or in up to a 90-day amount through a Participating Mail Order Pharmacy. Call Curative Member Services at 855-428-7284 for more information.

Diabetic Prescriptions:

- Insulin and insulin analog preparations;
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and
- Glucagon emergency kits

Diabetic Supplies:

- Test strips for blood glucose monitors;
- Lancets and lancet devices;
- Visual reading and urine test strips and tablets which test for glucose, ketones and protein;
- Injection aids, including devices used to assist with insulin injection and needleless systems;
- Insulin syringes; and
- Biohazard disposable containers.

Note: All diabetic supplies listed above, along with blood glucose monitors (including noninvasive glucose monitors and monitors for the blind) and Continuous Glucose Monitors, are covered under the prescription drug program.

Diabetic Management Services/Diabetic Self-Management Training Programs, includes initial and follow-up instruction concerning:

- The physical cause and process of diabetes;
- Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
- Prevention and treatment of special health problems for the diabetic patient;
- Adjustment or lifestyle modifications; and
- Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Training will include the development of an individualized management plan that is created for and in collaboration with the patient (and/or family) to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and diabetic supplies.

Diagnostic and Screening Mammograms

The Health Plan will cover, for a female 35 years of age or older, an annual screening by all forms of low-dose mammography for the presence of occult breast cancer. Covered Health Services under this section will be treated in the same manner as other radiological examinations under the Plan and will be subject to the same dollar limits, Deductibles, and Coinsurance factors as coverage for other radiological examinations under the Plan.

The Health Plan will also provide mammogram coverage for diagnostic imaging that is:

- no less favorable than the coverage for a screening mammogram;
- designed to evaluate an abnormality detected by a patient and an individual with dense breast tissue;
- not limited to females age 35 years or older; and
- in accordance with applicable coverage requirements for preventive care services under federal law.

Durable Medical Equipment (Prior Authorization recommended for DME exceeding $750 in charges)

The Health Plan covers the rental (or purchase at the discretion of the Claims Administrator) of therapeutic supplies and rehabilitative equipment required for therapeutic repeated use. These items include, but are not limited to, a standard wheelchair, crutches, walker, bedside commode, hospital-type bed, suction machine, artificial respirator, or similar equipment.

Equipment to alleviate pain and provide patient comfort (including, but not limited to, over-the-counter splints or braces, air conditioners, humidifiers, dehumidifiers, air purifiers, physical fitness and whirlpool bath equipment, personal hygiene products and home air fluidized beds) is not covered, even if prescribed by your physician.

Emergency Care

The Health Plan covers emergency services for emergency medical conditions in the United States. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

In case of an emergency call 911 or go to the nearest emergency room. If you require hospitalization, notify the Health Plan at the number on the back of your ID Card within 48 hours of admission, or as soon as reasonably possible.

All emergency care facilities connected to and associated with an inpatient facility, whether provided by an In-Network provider or Out-of-Network providers, will be covered at the In-Network level of benefits. Out-of-Network emergency care providers are prohibited by law from balance billing you for any amount above the amount paid by your Plan. If you continue to be treated by an Out-of-Network provider after you receive emergency care and you can safely be transferred to the care of an In-Network provider, Out-of-Network benefits will be applied. In such a case, Out-of-Network providers may balance bill you for those services

What is emergency care?

Emergency care means emergency services for an emergency medical condition provided in a hospital emergency facility (emergency room), freestanding emergency medical care facility. An "emergency medical condition" is a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate care could result in:

- Placing the person's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant woman, there is serious jeopardy to the health of the fetus, there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

"Emergency services" include both of the following:

- *Initial services.* A medical screening examination within the capability of a hospital emergency department or freestanding independent emergency department, including ancillary services routinely available in the emergency department, to determine whether an emergency medical condition exists.
- *Post-stabilization services.* To the extent required by law, additional services covered under the Health Plan that are furnished by a nonparticipating provider or nonparticipating emergency facility after a participant or beneficiary is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the initial services were provided.

Formulas for Phenylketonuria or a Heritable Disease (Prior Authorization recommended)

The Health Plan covers formulas necessary to treat phenylketonuria or a heritable disease to the same extent that the Plan provides coverage for prescription drugs.

Gender Affirmation Surgery and Treatment (Prior Authorization recommended)

The Health Plan covers medically necessary surgery, related to the treatment for a Transgender Member who:

- Has reached physical maturity and is 18 years of age and older;
- Has been diagnosed with Gender Dysphoria specific to the same gender for 12 months or greater; and
- Has been under the care of a Psychiatrist/Psychologist for 12 months or greater.

Covered services may include, but are not limited to:

- Psychological evaluations as needed;
- Psychotherapy;
- Hormone therapy;
- Medically indicated prescriptions; and

Services that are not covered include, but are not limited to:

- Breast augmentation or removal.
- Facial treatment or reconstruction surgery.
- Laryngeal prominence modification.

For questions regarding Gender Affirmation Surgery and Treatment coverage, please contact Curative Member Services at 855-428-7284.

Hearing Care and Cochlear Implants

The Health Plan covers therapy due to the loss or impairment of hearing.

Coverage includes both routine care (one exam per year) and for medical conditions or accidents. Hearing aids are limited to 1 Binaural Hearing Aid or 2 Monaural Hearing Aids every 36 months, excluding add-ons, deluxe/upgrade options, batteries, etc.

Cochlear Implants and related services and supplies, including fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids, are eligible for Members 18 years old and younger when determined to be medically necessary. Coverage includes treatment for habilitation and rehabilitation, an external speech processor and controller with necessary components and replacement every three years.

Home Health Care (Prior Authorization recommended)

The Health Plan covers medically necessary services and supplies provided in the patient's home during a visit from a home health agency as part of a physician's written home health care plan. Coverage includes:

- Coordinated Home Care provided by a Registered Nurse (RN), Advanced Practice Nurse (APN) or Licensed Vocational Nurse (LVN);
- Part-time or intermittent home health aide services for patient care;
- Physical, occupational, speech and respiratory therapy services provided by licensed therapists;
- Supplies and equipment routinely provided by the home health agency; and
- If care is taught to a caretaker, this service will not be covered after training has been provided.

Home health care benefits are not provided for food or home-delivered meals, social casework or homemaker services, transportation, or services provided primarily for Custodial Care.

Hospice Care (Prior Authorization recommended)

The Health Plan covers services provided by a hospice to patients confined at home or in a hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

The following services are covered for hospice care in the home:

- Part-time or intermittent nursing care by a Registered Nurse (RN), Advanced Practice Nurse (APN) or Licensed Vocational Nurse (LVN);
- Part-time or intermittent home health aide services for patient care;
- Physical, respiratory, and speech therapy by licensed therapists; and

- Counseling services routinely provided by the hospice agency, including bereavement counseling.

The following services are covered in a Hospice facility:

- All usual nursing care by a Registered Nurse (RN), Advanced Practice Nurse (APN) or Licensed Vocational Nurse (LVN);
- Room and board and all routine services, supplies and equipment provided by the hospice facility;
- Physical, speech and respiratory therapy services by licensed therapists; and
- Counseling services routinely provided by the hospice facility, including bereavement counseling.

Hospital Admission (Prior Authorization recommended)

The Health Plan covers room and board (up to the hospital's semi-private room rate), general nursing care, and other hospital services and supplies. It does not cover personal items such as telephones and television rentals.

Infertility Services

Testing for diagnosis of infertility is covered.

Lab and X-ray Services

The Health Plan covers medically necessary laboratory and radiographic procedures, services, and materials, including diagnostic X-rays, X-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests, and therapeutic radiology services when ordered by a provider.

In-Network providers are responsible for referring patients to In-Network labs, imaging centers or an outpatient department of an In-Network hospital for medically necessary lab and X-ray services that are not available in a provider's office. However, you should always remind your provider that you will receive a higher level of benefits offered under your plan when using In-Network providers.

Maternity Care (Prior Authorization for delivery recommended)

The Health Plan covers maternity related expenses for Members. Maternity care includes diagnosis of pregnancy, pre- and post-natal care, and delivery. The Health Plan covers inpatient care for the mother and newborn child in a healthcare facility for a minimum of 48 hours following an uncomplicated vaginal delivery and for a minimum of 96 hours following an uncomplicated delivery by Cesarean section. Concurrent reviews will be required for prolonged stays exceeding the standard coverage period.

Inpatient hospital expenses incurred by the mother for delivery of a child will not include charges for routine well-baby nursery care of the newborn child during the mother's hospital admission for the delivery. These charges will be considered expenses of the child and may be subject to the benefit provisions and benefit maximums described in the Benefit Summary, however during the first 30 days the newborn will not have a separate deductible from the mother when utilizing In-Network providers. Complications of Pregnancy are covered as any other covered illness or

sickness under the Plan.

The Health Plan will only allow services provided by a midwife if affiliated with an In-Network OB/GYN provider.

How are doctor's charges for maternity care covered?

- Any services received In-Network during the first 120 calendar days are covered at a $0 Copay, $0 Deductible and 0% Co-Insurance.

- If you have completed your Baseline Visit during the first 120 days of enrollment there will be no Copay or Deductible for In-Network services.

- If you have not completed your Baseline Visit within the first 120 calendar days, services received In-Network starting on your 121st day of enrollment may be subject to a copay after the Deductible is met. Delivery charges will be subject to the Deductible and Coinsurance.
- Reference the "On Renewal" information under The Baseline Visit above for coverage in renewal years.

How is a newborn child covered under the Health Plan?

The Health Plan automatically provides coverage for a newborn of a covered Member for the first 30 days after the date of birth, but this coverage terminates at the end of 30 days unless the newborn is added to the employee's coverage. To add coverage for the newborn beyond the first 30 days, you must make the appropriate changes to your benefit election within the 31-day period after the birth. Enrollment changes must be made through your Employer's Benefits Office. You will need to enroll your newborn in the Health Plan within 31 days of birth. If you fail to enroll at that time, your next opportunity will be at Open Enrollment. You may then enroll for coverage for your dependent during the next open enrollment period or when a qualified change of status event occurs. Please contact your Employer's Benefits Office with questions or changes in status information.

For grandchildren to be eligible for newborn coverage, the grandchild must be added to the employee's coverage for benefits within 31 days of the newborn's birth. An eligible grandchild must be a dependent of the employee for federal tax purposes at the time the application for coverage of the grandchild is made. Consult your Employer's Benefits Office for more information about grandchildren as eligible dependents.

For In-Network services, the newborn's deductible is included in the mother's deductible if she is enrolled in the Health Plan and not separate for the first 30 days.

Medical Expenses

The Health Plan provides coverage for medical expenses for you and your covered dependents. These benefits include, but are not limited to:

- Service of physicians and other professional providers;
- Services of certified registered nurse-anesthetist (CRNA);
- Diagnostic X-ray and laboratory procedures;
- Radiation therapy;

- Anesthetics and its administration, when performed by someone other than the operating physician or other professional provider;
- Oxygen and its administration provided the oxygen is used;
- Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Member;
- Prosthetic appliances, required for the alleviation or correction of conditions arising from an Accidental Injury occurring or illness commencing after the Member's effective date of coverage under the Plan, excluding all replacements of such devices other than those necessitated by growth to maturity of the Member;
- Services and supplies used by the Member during an outpatient visit to a hospital, a therapeutic center, or a substance use disorder treatment center, or scheduled services in the outpatient treatment room of a hospital;
- Certain diagnostic procedures including, but not limited to, bone scan, cardiac stress test, CT Scan, MRI, myelogram, PET Scan;
- Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes; and
- Injectable drugs, administered by or under the direction or supervision of a physician or other professional provider

Services and supplies for medical expenses must be furnished by or at the direction or prescription of a physician or other professional provider. A service or supply is furnished at the direction of a physician or other professional provider if the listed service or supply is:

- Provided by a person employed by the directing physician or other professional provider;
- Provided at the usual place of business of the directing physician or other professional provider; or
- Billed to the patient by the directing physician or other professional provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Mental Health / Behavioral Health

The Health Plan covers the treatment of Mental Health and Behavioral Health on the same basis as any other illness.

Mental health treatment is a planned, structured, and organized care plan to promote stable mental health. A program may include different facilities and modalities, such as intensive inpatient treatment, inpatient rehabilitation/treatment, partial hospitalization, intensive outpatient treatment or a series of these levels of treatments without a lapse in treatment. A series is complete when a Member is discharged on medical advice to outpatient care or when a Member fails to materially comply with the mental health treatment program.

The Health Plan covers charges for inpatient and outpatient mental health and behavioral health care for:

- Individual or group psychotherapy;
- Diagnosis or treatment of a condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system used by Curative; and
- Diagnosis or treatment of any symptom, condition, disease or disorder by a provider, or any person working under the direction or supervision of a provider, when the eligible expense is for:

- Individual and group psychotherapy;
- Counseling;
- Psychological testing and assessment;
- Hospital visits or consultations in a facility providing such services
- Inpatient Care; and
- Electroconvulsive treatment

Intensive Outpatient Program / Partial Hospitalization Treatment Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness conditions. If you are recovering from severe and/or chronic Mental Illness conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute inpatient, residential care or a Partial Hospitalization Treatment Program.

All inpatient and certain outpatient treatment for behavioral health should be Prior Authorized by calling Curative Member Services at 855-428-7284.

Obesity (Prior Authorization recommended)

Surgical treatment of morbid obesity may be covered when it satisfies the criteria established by Curative medical policy guidelines.

Covered medical expenses for bariatric surgery include charges made by a hospital or a physician for the surgical treatment of morbid obesity of a Member.

All underlying medical conditions that will likely impact or complicate the patient's surgical and postoperative course must be adequately controlled before surgery.

Covered procedures include:
• Open or laparoscopic Roux-en-Y gastric bypass;
• Laparoscopic sleeve gastrectomy; or
• Open or laparoscopic biliopancreatic diversion with or without duodenal switch.

Coverage is limited to one procedure per lifetime under this plan regardless of when or where the surgery was performed.

Contact Curative Member Services at 855-428-7284 for current medical necessity determination criteria.

Oral Surgery (Prior Authorization recommended)

When medically necessary as deemed by the Claims Administrator and prescribed by your doctor, covered oral surgery is limited to:

- Services provided to a newborn for treatment or correction of a congenital defect;

- Correction of damage caused solely by external violent Accidental Injury to healthy, un-restored natural teeth and supporting tissues, if the accident occurs while the Member is covered by the Health Plan. Initial visit must occur within 72 hours of the accident and treatment must be completed within 24 months; or

- Orthognathic surgery for Members 18 years old and younger.

What oral surgery is covered?
Covered oral surgery means maxillofacial surgical procedures limited to:

- Excision of non-dental related neoplasms; including benign tumors and cysts, and all malignant and premalignant lesions and growths;
- Incision and drainage of facial abscess;
- Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; or
- Surgical and diagnostic treatment of conditions affecting the temporomandibular joint with radiographic evidence of derangement.

General dental services are NOT covered by the Health Plan.

Organ and Tissue Transplants (Prior Authorization recommended)

Organ and tissue transplants (bone marrow, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung) and related services and supplies are covered if:

- Transplant is not experimental/investigational in nature;
- Donated human organs or tissue or an approved artificial device are used;
- Recipient is a Member under the Health Plan;
- Recipient meets all the criteria established by Center of Excellence (COE) Hospital in its written policy guidelines; and
- Recipient meets all the protocols established by the COE hospital in which the transplant is performed.

Covered services and supplies include:

- Evaluation of organs or tissues including, but not limited to, the determination of tissue matches;
- Donor search and acceptability testing of potential live donors;
- Removal of organs or tissues from deceased donor; and
- Transportation of organs or tissues from deceased donors.

Covered services and supplies related to an organ or tissue transplant include, but are not limited to, X-rays, laboratory testing, chemotherapy, radiation therapy, and complications arising from such transplant.

Services and supplies NOT covered by the Health Plan include:

- Living and/or travel expenses of the recipient or live donor;
- Expenses related to maintenance of life for donor; for purposes of organ or tissue donation;

- Purchase of the organ or tissue; or
- Organs or tissue (xenograft) obtained from another species.

Orthotics

The Health Plan covers appropriate orthotic devices that adequately meet the medical needs of the Member to participate in ADL/standard activities. Orthotic devices include, but are not limited to, braces (i.e. an orthopedic appliance used to support, align, or hold body parts in a correct position) and crutches, including rigid back, leg or neck braces; casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets; and physician-prescribed, directed or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.

Non-covered items include, but are not limited to, splints and bandages available for purchase over the counter for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace; specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or effect changes in the foot; or foot alignment, arch supports, elastic stockings, and garter belts.

Maintenance and repairs to orthotics resulting from accident, misuse or abuse are the Member's responsibility and not covered by the Health Plan.

Outpatient Facility Services (Prior Authorization recommended)

The Health Plan covers the following services provided through a hospital outpatient department or a free-standing facility when medically necessary:

- Radiation therapy;
- Chemotherapy;
- Dialysis;
- Rehabilitation services; and
- Outpatient surgery.

Palliative Care (Prior Authorization recommended)

The Health Plan provides Palliative Care coverage for Members with a chronic, complex, or terminal illness.

Prenatal Testing

Benefits for eligible expenses incurred for prenatal genetic and chromosomal metabolic testing include amniocentesis and chorionic villus sampling (CVS). These tests are eligible for coverage for the specific conditions:

- NIPT / NIPS is covered in the first trimester of pregnancy; and
- Quad Screen and Nuchal Translucency is covered in the second trimester of pregnancy

Preventative Care

The Health Plan encourages preventive care and maintenance of good health.

Covered services under this benefit must be billed by the provider as "preventative care". Preventive care benefits will be provided for the following covered services. When using

In-Network providers, the services will not be subject to a Copay, Deductible, Coinsurance or dollar maximum unless stated as covered on the same basis as for any other illness.

- Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);

- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved; and

- Evidence based preventive care recommended by American Academy of Pediatrics and Bright Futures.

- Immunizations are available from your provider or at a Pharmacy location.

The preventive care services described above may change as USPSTF, or other national guidelines are modified. For the most recent list of recommended services, check with your doctor or visit www.healthcare.gov.

More about Preventive Care Benefits:

Benefits for the Prevention and Detection of Osteoporosis
Benefits are available on the same basis as for any other illness to qualified Members for medically accepted bone mass measurement for the detection of low bone mass and/or to determine the Member's risk of osteoporosis and fractures associated with osteoporosis.

Qualified Members are those who are:

- Postmenopausal and not receiving estrogen replacement therapy
- An individual with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures
- An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or effectiveness of approved osteoporosis drug therapy

Medications for the prevention and treatment of osteoporosis can be found on the Formulary with a $0 Copay. These include alendronate, risedronate, and ibandronate,.

Benefits for the Prevention and Detection of Breast Cancer
Benefits are available for annual screening low-dose digital mammograms and breast tomosynthesis for a Member who is 35 years of age and older.

Benefits for Certain Tests for Detection of Prostate Cancer
Benefits are available to male Members for a medically recognized diagnostic examination for the detection of prostate cancer. Benefits will include:

- A physical examination for the detection of prostate cancer; and
- A prostate-specific antigen test used for the detection of prostate cancer for each covered male who is at least 50 years of age and asymptomatic, or 40 years of age with a family history of prostate cancer or another prostate risk factor.

Benefits for Colorectal Cancer Screening

Benefits are available for colorectal cancer screening for Members who are 45 years of age and older and who are at normal risk for developing colon cancer coverage for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include:

- A Cologuard Test performed every 3 years;
- A colorectal cancer examination, preventive services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals; and
- An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

Benefits for Certain Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Benefits are available to each woman 18 years of age or older enrolled in the Plan for expenses for an annual medically recognized diagnostic examination for the early detection of ovarian cancer and cervical cancer. This includes:

- a CA 125 blood test;
- a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus; and
- any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer.

Benefits for Early Detection Tests for Cardiovascular Disease

Benefits are available for one of the following non-invasive screening tests for atherosclerosis and abnormal artery structures and function every 5 years. Eligible tests are available to each Member who is diabetic or has a risk of developing coronary heart disease and who is:

A male older than 45 years of age and younger than 76 years of age; or

- A female older than 55 years of age and younger than 76 years of age.

  Eligible Tests include:
  - Computed tomography (CT) scanning measuring coronary artery calcifications; or
  - Ultrasonography measuring carotid intima-media thickness and plaque.

Benefits for Speech and Hearing Services

Benefits are available on the same basis as for any other illness for the services of a provider to restore the loss of or correction of impaired speech or hearing function. For more information regarding this benefit refer to the Hearing Care and Cochlear Implants information in this section.

Benefits for Screening Tests for Hearing Impairment

Benefits are available for a covered dependent child for a screening test for hearing loss from birth through the date the child is 30 days old and for necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months old.

Immunizations
Benefits are available for immunizations for those recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) based on the Member's age requirements.

Immunizations that are covered at 100% In-Network and Out-of-Network for covered children until they reach their 6th birthday are:

- Diphtheria;
- Haemophilus influenzae type b;
- Hepatitis B;
- Measles;
- Mumps;
- Pertussis;
- Polio;
- Rubella;
- Tetanus;
- Varicella; and
- Any other immunizations that may be required by law

Professional Services

Covered services must be medically necessary as determined by the Claims Administrator and provided by a licensed physician or by other covered health providers as listed below. Benefits for services for diagnosis and treatment of illness or injury are available on an inpatient or an outpatient basis or in a provider's office.

Covered Health Providers:

- Advanced Practice Nurse (APN)
- Board Certified Behavioral Analyst
- Doctor of Medicine
- Doctor of Optometry
- Doctor of Osteopathy
- Doctor of Podiatry
- Doctor of Psychology
- Licensed Audiologist
- Licensed Chemical Dependency Counselor
- Licensed Dietician
- Licensed Hearing Instrument Fitter and Dispenser
- Licensed Marriage Family Therapist (LMFT)
- Licensed Clinical Social Worker
- Licensed Nurse Practitioner
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Licensed Professional Counselor
- Licensed Speech-Language Pathologist
- Physician Assistant (PA)

Prosthetic Devices (Prior Authorization recommended)

The Health Plan covers appropriate prosthetic devices that adequately meet the medical needs of the Member to participate in ADL/standard activities. These prosthetic devices include replacements necessitated by growth to maturity of the Member. Coverage is provided for medically necessary artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices (excluding dental appliances and the replacement of cataract lenses).

Maintenance and repairs to prosthetic devices resulting from accident, misuse or abuse are the Member's responsibility.

For purposes of this definition, a wig or hairpiece is not considered a prosthetic appliance.

Reconstructive Surgery (Prior Authorization recommended)
The Health Plan covers charges made by a physician, hospital or surgery center for reconstructive services and supplies, including:

- Surgery needed to improve significant functional impairment of a body part;
- Surgery to correct the result of an Accidental Injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18;
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury. (Note: Injuries that occur as a result of a medical (i.e. non-surgical) treatment are not considered accidental injuries, even if planned or unexpected); and
- Surgery to correct Craniofacial abnormalities up to the age of 18.

Covered expenses include reconstruction of the breast on which a medically necessary mastectomy for malignancy was performed, including an implant and areola reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of a mastectomy, including lymphedema. Reconstructive Surgery coverage does not include the replacement of prior elective breast implants.

Elective Cosmetic Surgery is NOT covered.

Reconstructive surgery is covered to the extent required by the Women's Health and Cancer Rights Act of 1998.

Rehabilitation Services (Physical, Speech and Occupational Therapies) (Prior Authorization recommended)

The Health Plan covers rehabilitation services and physical, speech and occupational therapies that are medically necessary, meet or exceed the treatment goals for the Member, and are provided on an inpatient or outpatient basis or in the provider's office. For a physically disabled person, treatment goals may include maintenance of function or prevention or slowing of further deterioration. See limitations that apply to the number of visits per year in the Summary of Benefits for Physical and Occupational Therapies.

For inpatient rehabilitation, the Member must participate in at least 15 hours per week of intensive rehabilitation therapy.

Skilled Nursing Facility (Prior Authorization recommended)

The Health Plan covers care in a Skilled Nursing Facility and includes:

- Room and board;
- Routine medical services, supplies, and equipment provided by the skilled nursing facility;
- General nursing care by a Registered Nurse (RN), Advanced Practice Nurse (APN) or Licensed Vocational Nurse (LVN); and
- Physical, occupational, speech therapy, and respiratory therapy services by a licensed therapist.

Substance Use/Opioid Use Disorder Treatment/Behavioral Health (Prior Authorization recommended)

Substance Use Disorder Treatments are an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility which may include, but is not limited to, Acute Treatment Services and Clinical Stabilization Services. It does not include programs which are primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental disabilities or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Substance Use Disorder means a condition or disorder that falls under any of the substance use disorder diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Substance Use Disorder Treatment Facility means a facility (other than a hospital) whose primary function is the treatment of Substance Use Disorder and is licensed by the appropriate state and local authority to provide such service, when operating within the scope of such license. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

A series of treatments is a planned, structured, and organized program to promote substance-free status. A program may include different facilities and modalities, such as inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient treatment or a series of these levels of treatments without a lapse in treatment. A series is complete when a Member is discharged on medical advice or when a Member fails to materially comply with the treatment program.

Inpatient treatment of substance use disorder must be provided in a substance use disorder treatment center. Benefits for the medical management of acute, life-threatening intoxication (toxicity) in a hospital will be available on the same basis as any other illness.

The Health Plan covers medically necessary inpatient and out-patient treatment for Substance Use Disorder in a Day Treatment Facility, a Crisis Stabilization Unit or Facility, a Residential Treatment Center, or a Residential Treatment Center for Children and Adolescents.

Intensive Outpatient Program / Partial Hospitalization Treatment Program services may be available with less intensity if you are recovering from Substance Use Disorder conditions. If you are recovering from Substance Use Disorder conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and

managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute inpatient, residential care, or a Partial Hospitalization Treatment Program.

All inpatient and certain outpatient treatment for behavioral health should be Prior Authorized. If you have questions contact Curative Member Services at 855-428-7284.

Opioid Cumulative Dosing:
To ensure your medication is safe and effective and as recommended by the CDC Guideline, your opioid medication may require Prior Authorization by Curative or further review by your pharmacy. Please see Opioid Cumulative Dosing under Pharmacy for details.

Telemedicine / Telehealth

The Health Plan covers the use of synchronous, interactive audio, video, or other electronic media for the health care provided by your Physician. These services can be for either a medical or mental health related issue. Telemedicine / Telehealth services provided by a preferred or contracted provider is covered by the Health Plan on the same basis and to the same extent that the Plan covers the service in an in-person setting.

Telemedicine On Demand

The Health Plan also offers at no cost to the Members a **Telemedicine On Demand Visit** with a 24/7/365 On Demand synchronous, interactive audio, video, or other electronic media to deliver health care as needed by a contracted telemedicine On Demand Physician or Pediatrician. These services can be for either a medical or mental health related issue.

Some of the typical conditions that can be treated by a Telemedicine On Demand Visit include, but are not limited to:

- COVID-19, cold and flu symptoms
- Skin rashes and infections
- Pink eye
- Cough and sore throat
- Insect bites and stings
- Earaches and swimmer’s ear
- Seasonal allergies
- Sinus infections
- Urinary tract infections
- Yeast infections
- Nausea and diarrhea
- Minor back or shoulder pain
- Minor injuries, sprains, and strains
- Minor trauma, burns or lacerations
- General health and medication questions
- Stress, anxiety, or depression

Wigs

Wigs are approved under the plan when hair loss is the result of an injury, disease, or treatment of a disease, not to exceed a maximum $200 benefit per plan year.

Your prescription drug benefits

The Health Plan wants to ensure Members have access to high quality prescription drugs. The Prescription Drug Program covers medically necessary prescriptions based upon the following:

- The drug is included on our approved Formulary;
- It has been approved by the United States Food and Drug Administration (FDA) for at least one indication; and
- Is recognized by the following for treatment of the indication for which it is prescribed
    - substantially accepted peer-reviewed medical literature.

The Health Plan's covered drugs are identified on a covered drug list, or Formulary. The Formulary will show if your drug is on Formulary and if it is a Preferred, Non-Preferred Generic and Brand Name, or Non-Preferred Specialty Drug. That, in combination with your pharmacy choice, determines your drug cost.

For a list of drugs on the Curative Formulary, visit our website at www.curative.com/pharmacy or call Curative Member Services at 855-428-7284.

Any Members cost-share, limitations and exceptions for a prescription is noted in the Summary of Benefits. Using drugs from the Preferred Drug category will save you money. Unless otherwise indicated, any prescription drug Copays listed are for up to a 30-day supply of medication.

The categories of prescription benefit levels noted in the Summary of Benefits are:

Preferred Drugs are a list of Generic, Brand Name, Over the Counter, and Specialty medications preferred for their clinical effectiveness and opportunities to help contain Member and plan costs. The Health Plan has designed this level of benefit to include at least one drug of each type, including high-cost specialty drugs, so that a Preferred option is always available for any situation.

Non-Preferred Generic and Brand Name Drugs are medications that are not in the Preferred Drug category because there are more effective and/or less expensive alternatives available. These medications require a higher Copay.

Non-Preferred Specialty Drugs are typically the highest cost prescriptions and used to treat complex chronic conditions including, but not limited to, rheumatoid arthritis, psoriasis, cancer and multiple sclerosis that are not in the Preferred Drug category because there are more effective and/or less expensive alternatives available.

If you qualify for the In-Network cost-sharing waiver (either in the first 120 days of enrollment or after completion of the Baseline Visit):

- Preferred drugs will be available with $0 Copay, $0 Deductible and 0% Coinsurance,
- Non-preferred Generic and Brand Name drugs will be available with $50 Copay, $0 Deductible and 0% Coinsurance.
- Non-preferred Specialty drugs will be available with $250 Copay, $0 Deductible and 0% Coinsurance.

Note: It is recommended that you prior authorize some drugs, and some drugs will require Step Therapy and Quantity Limitations. See the Formulary for additional information.

If you are prescribed a new medication by your provider, the first prescription dispensed may be limited to a 14-day supply (at ½ copay), and then the remainder of the 30-day supply may be dispensed to determine safety, tolerability, and efficacy.

In the event a drug is not included on the Formulary and is approved for coverage, the Non-preferred drug cost-share will apply for brand or generic drugs. The Non-preferred specialty drug cost-share will apply for specialty drugs.

In addition to the co-pay, you may be responsible to pay a dispense as written (DAW) pricing penalty. This means you may be responsible for the difference between the Non-Preferred Brand Name Medication and the equivalent Generic Medication, where generic is available. Note: Certain medications are excluded from the pricing penalty. A DAW pricing penalty brand exception may be requested.

Limits on Copays

The Health Plan will not require you to make a payment for a prescription drug at the point of sale in an
amount that is greater than the lesser of:

- The applicable copayment
- The allowable claim amount for the prescription drug
- The amount you would pay if you purchased the drug without using a health benefit plan or any other source of drug benefits or discounts.

Limits on Insulin Cost-Sharing

Cost-sharing for insulin included on the Curative Formulary Drug List shall not exceed $25.00 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.

Prescription Eye Drops

Prescription eye drops to treat a chronic eye disease or condition can be refilled if you pay at the point of sale the required copay and:

- The original prescription states that additional quantities of the eye drops are needed
- The refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription, including refills; and
- The refill is dispensed on or before the last day of the prescribed dosage period and:
    - not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops are dispensed;
    - not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops are dispensed; or
    - not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops are dispensed.

Prescription Drug Synchronization

The Health Plan will prorate any cost-sharing amount charged for a partial supply of a prescription drug
if:

- The pharmacy or the enrollee prescribing physician or health care provider notifies the health benefit plan that:
  - the quantity dispensed is to synchronize the dates that the pharmacy dispenses the enrollee's prescription drugs; and
  - the synchronization of the dates is in the best interest of the enrollee
- You agree to the synchronization
- The proration is based on the number of days; supply of the drug actually dispensed

Pharmacy Access

Retail Pharmacies:
You can go to any In-Network Pharmacy of your choice. Retail medications are normally limited to a 30-day supply but may be increased to 90 days if they are purchased at an In-Network Retail Pharmacy and the prescription is for a 90-day quantity.

Pick up your prescriptions at a network neighborhood pharmacy or have them delivered conveniently from a designated pharmacy. Find a contracted In-Network Pharmacy near you at www.curative.com/pharmacy.

Mail Order Pharmacies: The Health Plan also offers a Mail Order option which provides members the opportunity for further savings and convenience. Mail Order is only available through pharmacies designated at www.curative.com/curative-pharmacy. Mail Order is a particularly good option for your Maintenance (long-term) Medications. After the first two fills of a Maintenance Medication at an In-Network Retail Pharmacy, all refills going forward must be filled through the Curative mail order pharmacy, or other designated pharmacy if you are outside of the Curative service area. Review the Mail Order pharmacy for your area at www.curative.com/curative-pharmacy.

Specialty Pharmacies: Specialty drugs are subject to a 30-day supply limit. Members who are prescribed specialty drugs must fill those specialty drugs at Curatives designated Specialty Pharmacy. Find information at www.curative.com/pharmacy. There are some specialty drugs on the Formulary in the Preferred Drug category that are available at no cost.

Off-Label Coverage

The Health Plan will cover a drug prescribed to treat a chronic, disabling, or life-threatening illness
covered under the plan if the drug:

(1) has been approved by the United States Food and Drug Administration for at least one indication; and
(2) is recognized by the following for treatment of the indication for which the drug is prescribed:
(A) a prescription drug reference compendium approved by the commissioner for purposes of this section; or
(B) substantially accepted peer-reviewed medical literature.

Coverage of a drug under this section includes coverage of medically necessary services associated with the administration of the drug.

Coverage of a drug under this section does not include:

(1) experimental drugs that are not otherwise approved for an indication by the United States Food and Drug Administration;

(2) any disease or condition that is excluded from coverage under the plan; or

(3) a drug that the United States Food and Drug Administration has determined to be contraindicated for treatment of the current indication.

Opioid Cumulative Dosing

Per CDC guidelines, to ensure your medication is safe and effective, your medication may be limited for any of the following scenarios: 1.) You are prescribed a dose above the recommended quantity 2.) You are currently using other medications such as benzodiazepines that may interact with your opioids or 3.) You are new to opioid treatment. The Health Plan will limit your opioids to a maximum of 7 days if you're new to opioid treatment and limit your dose to a maximum of 90 Morphine Milligram Equivalents (MME) per day for all members.

Your pharmacy may work with your doctor to obtain the necessary information to help process your claim. If you have any condition(s) such as cancer, sickle cell disease or in palliative care, this limitation may not apply to you. Call Member Services at 855-428-7284 if you have any questions about your pharmacy claims.

Opioid Overdose:
The Health Plan will cover preferred generic or OTC naloxone (injection and nasal spray) at $0 Copay. These medications will help to prevent an overdose and do not require a prescription to be filled by your pharmacy. See the Formulary Preferred Drug category for a list of preferred naloxone medications.

Vaccinations at Pharmacies

The Health Plan covers select medically necessary vaccinations administered through Pharmacies. Eligibility for vaccination coverage may depend on determining factors for some vaccinations, including, but not limited to, age and recommended frequency of the vaccination. Note:

- Travel vaccinations are NOT covered through the pharmacy benefit; and
- When obtaining your vaccination from an Out-of-Network pharmacy, you will be required to submit a claim with an itemized receipt, if the pharmacy is unable to submit the claim to Curative electronically.

The following vaccines will be covered at your pharmacy. This is not all inclusive, see the PDL for a complete list:

Pneumococcal Vaccine	Influenza (Flu shots)	Human Papilloma Virus (HPV)
Shingrix	Hepatitis B	Meningococcal Vaccine
RSV	COVID-19	

Smoking Cessation

Your pharmacy benefit will allow coverage for Over-the-counter (OTC) Smoking Cessation agents such as patches, gums, and lozenges as well as prescription drugs for Smoking Cessation. These will be covered with a $0 Copay. A prescription from your doctor is needed to obtain these products from your pharmacy.

Step Therapy

Some prescriptions that are included in the Curative Formulary require Members use a clinically acceptable alternative medication prior to allowing a certain Prescription to be dispensed. Step Therapy ensures that clinical guidelines are met. There may be exceptions to Step Therapy requirements if the patient has experienced allergies, ineffectiveness, or adverse events to the preferred drug(s).

If you are using an Out-of-network Pharmacy, they may not be aware of the required Step Therapy and your claim may be denied due to non-adherence to the Step Therapy requirements. If you have any questions about which drugs are applicable to Step Therapy, please visit our website at www.curative.com/pharmacy or call Curative Member Services at 855-428-7284.

Step Therapy will not apply to prescriptions related to the diagnosis of Stage-Four Advanced Metastatic Cancer, associated conditions, and terminal illnesses.

If your Provider would like an exception to the Step Therapy requirement, they may submit a request to Curative at 855-428-7284. The Claims Administrator will review and provide an answer within 72 hours of the request. If we deny, you have the right to request an expedited internal appeal and also have the right to request a review by an Independent Review Organization (IRO) as explained in the Claims Section of this Benefit Booklet.

Prior Authorization for Prescriptions

Prior Authorizations are recommended to ensure the appropriate use, including safety and efficacy, of a drug. A list of the prescriptions for which Prior Authorization is recommended is available at www.curative.com/pharmacy or you can contact Curative Member Services at (855) 428-7284.

It is recommended that your Physician submit an authorization form at the time they are prescribing. If you are obtaining a prescription from a non-network Pharmacy, you should inform them that Prior Authorization is recommended,

For more information regarding the procedures to follow for Prior Authorization claims and appeals, please see “Claims” below.

See the Limitations and Exclusions section of this Benefit Booklet for more detail on drugs that may not be covered.

Adverse Determination Due to Formulary Limitation

If the Claims Administrator denies a prescription drug that has been prescribed to you because the drug is not included on the drug formulary, and the prescribing physician has determined that the drug is medically necessary, the Health Plan will provide appeal rights to you in the same manner as any other Adverse Determination.

Limitations and Exclusions

In addition to limitations and exclusions noted in the What the Plan Covers section of this Benefit Booklet, the Health Plan does not cover the following medical expenses:

1. Services received from Out-of-Network providers unless In-Network services were unavailable as described in the "Out-of-Network" Services section of this Benefit Booklet.

2. Any services, supplies or drugs that are not medically necessary and essential to the diagnosis and direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.

3. Any experimental or investigational services, supplies, or drugs except for applicable clinical office visits and labs.

4. Any portion of a charge for a service, supply or drug that is in excess of the Allowable Amount as determined by the Claims Administrator.

5. For services received from a Network Provider, you will not be responsible for any portion of the Provider's charges not paid. For services received from Out-of-Network Providers, the Out-of-Network Provider may bill you for any difference between the Provider's charges and the amount paid by the Health Plan. The underlying service must be a Covered Service and medically necessary.

6. Any benefits in excess of specified benefit maximums in this Benefit Booklet.

7. Claims submitted after 12 months from the date of service.

8. Any services, supplies or drugs provided in connection with an occupational sickness, or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under a Worker's Compensation plan.

9. Any services, supply, or drugs for which a Member is not required to make payment or for which a Member would have no legal obligation to pay in the absence of this or any similar coverage.

10. Any services, supplies or drugs provided for injuries sustained as a result of war (declared or undeclared), insurrection, participation in a riot, or from a criminal felonious activity.

11. Services related to a disaster. In the event of a major disaster, services shall be provided insofar as practical, according to the best judgment of health professionals and within the limitations of facilities and personnel available, but neither the Health Plan, nor any health professionals shall have any liability for delay or failure to provide or to arrange for services due to lack of available facilities or personnel.

12. Court ordered services. Healthcare services provided solely because of the order of a court or administrative body are excluded. Charges for a provider to appear in court are also excluded.

13. Reimbursement for services, supplies or drugs provided by an Out-of-Network provider or facility shall be subject to benefits as provided in this Benefit Booklet and limited to the Allowable Amount.

14. Coverage for any services, supplies or drugs furnished by a contracted facility or provider practicing outside of their scope of practice will be paid at an Out-of-network benefit level.

15. Any services, supplies or drugs provided to a Member incurred outside of the United States, even if the Member traveled to the location for the purpose of receiving medical services, supplies, or drugs.

16. Any services, supplies or drugs provided or prescribed by a provider that is related to the Member by blood or marriage.

17. Service provided by a Christian Science or other faith or culturally based facility or practitioner.

18. Any charges resulting from failure to keep a scheduled visit with a physician or other professional provider; or for completion of any insurance forms; or for acquisition of medical records.

19. Reimbursement for same day duplicate services by different providers.

20. Any services, supplies or drugs provided before the patient is covered as a Member in this Plan or any services or supplies after the termination of the Member's coverage.

21. Any services, supplies or drugs provided for Custodial Care, long term care, respite care (except as noted under Hospice Care).

22. Any services, supplies and drugs provided for any medical social services (except as provided as an extended care expense), bereavement counseling (except as provided under Hospice Care), and vocational counseling.

23. Room and board charges incurred during a hospital admission for diagnostic or evaluation procedures if the tests could have been covered on an outpatient basis without adversely affecting the Member's physical condition or the quality of medical care provided.

24. Home Infusion Therapy unless those services would be routinely provided in a facility.

25. Private Duty Nursing services.

26. Nursing and Home Health Aide services.

27. Weight loss drugs, food products, and exercise programs or equipment.

28. Bariatric surgery is limited to 1 surgery per lifetime. For more on bariatric treatment refer to the What's Covered section in this Benefit Booklet.

29. Food and Nutritional items including, but not limited to, diet foods, enteral formula if less than 100% of your nutritional intake, or guest meals.

30. Any services, supplies or drugs supplied to increase or decrease height or alter the rate of growth, including surgical procedures or devices to stimulate growth (except for certain endocrine conditions).

31. Any services, supplies or drugs in connection with:
    - Routine foot care, including but not limited to the removal of warts, corns or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease; or
    - Foot care for flat feet and fallen arches.

32. Replacement prosthetic appliances except those necessitated by growth due to maturity of the Member.

33. Non-covered Durable Medical Equipment includes, but not limited to, air conditioner, air purifier, cryogenic machine, humidifier, physical fitness equipment, and whirlpool bath equipment.

34. Immunizations that are not routine and are for the purpose of travel.

35. Outpatient drugs except as provided under the Health Plan in the Prescription Drug Program in this Booklet. This includes any drugs dispensed by your provider for outpatient use (including, but not limited to, compounded medications, dermatologic products, or physician developed product line unless included in the What's Covered section of this Benefit Booklet).

36. The use of any procedures or supplies or non-generic prescription drugs for treatment of sexual disfunction.

37. Over the Counter drugs and contraceptives prescribed by your provider that are not included on the Curative Formulary.

38. Over the Counter experimental devices.

39. Drugs that are not included in the Curative Formulary.

40. Non-FDA approved Drugs except those specifically noted in the What’s Covered section of this Benefit Booklet, and drugs dispensed to treat a condition for which they are not approved by the FDA for a particular use.

41. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this Benefit Booklet.

42. Drugs which are illegal, unethical, imprudent, or not Medically Necessary.

43. Drugs used to promote hair growth or to replace hair, including, but not limited to Rogaine or Minoxidil.

44. Compound medications are not covered unless noted in the What's Covered section of this Benefit Booklet.

45. Prescription drugs that require but have not met the required Step Therapy.

46. Replacement of drugs that have been lost, stolen, destroyed, or misplaced with an exception for stolen drugs included in a police report.

47. Cosmetic drugs used to enhance appearance, including, but not limited to skin aging and wrinkle reduction drugs.

48. Cosmetic services and Plastic Surgery.

49. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.

50. Orthognathic surgery for Members 19 years of age and above.

51. All expenses related to Dental Care or oral surgery (except for corrective treatment of an Accidental Injury to natural teeth; and Member must remain with Plan until all treatment completed for continued coverage) or any treatment relating to the teeth, jaws, or adjacent structures (for example, periodontium), including but not limited to:
    - Cleaning of the teeth;
    - Any services related to crowns, bridges , filings or periodontics;
    - Rapid palatal expanders;
    - X-rays or exams;
    - Dentures or dental implants;
    - Dental prostheses, or shortening or lengthening of the mandible or maxilla for Members over the age of 18, correction of malocclusion;
    - Any non-surgical dental care involved in the treatment of Temporomandibular Joint (TMJ) pain dysfunction syndrome, such as oral appliances and devices;
    - Treatment of dental abscess or granuloma;
    - Treatment of gingival tissues (other than tumors);
    - Surgery or treatment for overbite or underbite and any malocclusion associated thereto, including those deemed congenital or developmental anomalies;
    - Orthodontics, such as splints, positioners, extractions of teeth, or repairing damaged teeth; and
    - Odontogenic cysts.

52. Vision related services and supplies not noted in the What is Covered section of this Benefit Booklet.

53. Educational testing and therapy, motor or language skills, or services that are educational in nature or are for vocational testing or training (i.e. including, but not limited to, dyslexia, early childhood intervention (ECI), typing, language, or learning courses.)

54. Alternative / Optional Therapies (including, but not limited to, recreational therapy, exercise programs, hypnotherapy, music therapy, reading therapy, sensory integration therapy, vision therapy, vision training, orthoptic therapy, behavioral vision therapy,

integration vision therapy, orthotripsy, chelation therapy, cryotherapy, massage therapy, hair replacement or removal regardless of indication.

55. Any services or supplies provided for the following treatment modalities including, but not limited to:
    - Intersegmental traction;
    - Surface EMGs;
    - Spinal manipulation under anesthesia; and
    - Muscle testing through computerized kinesiology machines such as Issostation, Digital Myograph and Dynatron.

56. Biofeedback is not covered for any reasons except for urinary incontinence.

57. Extracorporeal Shock Wave Therapy (ESWT) except for treating kidney stones.

58. Physical Exams, Treatment and evaluations required or requested by employers, insurers, schools, camps, courts, licensing authorities, flight clearance and other third parties.

59. Athletic performance enhancing drugs.

60. Strength equipment or drugs.

61. Sports cords and TENS units or other Athletic Assist devices.

62. Disposable outpatient supplies - Any outpatient disposable supply or device, including but not limited to bandages, testing supplies (except for diabetes), diapers, bedpans, support hose, compresses and other devices not intended for reuse.

63. Services and supplies used primarily for patient convenience.

64. Convenience services provided by a hospital (included, but not limited to, private rooms, guest beds, tv).

65. Personal comfort and convenience items, including, but not limited to, heating pads, air purifier.

66. Support garments including, but not limited to, compression support hose, compression socks, over the counter orthotic.

67. Home and mobility improvements including, but not limited to, widening doorways, ramps or home modification.

68. Medical costs for a transplant donor.

69. Transportation cost for personal transport and other than ambulance if not medically necessary.

70. Infertility treatment including medical services, artificial insemination and all drugs associated with the treatment of infertility or any assisted reproductive technology or related treatment.

71. Storage of body fluids, including, but not limited to semen, ovum and body parts.

72. Reversal of voluntary sterilization; any cost related to surrogate parenting; infertility services required because of a gender change by the Member.

73. Gene Therapy not noted in the What is Covered section of this Benefit Booklet.

74. Services related to Mental Illness and/or Substance Use Disorder that are provided by half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long term social needs, even if counseling is provided in such facilities. The Health Plan requires that any facility providing healthcare for Mental Illness and/or a Substance Use Disorder treatment program be accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children.

75. Any services, supplies or drugs not specifically defined as eligible expenses in this plan.

Utilization Management

Continuity of Care – Network Providers

If an In-Network Provider leaves the Curative network and the provider is currently treating a Member at the time of the network termination, the Health Plan will reimburse the provider at the same In-Network Provider rate if, at the time of the network termination, you are a "continuing care patient." If you have questions regarding your continuity of care rights and opportunities, please call or text Curative Member Services at 855-428-7284.

Continuity of Care

The Claims Administrator will provide notice to you if you are a "continuing care patient," and may provide transitional care for up to 90 days, if:

- the contractual relationship between Curative and the provider or facility is terminated due to expiration or non-renewal; or
- benefits provided under the Health Plan with respect to the provider or facility are terminated because of a change in the terms of participation of such provider or facility under the Health Plan.

You are a "continuing care patient" with respect to a provider or facility if you:

- are undergoing a course of treatment from the provider or facility for a "serious and complex condition;"
- are undergoing a course of institutional or inpatient care from the provider or facility;
- are scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care, from such provider or facility with respect to such a surgery;
- are pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- are or were determined to be "terminally ill" (a medical prognosis that your life expectancy is six months or less) and are receiving treatment for such illness from such provider or facility.

If you are a continuing care patient and elect to have continued care, the Health Plan will continue such coverage with respect to the course of treatment furnished by the provider or facility, under the same terms and conditions as would have applied under the Health Plan had such network termination not occurred during the period beginning on the date on which the Plan provides the notice to the Member of continuity of care rights and ending on the earlier of—

- 90 days thereafter; or
- the date on which the Member is no longer a continuing care patient with respect to such provider or facility.

Prior Authorizations

The Health Plan recommends advance approval (Prior Authorizations) for certain services. Prior Authorization establishes in advance the medical necessity of certain care and services covered under the Health Plan. Prior Authorizations will ensure that care services will not be denied on the basis of medical necessity. Benefit coverage is subject to other applicable

requirements including the network status of providers, limitations and exclusions, payment of premium and eligibility at the time care and services are provided.

Prior Authorization is recommended for the following types of services:

- All inpatient hospital admissions
- All outpatient surgical procedures
- Applied Behavioral Analysis
- Assistant Surgeon
- Non-Emergency Ambulance
- Biofeedback for urinary incontinence (Biofeedback is not covered for other indications)
- Drugs listed on the Pharmacy Prior Authorization Listing
- Molecular Genetic Lab Testing
- Radiation Therapy / Radiation Oncology
- Formula/Food Products/Liquid Nutrition
- Skilled nursing care in a skilled nursing facility
- Home health care
- Hospice Care
- Palliative Care
- Oncology Services (Chemotherapy, Radiation Therapy)
- Oral Surgery
- Observation
- Orthotics & Prosthetics
- Mastectomy
- MOHS procedures
- Rehabilitation Services (Physical, Speech and Occupational Therapies)
- Any durable medical equipment totaling over $750
- Transplants
- Dialysis
- Advanced Imaging
- Cochlear Implant
- Cardiology - All Tests and Procedures
- Joint and Spine Surgery
- Pain Management
- Psychological/Neuropsychological Testing
- Hyperbaric Therapy
- Sleep study
- Obesity Treatment
- Gender Affirmation Surgery and Treatment
- All inpatient treatment and behavioral health care, substance use disorder and Serious Mental Illness (Acute Inpatient, Intensive Outpatient (IOP), Partial Hospitalization, Residential Treatment Center); and
- The following outpatient treatment of behavioral health care, substance use disorder and Serious Mental Illness:
    - Electroconvulsive therapy
    - Partial Hospitalization
    - Intensive outpatient program

Prior Authorization may be available for other services. Call the Curative Members Services at 855-428-7284 for additional information.

Care should also be Prior Authorized if you or your provider wants to:

- Extend your hospital stay beyond the approved days (you or your provider must call for an extension before your approved stay ends); or
- Transfer you to another facility or from a specialty unit within the facility.

Note: Prior Authorization for medical necessity of services does not guarantee the network level of benefits. If you or an Out-of-Network provider is seeking to confirm whether out-of-network services will be covered under this Plan, call Curative Members Services at 855-428-7284 for additional information. Even if approved by the Claims Administrator, Out-of-Network providers paid at the allowable amount may balance bill for charges in excess of this amount, except as prohibited by law. You are responsible for these charges, which can be significant.

What happens if services are not Prior Authorized?

The Claims Administrator will review the medical necessity of your treatment during its review of your claim for benefits. If the Claims Administrator determines the treatment or service is not medically necessary, coverage will be denied. This is also referred to as an adverse determination. See the "Claims" section for how to file a claim and appeal an adverse determination.

How to Prior Authorize

To request prior authorization, you and your providers must call Curative Member Services at 855-482-7284. The call for Prior Authorization should be made between 6:00 am and 6:00 pm Central Standard Time on business days and 9:00 and 12:00 Noon Central Standard Time on non-business days. A Clinical Care Coordinator (CCC) will follow up with your provider's office.

Prior Authorization for Inpatient Hospital Admissions

In the case of an elective inpatient hospital admission, the call for Prior Authorization should be made at least three calendar days before you are admitted unless it would delay emergency care. If you are admitted to a hospital as a result of an emergency, Prior Authorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

When an inpatient hospital is Prior Authorized, a length of stay is assigned. The Health Plan cannot limit the length of stay in a hospital facility to less than the following stays:

- Maternity Care
  - 48 hours following an uncomplicated vaginal delivery
  - 96 hours following an uncomplicated delivery by Cesarean Section

- Treatment for Breast Cancer
  - 48 hours following a mastectomy
  - 24 hours following a lymph node dissection

Note: Your provider will not be required to obtain Prior Authorization from Curative for prescribing a length of stay less than 48 hours following a vaginal delivery (or 96 hours following a delivery by cesarean section) for maternity care. If you require a longer stay, your provider may seek an extension for the additional days by obtaining Prior Authorization from the Claims Administrator.

Renewal of Prior Authorization

Your provider may request a renewal of a Prior Authorization at least 60 days before the date the Prior Authorization expires. If the Claims Administrator receives a renewal request before the existing Prior Authorization expires, the Claims Administrator will, if practicable, review the request and issue a determination indicating whether the Prior Authorization is renewed before the existing Prior Authorization expires.

Prior Authorization Procedures

For more information regarding the procedures to follow for Prior Authorization claims and appeals, please see “Claims” below.

Claims

What are the Claims and Appeals Procedures?

To receive or apply for benefits, you or your covered dependent, or your authorized representative ("you" or “claimant” for purposes of this Section "Claims and Appeals Procedures") must take appropriate action to file a claim. Forms required to receive or apply for benefits under the Plan are available at health.curative.com. You can contact the Claims Administrator at Curative Claims Department, P.O. Box 1786, Austin, TX 78767; Phone: 855-428-7284.

The Plan Administrator or its delegate, such as the Claims Administrator, has the authority and responsibility to interpret the provisions of the Plan. The Plan Administrator or its delegate has the discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Plan Administrator or its delegate decides in its discretion that the applicant is entitled to them. The nature of this authority and the discretion afforded these persons is briefly described in “Plan Administrator's Discretion" section of the Addendum to this Benefit Booklet and is detailed in the applicable plan documents.

Submitting a Medical Claim

Generally, a request for benefits under the Plan is a claim. A claim also includes a request for reinstatement of coverage in cases where the coverage was retroactively rescinded for reasons other than your failure to timely pay contributions toward the cost of coverage. A general request for an interpretation of benefit plan provisions will not be considered to be a claim. Requests of this type, such as a request for an interpretation of eligibility provisions, should be directed to the Plan Administrator.

Presentation of a prescription to a pharmacy does not constitute a claim. If you are required to pay the cost of a covered prescription drug, however, you may submit a claim based on that amount to the Claims Administrator.

You and your provider should submit, and the Claims Administrator should receive, all claims for benefits under this plan within 180 days of the date on which you received the service unless the network contract dictates differently or the date a primary payer finalizes their claim submission.

Filing A Claim

When you receive treatment or care from an In-Network provider, you will not be required to file claims. The provider will submit the claims directly to the Claims Administrator for you.

You may be required to file your own claims when you receive treatment or care from an Out-of-Network provider. At the time services are provided, ask your Out-of-Network provider whether they will file the claim for you.

Benefit payments will be made directly to In-Network providers when they submit claims to the Claims Administrator. If the claim is for an Out-of-Network provider, the Claims Administrator may choose to pay either you or your provider. If you receive the payment from the Claims Administrator, it will be your responsibility to pay your provider for any billed services.

If allowed by law, any benefits available to you, if unpaid at your death, will be paid to your estate.

How to File a Medical Claim

Members submitting a claim directly to the Claims Administrator must submit the claim no later than 180 days after the date of service or, for a claim for prior authorization, as described in "Prior Authorizations."

- Obtain the Claim Form: They are available for downloading from the Claims Administrator on our website health.curative.com. Use a separate form for each Member and Provider. A claim to obtain prior authorization may also be filed with the Claims Administrator by telephone.

- Complete all information requested on the Claim Form. Any missing information may cause a delay in processing your claim. Some key items that must be completed on the form are:
  - Patient's full name
  - Member ID Number
  - Current Address
  - Diagnosis (provided by your provider and may be included on an itemized bill from them)
  - The procedure or nature of the treatment;
  - Date of injury, illness, or pregnancy
  - Whether the patient has other health insurance coverage

- Attachments: You should include a copy of the itemized bill from your provider with your Claim Form. The itemized bill from your provider should include the following:
  - Name and address of the provider providing the services
  - Date of Service
  - Type of Service
  - Charges for Each Service
  - Patient's Full Name
  - Diagnosis

- Claim Submission: The claim form and itemized bills should be mailed to:
  Curative Claims Department
  P. O. Box 1786
  Austin, TX 78767
  Note: Claims not in English should be translated, if they are submitted without translation, processing may be delayed.

- Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

- Claims submissions must be in a format acceptable to the Claims Administrator and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by the Plan.
- Claims submissions must be timely. Claims should be filed as soon as reasonably possible after they are incurred. Plan claims must be filed within 180 days after the claim is incurred. Plan benefits are only available for claims that are incurred while you are covered under the Plan.
- Claims submissions must be complete and include all information requested by the Claims Administrator.

Procedural Defects

When a claim is submitted to the Claims Administrator for processing it must contain all required information. If a pre-service claim submission is not made in accordance with procedural requirements, the Claims Administrator will notify the claimant of the procedural deficiency and how it may be cured within five (5) days (or within 24 hours, in the case of an urgent care claim) following the failure. A post-service claim that is not submitted in accordance with these claims procedures will be returned to the submitter.

Claims Decisions

After submission of a claim by a claimant, the Claims Administrator will notify the claimant within a reasonable time, as follows:

Pre-Service Claims

A Pre-Service Claim is a claim for a benefit that requires approval in advance of obtaining medical care.

The Claims Administrator will notify the claimant of a favorable or Adverse Determination within a reasonable time appropriate to the circumstances, but no later than 15 days after receipt of the claim by the Plan. However, this period may be extended by an additional 15 days, if the Claims Administrator determines that the extension is necessary due to matters beyond the control of the Plan. The Claims Administrator will notify the affected claimant of the extension before the end of the initial 15-day period, the circumstances requiring the extension, and the date by which the Claims Administrator expects to make a decision.

If the reason for the extension is because of the claimant's failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The claimant will have at least 45 days from the date the notice is received to provide the specified information.

Urgent Care Claims

An Urgent Care Claim is about care that, if you do not receive it within a narrow window of time, you could: (a) seriously jeopardize your life or health or your ability to regain maximum function, or (b) cause yourself severe pain which (in the opinion of a physician who knows your health condition) could not be managed without the requested services.

The Claims Administrator will determine whether a claim is an Urgent Care Claim. This determination will be made on the basis of information furnished by or on behalf of a claimant. In making this determination, the Claims Administrator will exercise its judgment, with deference to the judgment of a physician with knowledge of the claimant's condition. Accordingly, the Claims Administrator may require a claimant to clarify the medical urgency and circumstances that support the Urgent Care Claim for expedited decision-making.

The Claims Administrator will notify the claimant of a favorable or Adverse Determination as soon as possible, taking into account the exigencies particular to the claimant's situation, but not later than 72 hours after receipt of the Urgent Care Claim by the Claims Administrator. However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, expenses are covered or payable under the Plan, notice will be provided by the Claims Administrator as soon as possible, but not more than 24 hours after receipt of the Urgent Care Claim by the Claims Administrator. The notice will describe the specific information necessary to complete the claim.

The claimant will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information — but not less than 48 hours. The Claims Administrator will notify the claimant of an Urgent Care Claim determination as soon as possible, but in no event more than 48 hours after the earlier of: (1) the Claims Administrator's receipt of the specified information, or (2) the end of the period afforded the claimant to provide the specified additional information.

Concurrent Care Decisions

A Concurrent Care Claim is a claim involving an ongoing course of treatment to be provided over a period of time or number of treatments, which has been previously approved under the Plan. The Claims Administrator will notify a claimant of a Concurrent Care decision that involves a reduction in or termination of benefits that have been prior authorized. The Claims Administrator will provide the notice sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of the Adverse Determination before the benefit is reduced or terminated.

A request by a claimant to extend a course of treatment beyond the period of time or number of treatments in a non-urgent circumstance will be considered a new claim and decided according to the Post-Service or Pre-Service Claim timeframes, whichever applies. A request to extend a course of treatment that is a claim involving Urgent Care will be decided by the Claims Administrator as soon as possible, taking into account the medical or dental exigencies. The

Claims Administrator will notify a claimant of the benefit determination within 24 hours after receipt of the claim, provided that the claim is submitted to the Claims Administrator at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Post-Service Claims

A Post-Service claim is a claim (that is not a Pre-Service, Urgent Care or Concurrent Care Claim) for payment of benefits after services have been rendered.

The Claims Administrator will notify the claimant of a favorable or Adverse Determination within a reasonable time, but not later than 30 days after receipt of the claim. However, this period may be extended by an additional 15 days, if the Claims Administrator determines that the extension is necessary due to matters beyond the control of the Plan. The Claims Administrator will notify the affected claimant of the extension before the end of the initial 30-day period, the circumstances requiring the extension, and the date by which a decision will be made.

If the reason for the extension is because of the claimant's failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The claimant will have at least 45 days from the date the notice is received to provide the specified information. The Claims Administrator will make a decision no later than 15 days after the earlier of the date on which the information provided by the claimant is received by the Claims Administrator, or the expiration of the time allowed for submission of the additional information.

Times for Decisions

The periods of time for claims decisions presented above begin when a claim is received by the Plan, in accordance with these claims procedures. However, the time periods described above for the Claims Administrator to decide the claim or appeal will not run while the Claims Administrator is waiting for the claimant to provide information it has requested.

Adverse Determination Notices

Adverse Determination - A decision on a claim is a "denial" or "adverse" if it is (a) a denial, reduction, or termination of; or (b) a failure to provide or make payment (in whole or in part) for a Plan benefit. A rescission of coverage is treated as an adverse benefit determination (whether or not the rescission has an adverse effect on any particular benefit at that time). A rescission is a retroactive cancellation of coverage, other than for failure to pay premiums or as otherwise permitted under the ACA and applicable guidance.

Notice of an Adverse Determination (including a partial denial) will be provided to claimants on an explanation of benefits (EOB) summary prepared and sent to you through the Curative Member Portal, within the timeframes noted above. However, notices of Adverse Determinations involving Urgent Care Claims may be provided to a claimant orally within the timeframes noted above for expedited Urgent Care Claim decisions. If oral notice is given,

written notification will be provided to the claimant no later than 3 days after the oral notification. If you have any additional information that you believe could change the decision, send this additional information to Curative the Claims Administrator, and request a review of the decision as noted in the Claim Appeal Procedures.

A claims Adverse Determination notice will state:

- The specific reason or reasons for the Adverse Determination;
- The specific Plan provisions on which the determination is 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;
- The Plan's internal and external review procedures, including information regarding how to initiate an appeal or external review of an adverse benefit determination and the time limits applicable to such procedures;
- A statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If the Adverse Determination relied on an internal rule, guideline, protocol, or other similar criterion, a copy of that rule, guideline, exclusion, protocol or similar criterion or a statement that the claimant may receive a copy free of charge upon request;
- If the Adverse Determination is based on medical necessity, experimental or investigational treatment, or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's circumstances, or a statement that such explanation will be provided free of charge upon request;
- If the Adverse Determination is related to an Urgent Care Claim, the notice will provide a description of the expedited review procedures applicable to such claims; and
- Adverse determinations under the Plan will also include:
    - Information sufficient to identify the claim involved, including, to the extent available, the date of service, the provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
    - The denial code and its corresponding meaning, and a description of the standard, if any, that was used in denying the claim;
    - Contact information for any applicable office of health insurance consumer assistance or ombudsman established by the Department of Labor to assist individuals with the internal claims and appeals and external review procedures; and

- Such other information as the Claims Administrator determines is required by the Affordable Care Act or other applicable law.

Appeals of Adverse Determinations

You have the right to appeal any adverse determination of a claim and receive a fair review.

An appeal of an adverse determination (clinical or non-clinical) may be filed by you or a person authorized to act on your behalf. You must appeal an Adverse Determination within 180 days after receiving written notice of the Adverse Determination (or partial denial). An appeal may be made by a claimant in writing to the Claims Administrator, in person, or by mail, postage prepaid. However, a claimant on appeal may request an expedited appeal of an adverse Urgent Care Claim decision orally or in writing. In such case, all necessary information, including the benefit determination on review, will be transmitted by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

A claimant may review relevant documents free of charge, and may submit issues and comments in writing. In addition, a claimant on appeal may, upon request, discover the identity of medical, or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination being appealed, as permitted under applicable law.

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person that made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim. The individuals from the Claims Administrator deciding the appeal will not give deference to the initial decision to deny the claim.

If the Adverse Determination being appealed was based, in whole or in part, on a medical judgment, in addition to the foregoing, the Claims Administrator will:

- Consult with an appropriate named health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and is not the same individual (or a subordinate of the individual) who was consulted in the review of the initial claim or in the first-level appeal decision; and
- When requested by the claimant, identify medical or vocational experts whose advice was obtained on behalf of the Claims Administrator in connection with an adverse benefit determination or appeal decision, without regard to whether the advice was relied upon in making the benefit determination.

The Claims Administrator will notify the claimant of: (i) any new or additional evidence considered, relied upon, or generated in connection with the appeal, and (ii) any new or additional rationale for denying the claim on appeal. The Claims Administrator will provide the notice sufficiently in advance of issuing the notice of its appeal decision to give the claimant an opportunity to respond.

Time Period for Decisions on Appeal

Appeals of claims Adverse Determinations will be decided and notice of the decision provided as follows:

Urgent Care Claims. As soon as possible, but not later than 72 hours after the Claims Administrator has received the appeal request. (If oral notification is given, written notification will follow in hard copy or electronic format within the next three days.)

Pre-Service Claims. Within a reasonable period, but not later than 30 days after the Claims Administrator has received the appeal request.

Post-Service Claims. Within a reasonable period, but not later than 60 days after the Claims Administrator has received the appeal request.

Concurrent Care Decisions. Within the time periods specified above, depending on the type of claim involved.

Notice of Adverse Determination on Appeal

Notice of an Adverse Determination on appeal will be provided to claimants by mail, postage prepaid, by facsimile, or by email, as appropriate, within the timeframes noted above.

A notice that an appeal has been denied will:

- State the specific reason or reasons for the Adverse Determination and the specific Plan provisions on which the determination is based.
- If the Adverse Determination on appeal relied on an internal rule, guideline, protocol, or other similar criterion, a copy of that rule, guideline, protocol, or other criterion or a statement that the claimant may receive a copy free of charge upon request.
- If the Adverse Determination on appeal is based on medical or dental necessity, experimental or investigational treatment, or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's circumstances, or a statement that such explanation will be provided free of charge upon request.
- A statement that the claimant on appeal is entitled to receive upon request and without charge, reasonable access to and copies of any document, record or other information relevant to his or her appeal.
- If applicable, a statement of the claimant's right to bring a civil action under ERISA Section 502(a) after exhaustion of the final appeal;

The notice of the Adverse Determination on appeal will also include:

- Information sufficient to identify the claim involved, including, to the extent available, the date of service, the provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- The denial code and its corresponding meaning (if available), and a description of the standard, if any, that was used in denying the appeal and a discussion of the decision.
- A description of the external review process after exhaustion of the final appeal, including information regarding how to initiate external review of an Adverse Determination on appeal.

- Contact information for any applicable office of health insurance consumer assistance or ombudsman established by the Department of Labor to assist individuals with the internal claims and appeals and external review procedures.
- Such other information as the Claims Administrator determines is required by the ACA or other applicable law.

Exhaustion

Upon completion of the entire appeals process, a claimant will have exhausted his or her administrative remedies under the Plan. If the Claims Administrator fails to complete a claim determination or appeal within the time limits set forth above, the claimant may treat the claim or appeal as having been denied, and the claimant may contact the Claims Administrator to ask for confirmation that the claim has been denied, proceed to the next level in the review process, or (if applicable) bring a lawsuit under Section 502(a) of ERISA.

Assignments and Authorized Representatives

You may not assign your right to receive benefits payable under the Plan to any person, corporation, or other organization, including a physician or provider. Any attempted assignment you make will be void and will not be recognized by the Plan. The Plan is not liable to any provider to whom you may be liable for a provider's provision of health care, treatment, services, or supplies. A payment for covered services under the Plan to a provider is not a recognition by the Plan of a duty or obligation to pay such provider, nor does such payment waive the Plan's prohibition on assignments of benefits.

If you so direct, or for the Claims Administrator's convenience, payment for covered services under the Plan rendered by a provider may be made directly to the provider, but the Claims Administrator reserves the right to pay you or the provider. Your direction to pay benefits payable to you directly to a provider is not an assignment to the provider of any right under the Plan or of any legal or equitable right to institute any court proceeding.

You may designate an authorized representative to act on your behalf in pursuing a benefit claim or appeal. The designation must be explicitly stated in writing and it must authorize disclosure of individually identifiable health information with respect to the claim to the Plan, the Claims Administrator, and the authorized representative, and the designation must authorize the Plan, the Claims Administrator, and the authorized representative to disclose individually identifiable health information to one another. If a document is not sufficient to constitute a designation of an authorized representative, as determined by the Claims Administrator, then the Plan will not consider a designation to have been made.

- Any document designating an authorized representative must be submitted to the Claims Administrator in advance, or at the time an authorized representative commences a course of action on your behalf. At the same time, the authorized representative should also provide notice of commencement of the action on your behalf to you, which the Claims Administrator may verify with you prior to recognizing the authorized representative status.

- In any event, a provider with knowledge of your medical condition acting in connection with an Urgent Care Claim will be recognized by the Plan as your authorized representative.

- You should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of you, such as whether and how to appeal an Adverse Determination.

To obtain an authorization form, you or your representative may contact Curative Member Services at 855-428-7284 or email medicalmanagementteam@Curative.com.

Voluntary External Review Appeal

If a claim is still denied after the claimant has followed the Claim Administrator's appeal procedures, the claimant may have the option to file a voluntary appeal for external review by an independent review organization. This applies if the Adverse Determination is based on a determination that involves (i) medical judgment, such as the service or treatment is not medically necessary or is an experimental or investigational service, (ii) a rescission of coverage (i.e., a retroactive cancellation of coverage for reasons other than the claimant's failure to timely pay contributions toward the cost of coverage), or (iii) a determination that surprise medical billing protections do not apply.

How the Voluntary Review Appeal Works

The external review process gives the claimant the opportunity to have certain Adverse Determinations reviewed by independent physician reviewers. Under a voluntary external review:

- The Claims Administrator sends the claim to an independent review organization (IRO) with which it has contracted to provide review services;
- The IRO then refers the case for review to a medical professional it has selected with appropriate expertise in the area in question;
- Once all necessary information is submitted, the external review requests will generally be decided within 45 days of the request. Expedited reviews are available when the claimant's provider certifies that a delay in service would jeopardize the claimant's health, life, or ability to regain maximum function or in cases where the final Adverse Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services and has not been discharged from the facility; and
- The decision of the independent external expert reviewer is binding on the Claims Administrator and the Plan. The claimant will not be charged a professional fee for the review.

How to File for an External Review

The claimant generally must complete the standard internal appeal described above before requesting external review. The claimant must request an external review from the Claims Administrator within four (4) months after receipt of the final Adverse Determination notice under the standard appeal process. If no date corresponds to the date that is four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30,

because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a weekend or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

Subject to verification procedures, the claimant's authorized representative may act on the claimant's behalf in filing and pursuing this review. If a voluntary external review appeal is filed, any applicable statute of limitations or other timelines will be "tolled" (suspended) while the appeal is pending. Whether or not a claimant seeks an external review will have no effect on the claimant's rights to any other benefits under the Plan or information about applicable rules. Because an external review is voluntary, a claimant is not required to undertake an external appeal before pursuing legal action. Upon request, the claimant will be provided additional information about the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker.

If external review is not requested, the Plan will not assert that the claimant failed to exhaust administrative remedies due to that choice.

Subrogation, Reimbursement and Third-Party Recovery Provision

Subrogation

If the Health Plan pays and provides benefits for you and your dependents, the plan is subrogated to all rights of recovery which you and your dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the plan has paid or provided. That means the plan may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer. For the purpose of this provision, subrogation means the substitution of one person or entity (the Health Plan) in the place of another (you and your dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the right of the other in relation to the debt or claim, and its rights and remedies.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the Health Plan will have a right of reimbursement. If you and your dependent recover money from any person, organization, or insurer for any injury or condition for which the Health Plan paid benefits, you or your dependent agree to reimburse the Health Plan from the recovered money for the amount of benefits paid or provided by the plan. That means you or your dependent will pay to the Health Plan the amount of money recovered by you through judgment, settlement, or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Health Plan.

Right to Recovery by Subrogation or Reimbursement

You and your dependent agree to promptly furnish to the Health Plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Health Plan in protecting and obtaining its reimbursement and subrogation rights. You, your dependent and attorney will notify the plan before settling any claim or suite so as to enable the Health Plan to enforce its rights by participating in the settlement of the claim or suite. You and your dependent further agree not to allow the reimbursement and subrogation rights of the Health Plan to be limited or harmed by any acts or failure to act on your part.

Coordination of Benefits (COB)

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

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

Definitions

(a) A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

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

(b) "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

(c) "Allowable expense" is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

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

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense**.**

(4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care provider's or

physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(e) "Closed panel plan" is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

(f) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Order of Benefit Determination Rules

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

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with these rules is always primary unless the provisions of both plans state that the complying plan is primary.

(c) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must 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 Out-of-Network benefits.

(d) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(f) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

(g) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

(h) Each plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

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

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

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

(i) if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms,

that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

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

(I) the plan covering the custodial parent;

(II) the plan covering the spouse of the custodial parent;

(III) the plan covering the noncustodial parent; then

(IV) the plan covering the spouse of the noncustodial parent.

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

(D) For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, (h)(5) applies.

(E) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.

(3) Active, Retired, or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA,

state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of this Plan

(a) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(b) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by an out-of-network provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Benefits for Individuals who are Entitled to Medicare

If you (or one of your dependents) are entitled to Medicare benefits, the following rules apply:

(a) The Health Plan is the primary payer – in other words, your claims go to the Plan first – if either of the following apply:

(1) You are currently working, or are enrolled as a dependent of an active employee, and you (or your dependent) first becomes entitled to Medicare benefits because of age or disability, or

(2) You (or your dependent) first become entitled to Medicare benefits because you (or your dependent) have end-stage renal disease. In this case, the Health Plan is the primary payer for the first 30 months of Medicare entitlement due to end-stage renal disease. At the end of the 30-month period, Medicare will become the

primary payer. This rule applies regardless of whether or not you are currently working for the Employer.

(b) The Health Plan pays secondary and Medicare is the primary payer if you (or your dependent) are covered by Medicare, you (or your dependent) do not have end-stage renal disease and you are not currently working for the Employer (e.g., you are covered under COBRA coverage, retiree coverage, or coverage after the sixth month that you receive disability benefits).

(c) If you (or your dependent) are over age 65 and the Health Plan would otherwise be the primary payer because you are still working, you or your dependent may also enroll in Medicare and decline coverage under the Health Plan. If you are working and you (or your dependent) continue to receive coverage under the Health Plan and also decide to enroll in Medicare, the Health Plan will pay primary and Medicare will pay secondary. If you are working and elect Medicare, the Health Plan cannot, by law, pay benefits secondary to Medicare, except for certain individuals with end-stage renal disease.

Benefits for Disabled Individuals

If you stop working because of a disability, or if you retire before age 65 and subsequently become disabled as defined by Social Security, you must apply for Medicare Parts A and B. Medicare Part A provides inpatient hospitalization benefits, and Medicare Part B provides outpatient medical benefits, such as doctor's office visits. Medicare is the primary plan payer for most disabled persons.

Under the coordination of benefits rule for individuals who qualify for Medicare because of disability, Medicare is the primary payer; in other words, your claims go to Medicare first. If Medicare pays less than the current benefit allowable by the Plan, the Health Plan will pay the difference, up to the maximum current benefits allowable. In addition, if Medicare denies payment for a service that the Plan considers eligible, the Plan will pay up to its normal benefit amount after you meet the Plan year deductible, if any.
When Medicare is the primary payer, no benefits will be payable under the Plan for eligible Medicare benefits that are not paid because you did not enroll, qualify or submit claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Contact your local Social Security office for more information on Medicare benefits.

Compliance with Federal and State Laws Concerning Confidential Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. The Health Plan will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under the Health Plan must give the Health Plan any facts it needs to apply those rules and determine benefits.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by the Health Plan is more than it should have paid under this COB provision, it 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.

Plan Provisions

Eligibility

The eligibility date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when they become an employee or a dependent and is in a class eligible to be covered under the Plan.

Your eligibility date will be determined by the Plan in accordance with your Employer's established eligibility procedures.

Employee Eligibility

If you are eligible to participate in your Employer's Benefit Program as described in the Addendum to this Benefit Booklet, you are eligible for the benefits described in this Benefit Booklet.

For purposes of this Plan, the term Eligible Employee will also include those individuals who are no longer an employee of the Employer, but who are covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA). You may enroll for coverage for yourself (or for yourself and your dependents) on or before your benefit eligibility date, within 31 days of your eligibility date or during the annual enrollment period.

Dependent Eligibility

If you are eligible for coverage, you may include your dependents. If you and your spouse or domestic partner are both Eligible Employees under the Health Plan, then your children may be covered as dependents of either parent, but not both. In addition, a spouse or domestic partner that is an Eligible Employee under the Health Plan may not be covered as a dependent.

The Health Plan defines dependents as:

- Your spouse or domestic partner;
- Your children under the age of 26 regardless of their marital status, including:
    - Biological children;
    - Stepchildren and adopted children;
    - Grandchildren you claim as dependents on your federal income tax filing;
    - Children for whom you are named a legal guardian or who are subject of a medical support order requiring such coverage; and
    - Certain children over age 26 who are determined to be medically incapacitated and are unable to provide their own support.

LIFE EVENT CHANGES

You have 31 days from the date of a qualifying life event to notify your Employer and change your Plan elections. If you do not make the changes during the 31-day status change period, your changes cannot be made until the Annual Enrollment period for your Plan to be effective on the next Plan Year's effective date.

Qualified life events include:

- Marriage, Divorce, Annulment, Legal Separation or a Spouse's/Domestic Partner's death;
- Birth, Adoption, Medical Child Support Order, or Dependent's death;
- Significant change in residence if the change affects you or your dependent's current plan eligibility;
- Starting or ending employment, starting or returning from unpaid leave of absence, or change of job status affecting eligibility for benefits;
- Change in dependent eligibility; and
- Significant change in coverage or cost of other benefit plans available to you and your family.

Your benefit selection changes must be consistent with your change in status.

SPECIAL ENROLLMENT

Under the Health Insurance Portability and Accountability Act (HIPAA), you are allowed to enroll yourself and your eligible dependents outside of the annual enrollment period when certain events occur. Special enrollment rights exist when:

- You acquire a new dependent due to marriage, birth, adoption or placement for adoption;
- You declined coverage under the Plan during a previous enrollment period because you were covered under another group health plan (or group health insurance), but you subsequently lose your other coverage for any of the following reasons:
    - You or your dependents exhaust COBRA continuation coverage under another employer's group health plan (other than due to failure to pay contributions or for cause);
    - Employer contributions toward the other group health plan coverage terminate; or
    - You or your dependents lose eligibility under the other group health plan or health insurance coverage (other than due to your failure to pay contributions or for cause), including:
        - As a result of legal separation, divorce, cessation of dependent status, death, termination or reduction in hours of employment;
        - In the case of an individual HMO policy, loss of coverage because you no longer reside or work in the service area;
        - In the case of a group HMO, loss of coverage because you no longer reside or work in the service area, provided that no other benefit package is available to you; or
        - Your current employer decides to stop contributing for your coverage.

    - You or your dependent becomes:
        - Ineligible for coverage under a Medicaid plan or a state child health plan, and as a result coverage is terminated; or
        - Eligible for a premium assistance subsidy for the Plan under Medicaid or a state child health plan.

When your special enrollment right results from acquiring a new spouse or dependent through marriage, birth or adoption, you may enroll your new spouse or dependent in the Plan. In addition, if you are not already enrolled in the Plan, you may enroll yourself during the special enrollment period. If your spouse is not already enrolled in the Plan and you have

special enrollment rights because you acquire a new dependent, you may enroll your spouse during the special enrollment period. However, you may not enroll any other dependents who were already eligible for benefits but not previously enrolled in the Plan.

The request for a change in coverage must be made within 31 days of the special enrollment event, unless the special enrollment event is you or your dependent becoming ineligible for coverage under a Medicaid plan or a state child health plan, or you or your dependent becoming eligible for a premiums assistance subsidy for the Plan under Medicaid or a state child health plan. For these special enrollment events, the request for a change in coverage must be made within 60 days of the date you lose coverage or become eligible for coverage, as applicable.

Termination of coverage

Coverage under the Health Plan will terminate for you and your dependents if any of the following occur:

- Your portion of the premium cost-share is not received timely;
- The last day of the month in which you lose eligibility to participate in the plan;
- The plan is amended to terminate the coverage of the class of employees to which you belong; or
- A dependent ceases to meet the plan's definition of a dependent.

Coverage for a child of any age who is medically certified as disabled and dependent on the parent will not terminate upon reaching the limiting age shown in this Benefit Booklet if the child continues to be both disabled and dependent upon the employee as determined by the Plan as an incapacitated dependent.

As a condition to the continued coverage of a child as a disabled dependent beyond the limiting age, the Plan may require periodic certification of the child's physical or mental condition (but not more frequently than annually).

The coverage of all Members will be terminated if the plan is terminated in accordance with its terms.

Termination of Coverage - Fraud or Intentional Misrepresentation of a Material Fact

The Claims Administrator or the Plan Administrator will provide at least 30 days' notice to you that your coverage will end on the date the Claims Administrator or the Plan Administrator identifies in the notice, which date may be retroactive, because you engaged in an act or omission that constituted fraud, or an intentional misrepresentation of a material fact. You may appeal this decision prior to the termination date set forth in the notice. The notice will include information on how to appeal. If you have engaged in an act or omission that constitutes fraud or an intentional misrepresentation of material, fact the Claims Administrator or the Plan Administrator may demand that you pay back all amounts the Health Plan paid to you, or paid in your name, while coverage was incorrectly effective.

Continuation of Plan Coverage (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) passed by Congress provides that when Members (Employees and their Dependents) lose their eligibility for health coverage due to any of the qualifying events listed below, they may elect to continue their health plan coverage. The continued coverage can remain in for a maximum period of either 18, 29 or 36 months depending on the reason that eligibility for health plan coverage terminated.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "dependent child."

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's loses eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 29 or 36 months of coverage:

Disability Extension

If the qualifying event is an employee's termination or reduction in work hours, you or a covered dependent are determined to be "disabled" by the Social Security Administration ("SSA"), and you notify the COBRA Administrator in a timely fashion, you and your covered dependents may be entitled to an additional eleven (11) months of COBRA continuation coverage (yielding a total

of twenty-nine (29) months). The disability must have started before the 60th day of COBRA continuation coverage and must last until the end of the 18-month period of COBRA continuation coverage. For this extension to apply, evidence of disability under the Social Security Act must be provided to the COBRA Administrator within the initial eighteen-month continuation coverage time frame and within sixty days from the date of Social Security's determination. You will not be eligible for the additional eleven (11) months of COBRA continuation coverage if you fail to provide evidence of disability to the COBRA Administrator in accordance with the above.

If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan Administrator within thirty days after SSA's determination.

Multiple Qualifying Events

If your covered dependent experiences another qualifying event during the 18 months of COBRA continuation coverage, your covered dependent can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. The dependent qualified beneficiary may qualify for this 18-month extension of the continuation coverage period if the second qualifying event is:

- Death of the employee;
- Divorce or legal separation from the employee;
- Medicare eligible employee (employee becomes eligible for Medicare, leaving dependents without coverage); or
- Children who lose coverage due to eligibility requirements.

To be considered a multiple qualifying event, such event would have cause the qualified beneficiary to lose coverage had the first qualifying event not occurred. It is the responsibility of you or your dependent qualified beneficiary to notify the Employer (or their designated COBRA Administrator) within sixty days of the multiple qualifying event.

Eligibility for Continuation of Coverage

Members (employees and dependents) covered by the Plan at the time of the qualifying event are qualified beneficiaries and are eligible for continuation of coverage. Each may make an independent COBRA election. A child born or adopted by the employee during COBRA coverage is also eligible to be a qualified COBRA Member upon timely application.

How you can Elect COBRA Continuation Coverage

If the COBRA qualifying event is due to an employee's death, Medicare eligibility, or termination of employment (or reduction in hours), your Employer (or their designated COBRA Administrator) will provide you with a COBRA election notice after your loss of coverage. The notice will be sent to eligible Members.

- If the qualifying event is for either a divorce of an employee or a child becoming ineligible for coverage, the Member(s) losing coverage should notify the Employer (or their designated COBRA Administrator) within 60 days of the qualifying event. Then the COBRA election notice will be sent to either the spouse, domestic partner or child who is losing coverage.
- The notice must include the names of covered individuals and the reason for and date of the qualifying event. If a Member does not give notice within the required time period, the Member may not elect continuation coverage.

Eligible COBRA qualified beneficiaries will have 60 days after the later of the date of the COBRA election notice or their loss of coverage due to the qualifying event, or as otherwise provided in the COBRA election notices, to give written notice of their election to continue coverage.

Cost of COBRA Coverage

A service fee of 2% of the premium rate for Members is added to the premium and is payable by the continued Member. An extra premium of 50% may be added to the premium for Members who extend coverage from 18 months to 29 months due to disability. You are responsible for the full premium amount (employee and employer share). If the Health Plan benefits or rates change during the continuation period, the continued Member will receive the new benefits and the new rates will apply.

If you have any questions, please contact either the Plan Administrator or the COBRA Administrator.

Initial Payment

When electing continuation coverage, you are not required to remit any payment with the election. You have 45 days from the date of election (post-mark date if mailed) to remit your initial payment. Your first payment must include the premiums for coverage retroactively to the date you or your covered dependents would have lost coverage if you had not elected to continue coverage. Benefits will be reinstated back to the date of termination from the plan after the payment has been received and processed. You will need to make sure that the payment amount is correct. If you have any questions regarding the amount and how to make the payment, please contact the Employer or the designated COBRA Administrator.

Note: If payment is not received within the 45 days from your election date, you will not be eligible to continue coverage under the Plan.

Continuing Monthly Payments

After you have made your first payment, you will be required to make payments for each month. Payments are due on the first day of the month with a 30-day grace period. If the payment is not received by the due date, the coverage will be suspended, and benefits may not be accessible during this time until payment is received. If the payment is received prior to the end of the grace period, coverage will be reinstated once payment has been processed.

If you fail to make the full payment before the end of the grace period, you will lose all rights to continuation of coverage under the Plan.

Termination of Continuation of Coverage

A service fee of 2% of the premium rate for Members is added to the premium and is payable by the continued Member. An extra premium of 50% may be added to the premium for Members who extend coverage from 18 months to 29 months due to disability. You are responsible for the full premium amount.

If you have any questions, please contact either the employer or the Member’s continuation of coverage will terminate if any of the following occurs:

- The maximum qualifying time period expires;

- A continued Member obtains coverage after the date of election under any other health plan which does not contain an applicable exclusion for any Pre-existing Condition for the Member;
- A continued Member becomes covered by any Medicare benefits after the date of the election;
- The Employer no longer provides health coverage for their employees; or
- The required payment to continue coverage is not made on a timely basis.
- You file fraudulent claims or engage in other activities for which a similarly situated active employee would be terminated "for cause;" or
- If the COBRA continuation coverage was extended due to disability, the later of (a) the first day of the month that is at least 30 days after the date on which the Social Security Administration determines that you or your covered dependent, as applicable, is no longer disabled, or (b) the final date of the maximum coverage period that would have applied absent the disability determination.

A Member on Continuation Coverage may also be terminated for fraud or intentional misrepresentation of material fact to the same extent the coverage for a similarly situated non-continued Member could be terminated.

Benefits for a Member on Continuation Coverage will be the same as those for active Members. Premium rates will be based upon the Employer's rates for an active employee and dependents.

If continuation of coverage is not elected, your Plan coverage will end the last day of the month in which you were eligible and enrolled.

Glossary Of Terms

Accidental Injury means accidental bodily injury resulting, directly or independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

ADL (Activities of Daily Living) means the tasks of everyday living. Basic ADLs include eating, dressing, getting into and out of bed or chair, taking a bath or shower, and using the toilet.

Adverse Determination means (a) a denial, reduction, or termination of; or (b) a failure to provide or make payment (in whole or in part) for, a Plan benefit. A rescission of coverage is treated as an adverse benefit determination (whether or not the rescission has an adverse effect on any particular benefit at that time). A rescission is a retroactive cancellation of coverage, other than for failure to pay premiums or as otherwise permitted under the ACA and applicable guidance.

Allowable Amount means the maximum amount that will be paid by Curative for Covered Services. The Allowable Amount is determined by Us or as prescribed by applicable law or regulation.

- The Allowable Amount for Covered Services provided by In-Network providers is the terms of the Provider contract and the payment methodology in effect on the date of service.
- The Allowable Amount for Covered Services provided by Out-of-Network providers is the lesser of (1) the Provider's billed charges, or; (ii) the Out-of-Network Provider Reimbursement.
- Except as otherwise provided in this section, the Out-of-Network Provider Reimbursement is developed from base Medicare reimbursements adjusted by a predetermined factor established by Curative.
- For Out-of-Network Emergency Care, care provided by an Out-of-Network Facility-Based Provider at an In-network Facility, or Out-of-Network diagnostic imaging or laboratory services provided in connection with In-Network care, the Allowable Amount is the usual and customary rate as defined by Curative or as prescribed under applicable law or regulations.

Annual Open Enrollment Period means an annual thirty-one (31) day period, beginning no less than thirty (30) days prior to the beginning of the Plan Year, during which:

- If the Employer has established and maintained more than one Plan for their Eligible Employees, an Eligible Employee who had elected another Plan, and maintained

coverage under that Plan up to the beginning of the Annual Open Enrollment Period, can change to this Employer Contract.

- Eligible employees who decided not to enroll themselves and/or their Eligible Dependents for coverage under the Employer Contract during the Initial or Special Enrollment Periods can enroll.

Autism Spectrum Disorder means a neurobiological disorder that includes Autism, Asperger's syndrome, or Pervasive Development Disorder – Not Otherwise Specified.

Baseline Visit is the in-person meeting with a Curative Clinician to onboard you to the Health Plan, understand your health goals and how Curative can best work with you to meet your current and future healthcare needs. The Baseline Visit will also include an Evaluation of Preventive recommendations indicated by the United States Preventive Services Task Force (USPSTF) and evaluate whether your immunizations are up to date, all designed to keep you healthy.

Behavioral Health Practitioner - means a Physician or a Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Substance Use Disorder.

Biosimilar means a biologic medication. It is highly similar to a biologic medication already approved by the FDA – the original biologic (also called the reference product).

Brand Name Drugs are medications developed, patented, and sold under a trademarked name which typically will not be available as a Generic Drug until the patent has expired.

Child means a natural child, a stepchild, an adopted child (including a child for whom you or your spouse or domestic partner is a party in a suit in which the adoption of the child is sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, or any combination of those factors. A child of your child must be dependent on you for federal income tax purposes at the time of the enrollment of coverage for the child of your child is made under the Plan. A child not listed above whose primary residence is your household and to whom you are legal guardian or related by blood or marriage and who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States, is also considered a Dependent Child under the Plan.

Clinical Appeal means a request to change an Adverse Determination for care or services that were denied on the basis of lack of medical necessity, or when services are determined to be experimental, investigational or cosmetic. May be pre-service or post-service. Review is conducted by a physician. Members or their authorized representatives may file a Clinical Appeal. Providers may also file a Clinical Appeal on the Member's behalf.

Clinical Care Coordinator means the Claims Administrator designated clinical staff member who reviews requests for Utilization Management review.

Clinical Trial means an experimental or investigational research study performed to evaluate a new medical treatment prior to FDA approval.

Complications of Pregnancy means: (a) conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac

decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (b) non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Coinsurance means the percentage of covered expenses that must be paid by you after the applicable Copay and Deductible amounts. This percentage is shown on the Summary of Benefits.

Continuous Glucose Monitor (CGM) means a device that automatically estimates your blood glucose level or blood sugar throughout the day, and provides information on changes to your levels over time.

Coordinated Home Care means organized skilled intermittent patient care initiated by a hospital or other inpatient facility to facilitate the discharge and planning of its patients into home care under the orders of a qualified physician.

Copay (Copayment) means the amount You are required to pay to an In-Network Provider or other authorized provider in connection with the provision of Covered Health Services. The Copay amounts are indicated in the Summary of Benefits.

Covered Health Services or Covered Services means those medical and health care services and items specified and defined in the Benefit Booklet as being covered services but only when such services and items are medically necessary and when they are performed, prescribed, directed, or authorized in accordance with Our policies and procedures and this Benefit Booklet.

Crisis Intervention means a short-term process which provides intensive supervision and highly structured activities to the Member who is demonstrating an acute medical or psychiatric crisis of severe proportions, which substantially impairs the Member’s thoughts, perception of reality, and judgment, or which grossly impairs behavior.

Crisis Stabilization Unit or Facility means a 24-hour residential program that is usually short-term in nature and provides intensive supervision and highly structured activities to persons who are demonstrating an acute psychiatric crisis of moderate to severe proportions.

Cryotherapy (or cold therapy) means the treatment of pain and/or inflammation by lowering the temperature of the skin over the affected area.

Custodial Care means care not given primarily for therapeutic value in the treatment of an Illness or Injury and is provided primarily for the maintenance of the Member and is essentially designed to assist in the activities of daily living (ADL). We and/or an independent medical review board will decide if a service or treatment is Custodial Care.

Deductible means the amount of out-of-pocket expense that must be paid for health care services by the Member before becoming payable by the Health Plan. The family Deductible means that a family of 3 or more will only need to meet a total of 2 Members' individual Deductibles.

Dependent means your spouse, domestic partner, or any child covered under the Plan. For purposes of this Plan, the term Dependent will also include those individuals who no longer meet the definition of a Dependent but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Diabetic Supplies and Equipment means equipment and supplies for the treatment of diabetes for which a physician or practitioner has written an order, including blood glucose monitors, including those designed to be used by or adapted for the legally blind; test strips specified for use with a corresponding glucose monitor; lancets and lancet devices; visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein; insulin and insulin analog preparations; injection aids, including devices used to assist with insulin injection and needleless systems; insulin syringes; biohazard disposal containers; insulin pumps, both external and implantable, and associated appurtenances, which include insulin infusion devices; batteries; skin preparation items; adhesive supplies; infusion sets; insulin cartridges; durable and disposable devices to assist in the injection of insulin; and other required disposable supplies; repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump; prescription medications for controlling the blood sugar level; podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; glucagon emergency kits.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies shall be covered after the previous device’s life expectancy fails or fails due to no fault of the Member if determined to be medically necessary and appropriate by a treating physician or other practitioner through a written order. All supplies, including medications, and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitution is approved by the physician or practitioner who issues the written order for the supplies or equipment.

Diabetic Self-Management Training means training including (i) Training provided after the initial diagnosis of diabetes, including nutritional counseling and proper use of Diabetes Equipment and Supplies; (ii) additional training authorized on the diagnosis of a significant change in Your symptoms or condition that requires changes to Your self-management regime; and (iii) periodic or episodic continuing education training as warranted by the development of new techniques and treatments for diabetes.

Digital Mammography means Mammography creating breast images that are stored as digital pictures.

Domestic Partner means a person who is not married to the enrolled employee but is in a committed relationship and plans to remain in the relationship. The domestic partner must be 18 years of age and reside with the member. The domestic partner may be the same or opposite gender or the member.

Effective Date means the date on which coverage begins for You and your dependents if they are enrolled in the Plan.

Eligible Employee means an employee who works on a full-time basis, working a normal work week for the number of hours designated by their Employer to qualify as an eligible Member.

Eligible Expenses means either, Inpatient Hospital Expenses, Medical Expenses, Extended Care Expenses, DME, Prosthetics, or Pharmacy Expenses as described in this Benefit Booklet.

Emergency means the health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson to believe that the individual's condition if left untreated could place their health in serious jeopardy, impair bodily functions, or result in serious disfigurement, and for a pregnant woman, result in serious jeopardy to the health of the fetus. Emergency care also pertains to behavioral health services. The Health Plan covers medical emergencies wherever they occur in the United States. In case of an emergency, call 911 or go to the nearest emergency room.

Employer means the employer identified in the Addendum to the Benefit Booklet.

Enrollment Forms mean the forms the Member shall be required to complete and submit to the Employer for the purpose of enrolling them and any Eligible Dependents for coverage hereunder.

Experimental and Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical treatment of the condition being treated or any such items requiring Federal or other governmental agency approval not granted at the time services are rendered.

Facility means a health care or residential treatment center licensed by the state in which it operates to provide medical inpatient, residential, day treatment, partial hospitalization, or outpatient care.

Family means You and Your Dependents who are covered under this Plan.

Formulary (Curative Formulary) is a list of over the counter, generic, brand-name and specialty prescription drugs, devices and supplies that are covered and dispensed by a Pharmacy. The listing is developed based on the efficacy and safety of the drugs.

Freestanding Emergency Medical Care Facility means a facility, structurally separate and distinct from a hospital that receives an individual and provides emergency care, as defined under Chapter 254, Health and Safety Code.

Gender Dysphoria means the feeling of discomfort or distress that occurs when gender identity differs from the gender assigned at birth.

Generic Drugs are medications that by law must have the same active ingredients and are subject to the same US Food and Drug Administration (FDA) standards for quality, strength, performance, and purity as their Brand Name counterpart. Generic drugs usually cost less than Brand Name drugs.

Home Health Care means the skilled health care services that are provided during a visit by a Home Health Agency to Members confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is: (1) Licensed in accordance with state law; or (2) Certified by Medicare as a supplier of Hospice Care.

Hospital means an acute care institution licensed by the proper state authority, or agency, as a Hospital, and is accredited under the Joint Commission which is primarily engaged, on an inpatient basis, in providing medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, under supervision of a staff of Physicians and with 24-hour a day nursing and Physician service; provided, however, it does not include a nursing home or any institution or part thereof which is used principally as a custodial facility.

Identification Card (ID Card) means the card issued to the Member indicating pertinent information applicable to their coverage. This card should be presented to your healthcare provider at time of services.

In-Network means identified Physician, Behavioral Health Practitioner, Professional Other Providers, Hospitals, Pharmacies, and other facilities that have entered into agreements with Curative as a network contracted provider or facility.

In-Network Provider means a Hospital, Physician, Behavioral Health Practitioner, Pharmacy, or other Provider who has entered into an agreement with Curative as a network contracted provider.

Intensive Outpatient Program means a freestanding or hospital-based program that provides services in a facility for a few days per week, for few hours per day, to treat mental illness, drug addiction, substance abuse or alcoholism, or Substance Use Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorder.

Imaging Center means a Provider that can furnish technical services with respect to diagnostic imaging services and is licensed by the proper State authority, or agency, having legal authority to license, certify and approve.

Imaging Services including, but not limited to, CT Scan; MRI (Magnetic Resonance Imaging); PET Scan (Positron Emission Tomography).

In-Network Benefits means the coverage available under the plan for services, supplies and drugs that are provided by a Network Provider who has contracted with Curative.

Independent Review Organization (IRO) means an organization selected to review your medical care and benefit determination.

Life-Threatening means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Maintenance Medication means a prescription drug taken on a regular basis, often every day, that treats a wide range of ongoing illnesses or long-term conditions, such as high blood pressure, diabetes, asthma, or depression. Maintenance Medication would not include a controlled substance.

Mammography means the x-ray examination of the breast using equipment dedicated specifically for Mammography.

Maternity Care means care, and services provided for treatment of the condition of pregnancy.

Medical Copays and Deductibles means for services related to providers providing medical treatment. These do not reflect the Pharmacy benefit Copays, Deductible and annual maximum.

Medical Director means an accredited Physician designated by Curative to monitor appropriate provision of medically necessary Covered Health Services to Members in accordance with the Plan.

Medical Injectables means any medication that is infused via intravenous infusion (IV), injected intramuscularly (IM), where medical supervision is required, or must be administered at the point of care (i.e.: Dialysis Centers). These drugs will be defined by the Curative Pharmacy and Therapeutics Committee.

Medical Expenses means the Allowable Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Member, provided such items are:

- Furnished by or at the direction of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
- Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the discretion of a Physician, Behavioral Health Practitioner or Professional Provider if the listed service or supply is:

- Provided by a person employed by the directing Physician, Behavioral Health Practitioner or Professional Provider;
- Provided at the usual place of business of the directing Physician, Behavioral Health Practitioner or Professional Provider; and
- Billed by the directing Physician, Behavioral Health Practitioner or Professional Provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Medically Necessary/Medical Necessity means the health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider; and (d) 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 that patient's illness, injury, or disease. No service is a Covered Service unless it is Medically Necessary.

Medicare means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or subsequently amended.

Member means a person who has enrolled in the Health Plan as an Employee or Dependent and is eligible to receive Covered Health Services. This person sometimes is also referred to as a Participant, Enrollee or Patient

Neonatal Intensive Care Unit (NICU) means a special care nursery or intensive care nursery. Admission into NICU generally occurs but is not limited to when the Newborn is born prematurely, if difficulty occurs during delivery, or the Newborn shows signs of a medical problem after the delivery.

Neurocognitive Rehabilitation means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurophysiological Testing means an evaluation of the functions of the nervous system. (i.e. EMG- Electromyography, Intraoperative Neurological Monitoring)

Non-Clinical Appeal means a request to reconsider a previous inquiry, complaint or action by the Health Plan that has not been resolved to the Member's satisfaction. This relates to administrative health care services such as enrollment, access, claim payment, etc. and may be pre-service or post-service. Review is conducted by a Non-Medical Appeal Committee. Only Members or their authorized representatives may file a non-clinical appeal.

Open Enrollment means the annual period each year in which You can make changes to Your Plan benefits.

Oral Anticancer Drugs The Health Plan covers medically necessary Anticancer drugs that are used to treat cancer and are taken orally. They are typically part of the Specialty Drugs category and are categorized either traditional, targeted or hormonal. Refer to the Curative Formulary for the drugs that are covered in this category.

Organ Transplant means the harvesting of a solid and/or non-solid organ, gland, or tissue from one individual and reintroducing that organ, gland, or tissue into another individual.

Orthotics means prescribed medical devices that are applied to a part of the human body to correct a deformity, improve function, and relieve symptoms of a disease.

Out-of-Network means identified Physician, Behavioral Health Practitioner, Professional Other Providers, Hospitals, Pharmacies, and other facilities that have not entered into agreements with Curative as a network contracted provider or facility.

Out-of-Network Provider Reimbursement means the Allowable Amount Curative will consider as appropriate for eligible medical care from Out-of-Network providers. We determine this amount based on the payment methodology established by Curative. You may be responsible for the balance due to the provider over the amount considered as the Allowable Amount covered by Curative. Depending on your plan's Deductible terms, you may also be responsible for the Allowed Amount.

Out-of-Pocket Maximum means the total dollar amount a Member must pay each Plan Year before the Health Plan pay benefits at 100%. The Out-of-Pocket Maximum includes copayments. It does not include premiums, non-covered services, and balance billing amounts.

Over-the-Counter (OTC) means a drug that can be purchased without needing a prescription, however, coverage requires a prescription.

Palliative Care means specialized medical care focused to provide relief from the symptoms and illness with the goal of improving the quality of life for a patient with chronic, complex, or terminal illnesses.

Pharmacy and Therapeutics (P&T) Committee means a committee composed of healthcare providers and pharmacists who are involved in the use of medications and that is responsible for determining which drugs will be included on the Formulary. This committee is also responsible for creating medication policies by evaluating safety and efficacy.

Physician means any person who is duly licensed and qualified to practice within the scope of a medical practice license issued under the laws of the State of Texas or in which state treatment is received. Physicians include a doctor of osteopathic medicine.

Plan, Health Plan, Your Plan, The Plan means the coverage of health care services available to You under the terms of this Benefit Booklet.

Plan Year means the period specified in the Addendum to the Benefit Booklet.

Post-Acute Care means services provided after acute-care confinement and/or treatment that are based on an assessment of the patient's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or reestablishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Prescription Drug means any medicinal substance whose label is required to bear the legend "RX only" and FDA approved.

Prior Authorization means the review of the requested services for the medical appropriateness in advance of certain care and services under this Plan.

Prosthetics means prescribed devices meant to replace, wholly or partly, a lost limb or body part, such as an arm or a leg. Covered benefits may be limited to the appropriate model of prosthetic device that adequately meets the medical needs of the Members as determined by the Member’s physician.

Provider means a Hospital, Physician, Behavioral Health Practitioner, Other Provider, or any other person, company or institution furnishing to a Member an item of service, supply or drug covered by the Health Plan.

Partial Hospitalization /Psychiatric Day Treatment Facility means a free-standing facility that provides structured treatment for not more than eight hours in any 24-hour period after which the Member is allowed to leave. These facilities treat mental illness, drug addiction, substance abuse or alcoholism, or Substance Use Disorder or specialize in the treatment of co-occurring Mental Illness and Substance Use Disorder. The Joint Commission must accredit such facilities.

Remediation means the process(es) of restoring or improving a specific function.

Residential Treatment Center means a facility setting (including a Residential Treatment Center for Children and Adolescents) offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and 24-hour onsite nursing service. The Health Plan requires that any facility providing Mental Health Care and/or a Substance Use Disorder treatment program be accredited as a residential treatment center by the Council on Accreditation, the Joint Commission or the American Association of Psychiatric Services for Children.

Self-Injectables means any medication that is injected subcutaneously or specifically designed and generally accepted to be self-injected and does not require direct medical professional oversight. These drugs will be defined by the Curative Pharmacy and Therapeutics Committee.

Serious Mental Illness (SMI) means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM): bipolar disorders (hypomanic, manic, depressive, and mixed); depression in childhood and adolescence; major depressive disorders (single episode or recurrent); (obsessive-compulsive disorders); paranoid and other psychotic disorders; schizo-affective disorders (bipolar or depressive); and schizophrenia.

Skilled Nursing Facility means an institution which:
Is accredited under one program of the Joint Commission as a Skilled Nursing Facility or is recognized by Medicare as an Extended Care Facility:

- Is not a Rehabilitation Facility;
- Furnishes room and board and 24 hour-a-day skilled nursing care by, or under the supervision of a registered nurse (RN); and
- Is not a clinic, rest Facility, home for the aged, place for drug addicts or alcoholics, or a place for Custodial Care.

Special Enrollment Period means an enrollment period that is provided for employees and/or their dependents due to special circumstances as described in the Special Enrollment provision.

Telemedicine / Telehealth means a synchronous, interactive office visit with your provider through the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. The term does not include services performed using a telephone. Health care services will not be excluded based solely on the fact that they were provided through telemedicine / telehealth and not provided through a face-to-face consultation.

Total Disability (Totally Disabled) means the complete inability of that individual to perform all of the substantial and material duties and functions of the individual's occupation and any other gainful occupation in which the individual earns substantially the same compensation earned before the disability; and with respect to any other individual covered under a health plan, confinement as a bed patient in a hospital.

Ultrasound, Breast means a procedure that may be used to determine whether a lump is a cyst or a solid mass.

Us, We or Our means Curative.

Utilization Review means a system for prospective and/or concurrent review of the Medical Necessity and appropriateness of Covered Health Services Your provider is currently providing or proposes to provide to You. Utilization Review does not include elective requests by You for clarification of coverage. The Utilization Review provides:

- Pre-treatment Review;
- Concurrent Review;
- Discharge Planning; and
- Retrospective Review

Virtual Urgent Office Visit means a synchronous, interactive, virtual office visit with a 24/7/365 On Demand Urgent Care Doctor through the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education.

You or Your means a covered Member.

CURATIVE
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Curative respects the confidentiality of your individual health information. This Notice describes how we collect, use, and disclose PHI about you and our obligations related to your PHI, including when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights. HIPAA and other information privacy laws require that we maintain confidentiality of health information that identifies you, such as PHI, and HIPAA requires us to provide this Notice to you.

This Notice applies to Curative and its affiliated entities that operate under the same privacy practices.[1]

This Notice is effective from September 1, 2022.

Our Privacy Pledge for Your Health Information

Curative understands that information about you and your health is personal, and we are committed to protecting your privacy. When providing items and services to you, we create orders and other records regarding healthcare provided to you as well as payment for that healthcare. We have developed policies and procedures to ensure that we collect and maintain the information you provide to us in a confidential manner. This Notice applies to all healthcare records and healthcare information practices of ours and of any third party that assists us in providing items or services to you. Another provider outside Curative may have different policies or notices regarding the use and disclosure of healthcare information about you that they created.

What is Protected Health Information (PHI)?

PHI is information that identifies you, and relates to your past, present or future physical and mental health or conditions, the delivery of healthcare to you, or the past present, or future payment for your healthcare. PHI includes both medical information and individually identifiable information, including your name, address, telephone number, or Social Security number. We protect this information in electronic, written, or oral formats.

We understand the importance of protecting your PHI and restrict access to authorized workforce members who need that information for your treatment, for payment purposes, and for our operations related to your healthcare. We will not disclose your PHI without your authorization unless it is necessary to provide your health benefits, administer your benefit Plan, support Plan programs and services, or as required or permitted by law. If we need to disclose your PHI, we will follow the policies described in the Notice to protect your privacy.

How We Use Your Health Information

HIPAA and related laws allow us to use and disclose your information in many different ways. The following describes different ways that Curative may use and disclose information

about you, including your PHI. While we do not list every possible use or disclosure, all the ways we can use or disclose your information will fall within one of the described categories:

- **Appointment Reminders -** We may disclose your health information to remind you of appointments that you have with your providers or Curative.
- **As Authorized by You.** If you request, we will use or disclose your health information to you or others you authorize to receive your health information. You should remember that information used or disclosed with your authorization may lose its protected status under HIPAA.
- **As Required by Law** – We may use or disclose your health information when required to do so by federal, state, or local law.
- **Business Associates** - We may use or disclose your health information to business associates who perform functions on our behalf or provide us with services if the information is necessary for those functions or services. By contract, we require our business associates to protect the privacy of your information and not to use or disclose your information other than as specific in our contract. Our business associates are also directly subject to certain federal privacy laws.
- **Data Breach Notification** - We may use your contact information to provide notice of unauthorized acquisition, access, or disclosure of your health information as required by law.
- **Events and Fundraising** - We may contact you to provide you with information about events and activities, including fundraising programs. If we do contact you for these activities, the communication you receive will have instructions on how you may ask us not to contact you again for such purposes.
- **Health Care Operations** - We may use and disclose your health information to our employees or business associates when needed to operate our business in support of providing you with healthcare and related benefits or of securing payment for the items or services we provide. We may also use or disclose your health information to develop better services for you. Our employees and business associates will only receive the minimum necessary information needed to complete their duties.
- **Health or Safety Threat** - We may use or disclose your health information to avoid a serious and imminent threat to your health or safety or the health and safety of the public or another person.
- **Health Benefits and Services** - We may use or disclose your health information to contact you about benefits and services that we provide.
- **Health Oversight Activities** - We may use or disclose your health information to a health oversight agency for activities authorized by law. This may include licensing, audits, investigations, inspections, or other activities necessary for the government to monitor the healthcare system, governmental healthcare programs, and civil rights compliance.
- **Law Enforcement** - We may use or disclose your health information to law enforcement officials for purposes such as providing limited information to locate a missing person or report a crime.
- **Lawsuits and Disputes** – We may use or disclose your health information in response to a court or administrative order involving you. We may also use or disclose your health information in response to a subpoena, discovery request, or other lawful process by some

else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice) or to obtain an order protecting the requested information.

- **Organ and Tissue Donation Requests** – We may use or disclose your health information with organ procurement organizations.
- **Payment** - We may use or disclose your health information to make coverage determinations; to make or obtain payment for your items or services; and to determine and fulfill our responsibility to provide benefits under your Plan. We may also use or disclose your health information to another health plan or a healthcare provider to coordinate payment activities.
- **Persons Involved with Your Care** - We may use or disclose your health information to a person involved in your care or helping with payment of your care, such as a family member or friend, provided you agree to this disclosure or we give you an opportunity to object to the use or disclosure. If you are unavailable or unable to object, we will use our best judgment to decide whether the use or disclosure is in your best interest.
- **Personal Representatives** – We may use or disclose your health information to a person who is legally authorized to act for you. This could include a parent, legal guardian, administrator or executor of your estate, or another individual authorized under applicable law. We will treat this person the same way we would treat you with respect to your health information; however, we may decline to use or disclose information to a personal representative if we believe: (1) you are (or may be) a victim of abuse or neglect; (2) treating the person as a personal representative could endanger you; or (3) we determine, in our reasonable judgment, that it is not in your best interest to treat the person as your personal representative. You should also remember that parents and legal guardians are generally plan member representatives of minors, unless the minors are permitted by law to act on their own behalf and make their own medical or other decisions.
- **Public Health Activities** - We may use or disclose your health information to a public health organization or authority for public health activities, which may include, among other things, instances or risk for exposure to, or spreading of, a disease or condition or of defect or recall of products or devices.
- **Research** - We may disclose your PHI for research purposes under specific rules determined by the confidentiality provisions of applicable law. In some situations, federal law allows us to use or disclose your health information for research without your authorization, provided we get approval from a special review board. Such research will not affect your eligibility for benefits, treatment or welfare, and your health information will continue to be protected.
- **Specialized Government Functions** - We may use or disclose your health information for specialized government functions such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **Treatment** - We may use or disclose your health information to your healthcare provider for plan coordination; to help obtain services and treatment you may need; or to coordinate your healthcare and related services. This may include use or disclosure of your health information to contact you about possible treatment options or alternatives that may be of interest to you.
- **Underwriting** - We will not use or disclose your health information—specifically, genetic information—for underwriting purposes.

- **Victims of Abuse** - We may use or disclose your health information to government authorities that are authorized by law to receive information about victims of abuse, crime, or domestic violence, including a social service or protective service agency.
- **Workers' compensation** – We can use or disclose your health information for workers' compensation purposes, as authorized by, or to the extent necessary to comply with, state laws that govern job-related injuries or illnesses.

We may not use or disclose your health information for any other purpose than as described in this Notice without requesting a specific written authorization from you to disclose information for the specified purpose. If you give us authorization to disclose your confidential health information, you may revoke (cancel) your authorization in writing at any time, except if we have already acted based on your authorization. To revoke an authorization, you must do so in writing at the address below.

Know Your Rights Regarding Your Health Information

You have the following rights regarding the health information Curative maintains about you:

- **Right to Amend** – You have the right to request that we amend health information that we maintain about if you feel the information is incorrect or incomplete. Your request must be in writing and provide the reasons for the requested amendment. If we deny or partially deny your request, you may have a statement of your disagreement or rebuttal added to your health information. Amendments (and any related rebuttals) may be subject to disclosure to third parties when you authorize the use or disclosure of your health information. You can send an amendment request to the address listed below.
- **Right to Inspect and Copy** – You have the right to review and obtain a copy of health information that we may use to make decisions about you, including your medical and insurance records. In some cases, you may also receive a summary of this health information. You must make a written request to inspect and copy your health information, and you can send your request to the address listed below. In certain circumstances, we may deny your request to inspect or copy your health information, in which case, you may request that the denial be reviewed by a licensed healthcare professional not directly involved in the denial of your request. We may charge you a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.
- **Right to be Notified of a Breach** - You have the right to be notified if we, or a business associate helping us, become aware of a breach of unsecured health information that results in improper use or disclosure about you. We will give you such notice in accordance with applicable state or federal law.
- R**ight to Receive an Accounting of Disclosures** - You have the right to receive a list of certain disclosures of your health information. This is a list of the disclosures made by us during the 6 years prior to your request. This list will not include disclosures made: (1) prior to the 6-year period; (2) for treatment, payment, and healthcare operations purposes; (3) to your pursuant to your authorization; (4) to friends and family in your presence or because of an emergency; (5) to correctional institutions or law enforcement officials; and (6) other disclosures for which federal law does not require us to provide this list. You must submit your request in writing and state the time period for which you want to receive the accounting, which may not be longer than 6 years. We may give you the list in paper or electronic form. The first accounting you request in a 12-month period will be free of charge. We may charge you for responding to any additional requests in that same time period. We will inform you of any costs before you will be charged anything.

- **Right to Receive Confidential Communications -** You may ask to receive confidential communications about your health status or to have us provide your health information us in a certain way or at a certain location. You must make any such request in writing, and you must specify how or where we are to contact you. You can send your request to the address listed below. We will not ask you the reason for your request, and we will accommodate reasonable requests by you to receive communications of health information by alternative means or at alternative locations if you clearly state that the disclosure of all or part of your health information could endanger you.
- **Right to Receive Paper Copy of this Notice -** You have the right to receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically. You may ask us for a paper copy of this Notice at any time.
- **Right to Request Restrictions** – You have the right to restrict or limit use or disclosure of your health information treatment, payment, and health care operations. You also have the right to request that we limit the health information we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. Your request for restriction must be submitted in writing and state the specific restriction requested. We are not required to agree to your request, except as required by law. If we agree with your request for restriction, we will do so in writing, and we will comply with your request unless the information is needed in an emergency situation or as required by law. We may end a non-mandated restriction if we tell you, and if we do so, the lack of restriction will only affect your health information created or received after we notify you. To request restrictions, you must make your request in writing to the address listed below. Your request must include: (1) the information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply.
- **Checking Your Identity for Your Protection** - For your protection, we may check your identity whenever you have questions about your treatment or payment activities. We will check your identity whenever you get requests to access, copy. or amend your records, or to obtain a list of disclosures of your health information.

Changes to this Notice

Curative will abide by the terms of this Notice. However, Curative reserves the right to change this Notice and our Privacy Practices, to make such changes effective for health information we already have about you, as well as any information we receive in the future. When we make materials changes to this Notice and our Privacy Practices, we will provide you with a copy of our revised Notice at the time required and in a manner permitted by law.

How to Contact Us

You may contact us: (1) for confidential communications or to modify or cancel a prior confidential communication request; (2) for a copy of your records; (3) for amendments to your records, (4) for other rights as described in this Notice; or (5) to let us know something is wrong, at the following address:

ATTN: Privacy Officer
Curative
P.O. Box 1786
Austin, TX 78767
privacy@curative.com

You may make verbal inquiries for any of (1)-(3) above by calling us at 855-428-7284. To the extent possible, though, we ask that you contact us in writing, and we may ask you to fill out and return to us a form that we will provide to you.

If Something is Wrong, Let Us Know Right Away

If you believe that Curative has violated your privacy rights, you may file a complaint: (1) with us at the address or phone number above; (2) by mail to U.S. Department of Health & Human Services, Centralized Case Management Operations, 200 Independence Avenue SW, Room 509F HHH Bldg., Washington, DC 20201; (3) by phone to the OCR at 877.696.6775; or (4) by email at OCRComplaint@hhs.gov or via the OCR Online Portal.

You must submit all complaints in writing. ***Curative will not retaliate against or penalize you for exercising your rights or filing a complaint.***

Acknowledging this Notice

By completing your portion of the enrollment process with Curative and accessing this Notice through that process, you acknowledge your receipt and understanding of this Notice and affirmatively consent to the use and disclosure of your health information as described in this Notice.

Changes to this Notice

We are required to abide by the terms of the Notice currently in effect. We may change our Privacy Practices and the terms of this Notice at any time as allowed by law. We may, at our discretion, make the new terms effective for all of your PHI that we maintain, including any PHI we created or received before we issued the new Notice. When we make significant changes in our Privacy Practices, we will change this Notice and post it to our website at www.curative.com.

Effective Date of Notice: October 2022

[1] For purposes of this Notice, Curative operates as an "Organized Healthcare Arrangement" or "OHCA" under HIPAA. This means that "Curative" includes—and this Notice applies to—(1) Curative Insurance Company; (2) Curative Medical Austin PLLC; (3) Curative Pharmacy LLC; (4) Curative Labs Inc.; (5) Curative Inc.; (6) Curative Health Holdings Inc.; (7) Curative MSO LLC; and (8) Curative Administrators LLC.