# Nokia Medical Expense Plan For Active Employees

## Summary Plan Description –

## Surest Enhanced and Surest Standard Options

January 2026

This summary plan description replaces the prior summary plan description (titled “Summary Plan Description, Surest Enhanced and Surest Standard Options, January 2025 (Updated)”). This summary reflects the provisions of the Surest Enhanced and Surest Standard options under the Nokia Medical Expense Plan for Active Employees as of January 1, 2026.

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# Introduction

The Nokia Medical Expense Plan for Active Employees is designed to provide protection against the cost of medical care and prescription drugs for you and your Eligible Dependents. This booklet--called a summary plan description ("SPD")--is intended to summarize the material terms of the Plan as in effect on January 1, 2026 and thereafter. In particular, this SPD summarizes the material terms of the plan design under both the Enhanced and Standard "Surest Plan" options (sometimes referred to herein collectively as the "Surest Plan" or the "Surest" options). It also summarizes the Plan's prescription drug program (for individuals covered by the Surest options) and the Plan's Employee Assistance Program ("EAP"). This SPD does not describe the terms of any of the Plan's other programs, such as the UnitedHealthcare (UHC) options or any Health Maintenance Organization ("HMO") options (and the prescription drug programs for those options), which are set forth in other materials.

The actual terms of the Plan are reflected in the official Plan document, a copy of which can be obtained by writing to the Plan Administrator (see Section V., "Important Contacts," for the address of the Plan Administrator). Every care has been taken to ensure that this summary is accurate. In the event of a conflict between this document and the terms of the official Plan document, the official Plan document will control.

Nokia of America Corporation (the Plan's sponsoring employer, sometimes referred to herein as the "Company") expects to continue the Plan but reserves the right to amend, modify, or terminate it, in whole or in part (including any Plan option or program), at any time by resolution of the Company's Board of Directors or its duly authorized delegate(s), with or without advance notice to participants, for any reason, subject to applicable law. The Company also reserves the right to change the amount of required participant contributions under the Plan at any time, with or without advance notice to participants.

> This updated SPD replaces all prior communications regarding the Surest Enhanced and Standard Plan options under the Plan.

Because of the many detailed provisions of the Plan, no one other than the personnel or entities identified in this document is authorized to advise you concerning your benefits or the terms of the Plan. Questions regarding your benefits should be addressed as indicated in this booklet (see Section V., "Important Contacts," for a list of Plan resources and how to contact them). Neither the Company, nor any Participating Company, nor the Plan is bound by statements made by unauthorized persons or entities. Moreover, in the event of a conflict between any information provided to you by an authorized source and information in this document, this document will control.

## Section A. The Plan At-A-Glance

The Plan provides medical care and prescription drug coverage for Eligible Employees and their enrolled Eligible Dependents. Coverage is subject to limitations, as described below and elsewhere in this SPD. The Plan also includes an Employee Assistance Program ("EAP") for Plan participants and their family members. (See Section M., "Employee Assistance Program", for more details.)

Below is a summary of the key features of the Plan. (Certain words and phrases used in the table below and elsewhere in this SPD have specific meaning under the Plan. These terms are printed in initial capital letters and are defined in Section B., "Terms You Should Know".)

| Plan Features | Summary |
|---|---|
| **Eligible Employee** | You are an Eligible Employee if you are employed by a Participating Company as a full- or part-time employee and are not an Excluded Employee. |
| **Participating Company** | The following companies are Participating Companies:<br>• Infinera America Inc.<br>• Nokia of America Corporation<br>• Nokia Investment Management Corporation |
| **Excluded Employee** | An Excluded Employee is: (1) an individual who does not receive payment for services from a Participating Company's U.S. payroll, even if such individual is reclassified by a court or administrative agency as a common law employee of a Participating Company, (2) an employee who is employed by an independent company (such as an employment agency), (3) an employee whose services are rendered pursuant to a written agreement that excludes participation in the Company's benefit plans, (4) a Leased Employee, (5) a temporary employee (and any regular employee subclassified as a temporary employee), (6) a co-op student (other than an Eligible Co-op Student) or an intern (and any trainee/student subclassified as an intern) (other than an Eligible Intern), (7) a trainee (other than an International Graduate Trainee), (8) an International Assignee. |

| Plan Features | Summary |
|---|---|
| **Participation and Enrollment** | *Newly hired Eligible Employees (other than Eligible Co-op Students)*<br><br>Newly hired Eligible Employees (other than Eligible Co-op Students) are automatically enrolled in the Plan as of their first day of employment and are assigned to the Surest Enhanced option. Employees who were not previously Eligible Employees but who become such (for example, they transfer employment from a Nokia Group company that is not a Participating Company to a Participating Company) are (unless they are Eligible Co-op Students) automatically assigned to the Surest Enhanced option under the Plan as of their first day of eligibility.<br><br>Such newly hired and newly eligible employees then have 31 days within which to change their Coverage Option (see "Coverage Options", below) and/or to add Eligible Dependents (see "Eligible Dependents", below). If they do not do so within this 31-day period, they may change their Coverage Option and add or drop Eligible Dependents only during the Plan's Annual Open Enrollment Period (or if they have a Qualified Status Change).<br><br>*Eligible Co-op Students:*<br><br>Eligible Co-op Students must affirmatively enroll in the Plan within 31 days of receiving enrollment materials by contacting the NBRC or logging onto YBR. At that time, such Eligible Co-op Students will also have the opportunity to enroll their Eligible Dependents. Eligible Co-op Students who do not enroll in the Plan within such 31-day period may enroll in the Plan and add or drop Eligible Dependents only during the Plan's Annual Open Enrollment Period (or if they have a Qualified Status Change).<br><br>*Already-Enrolled Eligible Employees (including Eligible Co-op Students)*<br><br>Employees who are already enrolled in the Plan may change their Coverage Option and add or drop Eligible Dependents only during the Plan's Annual Open Enrollment Period (or if they have a Qualified Status Change). |
| **Eligible Dependents** | If you are eligible to participate in the Plan, you may also enroll your Eligible Dependents, defined as follows:<br><br>• Your Spouse/Domestic or Civil Union Partner<br>• Your Children (including your Spouse's children, i.e., your stepchildren), up until the end of the month in which they turn age 26) |

| Plan Features | Summary |
|---|---|
| | • The Children of your Domestic or Civil Union Partner, provided they live with you, up until the end of the month in which they turn age 26<br>• Your Adult Disabled Children.<br><br>Note: Each of the above terms has a specific definition. See Section B., "Terms You Should Know," for more detail regarding who is an Eligible Dependent under the Plan. |
| **Coverage Options** | The Plan offers the following medical coverage options under the "Surest" plan design:<br><br>• Surest Enhanced option--a plan providing a high level of benefit coverage (but requiring higher monthly contributions)<br>• Surest Standard option--a plan with a lower level of benefit coverage (with lower monthly contributions).<br><br>To see the differences between the level of coverage offered under the Surest Enhanced option and the Surest Standard option, see Section F., "What's Covered Under the Surest Enhanced Option," and Section G., "What's Covered Under the Surest Standard Option." |
| **Coverage Categories** | The following are the Coverage Categories for the Plan:<br><br>• You only<br>• You + your Spouse/Domestic or Civil Union Partner<br>• You + your Children (including your Adult Disabled Children and, if applicable, the Children of your Domestic or Civil Union Partner)<br>• You + your Family (i.e., your Spouse/Domestic or Civil Union Partner and your Children, including your Adult Disabled Children, and, if applicable, the Children of your Domestic or Civil Union Partner) |
| **Cost of the Plan** | You are required to contribute to the cost of coverage under the Plan for yourself and your enrolled Eligible Dependents. The cost of Plan coverage depends on the Coverage Option and Coverage Category (see above) you choose. In most instances, the cost of coverage is deducted from your paycheck on a pre-tax basis. (See Section D., "The Cost of Plan Coverage.") |

| Plan Features | Summary |
|---|---|
| | Information on the cost of coverage is available from the Nokia Benefits Resource Center (the NBRC) and through the Your Benefits Resources (YBR)™ website when you enroll in the Plan.<br><br>For more information on how to contact the NBRC or how to log onto YBR, see Section V., "Important Contacts." |
| **Other Plan Costs** | Depending on the Medical Plan option in which you enroll and whether you utilize an In-Network or Out-of-Network provider, you might also need to pay a Copay amount.<br><br>Copays are described further in Section F., "What's Covered Under the Surest Enhanced Option," and Section G., "What's Covered Under the Surest Standard Option." |
| **What's Covered** | For a service or supply to be covered, it must be:<br><br>• Medically necessary for the treatment of an illness or injury, or for preventive care benefits that are specifically stated as covered<br>• Provided under the order or direction of a physician<br>• Provided by a licensed and accredited healthcare provider practicing within the scope of his or her license in the state where the license applies<br>• Listed as a covered service and satisfy all the required conditions of services of the applicable options, and<br>• Not specifically listed as excluded.<br><br>Note: In some cases, there may be additional required criteria and conditions. Services and supplies meeting these criteria will be covered up to the allowable amount or the negotiated rate, if applicable. |
| **Annual Open Enrollment Period** | The Annual Open Enrollment Period is the period when you can make selections regarding coverage for the upcoming Plan Year. You may add or cancel coverage for yourself, enroll or disenroll Eligible Dependents, and/or change your Coverage Option. Information about the Annual Open Enrollment Period, including information about any changes being made to the Plan, is communicated in the fall (usually between September and November). |
| **Qualified Status Change** | Eligible Employees may be able to change their coverage option and add or drop Eligible Dependents outside of the Plan's Annual Open Enrollment Period if they experience a Qualified Status |

| Plan Features | Summary |
|---|---|
| | Change. See "Changing Your Coverage During the Plan Year" in Section C., "Eligibility and Enrollment," for more information. |
| **COBRA/ Continuation of Coverage** | Eligible Employees (and their qualified beneficiaries) may be able to continue coverage under the Plan (for a period of time) if they would otherwise experience a loss of coverage due to a Qualifying Event (such as termination of employment). See Section Q., "COBRA Continuation Coverage," for more information. |
| **Claims Administrator** | The third-party hired to process claims for benefits under the Plan. The current claims administrator for the Surest Enhanced and Surest Standard options is Surest, a UnitedHealthcare Company. The current claims administrator for the Prescription Drug Program is CVS Caremark. The current claims administrator for the Employee Assistance Program is Magellan. See Section V., "Important Contacts," for information on how to contact each of these claims administrators. |
| **Nokia Benefits Resource Center (NBRC)** | The Nokia Benefits Resource Center (NBRC) is the service center for the Plan and your point-of-contact for information about, and transactions concerning, the Plan. The NBRC is also your point-of-contact during the Annual Open Enrollment for the Plan. See Section V., "Important Contacts," for information of how to contact the NBRC. |
| **Your Benefits Resources (YBR)™** | Your Benefits Resources (YBR)™ is your on-line access point for the Plan. See Section V., "Important Contacts," for information of how to access YBR. (Your Benefits Resources is a trademark of Alight Solutions LLC.) |

## Section B. Terms You Should Know

There are several words and phrases that have specific meaning under the Plan. This section explains those terms so you can better understand your benefits. These terms are capitalized when they appear in this SPD.

**Adult Disabled Child:** With respect to an Eligible Employee, such Eligible Employee's Child who has attained age 26, provided such Child meets all of the following requirements:

- The Child was covered under the Plan as an eligible dependent immediately prior to attaining age 26 (note: for newly hired employees, a Child who has been continuously covered under another employer's group health plan since immediately before turning age 26 is treated as satisfying this requirement), and
- The Child, prior to attaining age 26 and thereafter was and remains--
  - Physically, mentally, or developmentally disabled, and
  - Incapable of self-support, and
  - Fully dependent on the Eligible Employee for support; and
- The Child is certified by the claims administrator for the Plan as incapacitated due to disability (certification process must be started within 31 days of the end of the month in which the Child turns age 26).

*Note: Adult Disabled Child coverage is available only with respect to the Child(ren) of an Eligible Employee (including stepchildren). It is not available with respect to the Child(ren) of a Domestic or Civil Union Partner.*

**Adverse Benefit Determination:** A denial, reduction of or a failure to provide or make payment, in whole or in part, for a Benefit, including those based on a determination of eligibility, application of utilization review, or Medical Necessity.

**Allowable Amount:** The portion of a Provider's charge that is eligible for reimbursement either in full or in part. Any amount by which the Provider's charge exceeds the Allowable Amount is not reimbursable under the Plan.

**Alternate Facility:** A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services
- Emergency Health Services
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

**Ancillary Services:** Items and services provided by Out-of-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by an Out-of-Network Physician when no other Network Physician is available.

**Annual Deductible (or Deductible):** The aggregate amount of covered charges each calendar year that the Participant must pay before the Prescription Drug Program begins to pay Out-of-Network benefits each calendar year.

**Annual Maximum:** The maximum benefit available from the Medical Plan each calendar year for each Participant. Once the annual maximum benefit has been paid, no other benefits are available under any circumstances. You are responsible for all charges above the Annual Maximum benefit.

**Annual Open Enrollment:** The period of time each year designated by the Company during which you can generally make changes to your benefits. Elections made during the Annual Open Enrollment period are effective as of the first day of the subsequent calendar year.

**Autism Spectrum Disorder:** A range of complex neurodevelopmental disorders, characterized by persistent deficits in social communication and interaction across multiple contexts, restricted repetitive patterns of behavior, interests, or activities, symptoms that are present in the early development period that cause clinically significant impairment in social, occupational, or other important areas of functioning and are not better explained by intellectual disability or global developmental delay. Such disorders are determined by criteria set forth in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association*.

**Benefits:** Plan payments for covered services, subject to the terms and conditions of the Plan.

**Beneficiary:** with respect to a Participant, an Eligible Dependent who has been enrolled in and is Covered by the Plan.

**Birthing Center:** A facility for prenatal, delivery and postpartum care that:

- Is staffed by certified nurse-midwives

- Has 24-hour access to consultation with an obstetrician/gynecologist with admitting privileges at a nearby Hospital
- Is accredited by the National Association of Childbearing Centers or the Joint Commission on the Accreditation of Healthcare Organizations, and
- Is licensed by the state.

**BMI or Body Mass Index:** A calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

**Brand Name Drug:** A medication that has been patented and is produced by only one manufacturer.

**Cellular Therapy:** Administration of living whole cells into a patient for the treatment of disease.

**CHD:** See Congenital Heart Disease (CHD).

**Chemical Dependency:** Both alcoholism and drug dependency as classified by the U.S. Department of Health and Human Services' International Classification of Diseases.

**Child:** With respect to an Eligible Employee, such Eligible Employee's child(ren), up to the end of the month in which such child(ren) turn(s) age 26. For this purpose, child(ren) means:

- The Eligible Employee's biological child(ren)
- The Eligible Employee's stepchild(ren) (i.e., the biological child(ren) of the Eligible Employee's Spouse)
- The Eligible Employee's legally adopted child(ren), including child(ren) who are placed with the Eligible Employee for adoption
- The legally adopted child(ren) of the Eligible Employee's Spouse, including child(ren) who are placed with the Eligible Employee's Spouse for adoption
- Child(ren) for whom the Eligible Employee and/or the Eligible Employee's Spouse is (are) appointed as legal guardian as defined by a court order (this does not include wards of the state or foster child(ren)); and
- Child(ren) for whom the Eligible Employee is required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

**Child of a Domestic or Civil Union Partner:** With respect to an Eligible Employee's Civil or Domestic Union Partner, such Domestic or Civil Union Partner's child(ren), up to the end of the month in which such child(ren) turn(s) age 26. For this purpose, child(ren) means:

- The Domestic or Civil Union Partner's biological child(ren), provided such child(ren) is (are) living with the Eligible Employee
- The Domestic or Civil Union Partner's legally adopted child(ren), including child(ren) placed with such partner for adoption, provided such child(ren) is (are) living with the Eligible Employee

- Child(ren) for whom the Domestic or Civil Union Partner is appointed as legal guardian as defined by a court order (this does not include wards of the state or foster child(ren)), provided such child(ren) is/are living with the Eligible Employee.

**Civil Union Partner:** See Domestic or Civil Union Partner.

**Claim:** A request for Benefits made by a Participant or his/her Authorized Representative in accordance with the procedures described in this SPD. It includes Prior Authorization requests; pre-service request for Benefits and appeals; urgent care request for Benefits and appeals; concurrent care request for Benefits and appeals; and post-services Claims.

**Claims Administrator:** The third-party hired to process claims for benefits under the Plan. See Section V., "Important Contacts," for information of how to contact the Claims Administrator.

**Clinical Trial:** A scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

**COBRA:** An acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. This refers to federal legislation that governs the offer of temporary continued Plan coverage to participants who otherwise would lose coverage due to certain reasons, such as loss of employment.

**Coinsurance:** The cost-sharing method pursuant to which the Prescription Drug Program pays a percentage of Eligible Expenses (for example, 50 percent) and you pay a percentage (for example, 50 percent). Your Coinsurance is your share of the cost.

**Company:** Nokia of America Corporation, a Delaware corporation, or its successor(s).

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

**Congenital Heart Disease (CHD):** Any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited)
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy
- Have no known cause.

**Continuity of Care:** The option for existing Participants to request continued care from their current health care professional if that professional is no longer working with their health plan and is now considered Out-of-Network.

**Copayment (or Copay):** A flat dollar amount (such as $20) that you are required to pay for a certain medical service (such as an office visit or supply).

**Cosmetic:** Services, medications, and procedures that improve physical appearance but do not correct or improve a physiological function or are not Medically Necessary.

**Cost Effective:** The least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

**Covered Dependent:** With respect to an Eligible Employee who is enrolled in the Plan, each Eligible Dependent of such employee who is enrolled in the Plan.

**Covered Health Services:** Health care services, including supplies or Pharmaceutical Products, which are determined to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms
- Medically Necessary
- Described as a Covered Health Service in this SPD
- Provided to a Covered Person who meets the Plan's eligibility requirements, and
- Not otherwise excluded in this SPD.

**Covered Person:** Either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

**Custodial Care:** Services that are any of the following non-Skilled Care services:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

**CVS Caremark:** The company that administers the Prescription Drug Program for participants in the Enhanced -Surest and Enhanced-Standard options under the Plan.

**Deductible:** See Annual Deductible.

**Default Option:** The Medical Plan option to which you are assigned if you are an Eligible Employee and have not actively enrolled in the Medical Plan or if your current option is eliminated and you do not actively select a new option. Eligible Employees working less than 20 hours per week are not assigned a Default Option; these Eligible Employees must actively enroll in the Medical Plan to have coverage.

**Definitive Drug Test:** A test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

**Dependent:** An individual who meets the eligibility requirements specified in the Plan. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

**Designated Provider:** A provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions, or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

**Designated Virtual Network Provider:** A provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Services through live audio with video technology or audio only and/or through federally compliant secure messaging applications.

**Domestic or Civil Union Partner:** An individual, regardless of sex or gender, who, together and with respect to an Eligible Employee, meets the following criteria:

(A) If the Eligible Employee and the individual reside in a state or locality that maintains a registry of domestic partnerships or civil union partnerships, comply with such state or local registration process.

(B) If the Eligible Employee and the individual do <u>not</u> reside in a state or locality that maintains a registry of domestic partnerships or civil union partnerships, meet all of the following criteria (and so certify under penalty of perjury)--

(i) They reside in the same household

(ii) They are each age 18 or older

(iii) They have the mental capacity sufficient to enter into a valid contract

(iv) They are not related to each other by blood

(v) They are not married to each other or to another person and are not the domestic partner or civil union partner of another individual

(vi) They consider themselves to have a close and committed personal relationship and have no other such relationship with any person

(vii) They are responsible for each other's welfare and financial obligations, and

(viii) They provide such other information as may be necessary for the Plan to determine whether the individual (or the Children of such individual) are Eligible Dependents under the Plan.

An Eligible Employee may not enroll more than one Domestic or Civil Union Partner in the Plan (and, if the Eligible Employee has a Spouse, may not enroll any Domestic or Civil Union Partner in the Plan).

**Domestic or Civil Union Partnership:** With respect to an Eligible Employee, the status of having a Domestic or Civil Union Partner.

**Domestic Partner:** See Domestic or Civil Union Partner.

**Domiciliary Care:** Living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

**Durable Medical Equipment (DME):** Medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a sickness or injury.
- Primarily used within the home.

**Eligible Charge:** A charge for health care services, subject to all of the terms, conditions, limitations, and exclusions for which the Plan, or Participant will pay.

**Eligible Co-op Student:** A co-op student who completes an average of 28 or more hours of service per week. For this purpose, hours of service shall be calculated in a manner consistent with Section 4980H of the Code and any applicable regulations issued thereunder. Eligible Co-op Students shall be eligible to participate in the Plan upon calculation of such average of 28 or more hours of service per week.

**Eligible Dependent:** With respect to an Eligible Employee: the Eligible Employee's Spouse, Domestic or Civil Union Partner, as applicable; Child(ren); and Adult Disabled Child(ren). For Eligible Employees who have a Domestic or Civil Union Partner, Eligible Dependent also includes a Child of a Domestic or Civil Union Partner.

**Eligible Employee:** An individual employed by a Participating Company as a full- or part-time employee who is not an Excluded Employee.

**Eligible Expenses:** Charges for Covered Health Services that are provided while the Plan is in effect and determined by the Claims Administrator.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As indicated in the most recent editions of the Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) Codes.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Network Providers are reimbursed based on contracted rates. Out-of-network Providers are reimbursed at a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

Note: Out-of-network Providers may bill you for any difference between the Provider's billed charges and the Eligible Expense described above, except as required under the No Surprises Act, which is a part of the Consolidated Appropriations Act of 2021.

**Eligible Intern:** An intern who completes a 90-day period of continuous employment with a Participating Company and who completes an average 30 or more hours of service per week. For this purpose, hours of service shall be calculated in a manner consistent with Section 4980H of the Code and any applicable regulations issued thereunder. Eligible Interns shall be eligible to participate in the Plan beginning after the completion of such 90-day period with a Participating Company or, if later, after completion of such 90-day period and upon such time when the student intern averages 30 or more hours of service per week.

**Emergency:** A sudden onset or change of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in:

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

**Emergency Health Care Services:** With respect to an Emergency:

- An appropriate medical screening exam (as required under section *1867 of the Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and

- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).
- Emergency Health Care Services include items and services otherwise covered under the Plan when provided by an Out-of-Network Provider or facility (regardless of the department of the hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation or an inpatient stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions is met:
  - The attending Emergency Physician or treating Provider or facility determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
  - The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
  - The patient is in such a condition to receive information as stated in b above and to provide informed consent in accordance with applicable law.
  - The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
  - Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

**Employee Benefits Committee (EBC):** The committee appointed by the Company to undertake certain administrative responsibilities with respect to the Plan. The EBC serves as the final review committee for all questions relating to eligibility to participate in the Plan and all other questions related to administration of the Plan, to the extent not delegated to the Claims Administrator or to the Nokia Benefits Review Team. Decisions by the EBC are conclusive and binding on all parties and not subject to further internal review.

**ERISA:** The Employee Retirement Income Security Act of 1974 as amended from time to time. The federal law that regulates retirement and employee welfare benefit plans maintained by employers.

**E-Visit and Telephone Consult with Your Physician:** Services provided by Physician performed without physical face to face interaction, but through electronic (including telephonic) communication through an online portal or telephone. Examples are emails, texts, or patient portal messages.

**Excluded Employee:** Each of the following:

(1) an individual who does not receive payment for services from a Participating Company's U.S. payroll, even if such individual is reclassified by a court or administrative agency as a common law employee of a Participating Company
(2) an employee who is employed by an independent company (such as an employment agency)
(3) an employee whose services are rendered pursuant to a written agreement that excludes participation in the Company's benefit plans
(4) a Leased Employee
(5) a temporary employee (and any regular employee subclassified as a temporary employee)
(6) a co-op student (other than an Eligible Co-op Student) or an intern (and any trainee/student subclassified as an intern) (other than an Eligible Intern)
(7) a trainee (other than an International Graduate Trainee)
(8) an International Assignee.

**Experimental or Investigational Service(s):** A procedure, study, test, drug, equipment, or supply will be considered Experimental and/or Investigational if any of the following criteria/guidelines is met:

- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose, or effectiveness in comparison to conventional treatments.
- It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
- Other facilities/Providers/etc. studying substantially the same drug, device, medical treatment, or procedure refer to it as Experimental or as a research project, a study, an invention, a test, a trial, or other words of similar effect.
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or Investigational itself pursuant to the above criteria but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).
- It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
- It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
- It is the subject of an ongoing Clinical Trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).

- It is being used for off-label therapies for a non-indicated condition – even if FDA approve for another condition.

**Explanation of Benefits (EOB):** A statement that provides details about a Claim and explains what portion was paid to the Provider and what portion (if any) is the Participant's responsibility. The EOB is not a bill, it is a statement provided by the Claims Administrator to you, your Physician, or another health care professional that explains the Benefits provided (if any); the allowable reimbursement amounts; copayments; any other reductions taken; the net amount paid by the Plan; and the reason(s) why the service or supply was not covered by the Plan.

**Extended Care Facility:** See Skilled Nursing Facility.

**Family Security Program or FSP:** A program available to the Covered Dependent who is the surviving Spouse/Domestic or Civil Union Partner of an Eligible Employee who dies while employed by a Participating Company. Under the FSP (which is not a part of this Plan but rather is available through the Nokia Medical Expense Plan for Retired Employees (the "Retiree Medical Plan"), a component of the Nokia Retiree Welfare Benefits Plan), Company-provided group health plan coverage provided to your surviving Spouse/Domestic or Civil Union Partner (and your surviving Covered Dependents) who elected COBRA continuation coverage under this Plan can be continued under the Retiree Medical Plan. Information regarding the FSP is provided shortly before the end of your surviving Spouse's/Domestic Partner's original 36-month COBRA continuation period (unless such period terminated before the end of such 36-month period). **Note:** The FSP is not "lifetime coverage"; it may be modified or terminated by the Company at any time.

**Formulary:** A list of preferred prescription drugs selected by CVS Caremark for Prescription Drug Program participants in the Enhanced-Surest and Standard-Surest options under the Plan.

**FMLA:** The Family and Medical Leave Act of 1993, as amended from time to time.

**Freestanding Facility:** An outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

**Generic Drug:** A drug that does not bear the trademark of the original manufacturer but that is chemically identical to and generally costs less than a Brand Name Drug.

**Gender Dysphoria:** A disorder characterized by the diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association:*

**Gene Therapy:** Therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

**Genetic Counseling:** Counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders

- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing, and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

**Genetic Testing:** Exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

**Gestational Carrier:** A female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

**Health Plan Carrier(s):** Any company authorized by Nokia to provide services under the Medical Plan, including Surest and CVS Caremark.

**Home Health Agency:** A program or organization authorized by law to provide health care services in the home.

**Hospital:** An institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

**Hospital-based Facility:** An outpatient facility that performs services and submits claims as part of a Hospital.

**In-Network:** The benefit choice that permits you to access the services of contracted Network Providers.

**In-Network Benefits:** See Network Benefits.

**Independent Freestanding Emergency Department:** A health care facility that:

- Is geographically separate and distinct and licensed separately from a hospital under applicable state law; and
- Provides Emergency Health Care services.

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

**Injury:** Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

**International Assignee:** Any of the following:

- An Employee who is classified as an Expatriate (Outbound Assignee) meaning the employee's home country is the United States, and the Expatriate is on a long-term international assignment for the Company outside of the United States, or
- An Employee who is classified as an Inpatriate (Inbound Assignee) meaning the employee's home country is outside of the United States, and the Inpatriate is on a long-term or short-term international assignment for the Company in the United States, or
- An Employee who is classified as on an International Professional Contract (IPC) meaning the employee does not have a designated home country and is on an international assignment for the Company in the United States.

**Inpatient Rehabilitation Facility:** A long-term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

**Inpatient Stay:** An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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

**Intensive Outpatient Treatment:** A structured outpatient mental health or substance-related and addictive disorders treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

**Intermittent Care:** Skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

**Lifetime Maximum:** The maximum benefit available from the Medical Plan in a lifetime for each Participant with respect to certain services. Once the lifetime maximum benefit has been paid, no other benefits are available under any circumstances with respect to those services. You are responsible for all charges above the lifetime maximum benefit.

**Manipulative Treatment:** The therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

**Medicaid:** A federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

**Medical Plan:** The Nokia Medical Expense Plan for Active Employees, an employee welfare benefit plan (within the meaning of ERISA) maintained by the Company.

**Medically Necessary or Medical Necessity:** Health care services that are all of the following as determined by the Claims Administrator or the Claims Administrator's designee:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

*Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator has the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by the Claims Administrator.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting the Claims Administrator's determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Participants, Physicians and other health care professionals on Benefits.Surest.com. Participants may also call the telephone number on your ID card. .

**Medicare:** Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

**Mental Health Services:** Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Mental Health/Substance-Related and Addictive Disorders Administrator:** The organization or individual designated by the Plan who provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services.

**Mental Illness:** Those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Network or Network Provider:** When used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services or providers providing services to a Participant in a foreign country while the Participant is traveling outside the United States. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and an out-of-network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**Network Benefits:** The level of Benefits that are paid for Covered Health Services provided by Network providers.

**Network Retail Pharmacy:** A retail pharmacy that participates in the CVS Caremark network.

**Nokia Benefits Resource Center:** The resource to call to enroll, to make changes to your coverage or to ask questions about your Medical Plan options. See the Section V., "Important Contacts," for information on how to contact the Nokia Benefits Resource Center.

**Nokia Benefits Review Team:** The team within the Nokia Benefits Resource Center assigned the responsibility to decide claims for eligibility to participate in the Plan.

**Observation Stay:** Observation care consists of evaluation, treatment, and monitoring services (beyond the scope of the usual outpatient care episode) that are reasonable and necessary to determine whether the patient will require further treatment as an inpatient or can be discharged from the hospital.

**Out-of-Network:** When used to describe a provider of health care services, this means a provider that does not have a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network, including providers providing services to a Participant in a foreign country while the Participant is traveling outside the United States. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and an Out-of-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**Out-of-Network Benefits:** The level of Benefits paid for Covered Health Services provided by out-of-network providers. See Section F., "What's Covered Under the Surest Enhanced Option," and Section G., "What's Covered Under the Surest Standard Option" and Appendix 1, "Benefits at a Glance - Medical" for details.

**Out-of-Pocket Maximum:** The maximum amount you pay every calendar year with respect to certain benefits.

**Partial Hospitalization/Day Treatment:** A structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

**Participant:** Each Eligible Employee and such Eligible Employee's Eligible Dependents who are enrolled in and covered under the Plan.

**Participating Company:** Each of the following:

- Infinera America Inc.
- Nokia of America Corporation
- Nokia Investment Management Corporation.

**Pharmaceutical Product(s):** With respect to the Surest options, *U.S. Food and Drug Administration (FDA)*-approved prescription medications, products or devices administered in connection with a Covered Health Service by a Physician.

**Physician:** Any *Doctor of Medicine* (M.D.) or *Doctor of Osteopathy* (D.O.) who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other Provider who acts within the scope of their license will be considered on the same basis as a Physician. The fact that the Claims Administrator describes a Provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

**Plan:** The Medical Plan.

**Plan Administrator:** The Company or its designee.

**Plan Sponsor:** The Company.

**Plan Year:** The consecutive 12-month period commencing on January 1 and ending on December 31 (i.e., the calendar year).

**Pre-Admission Notification:** Process whereby the Provider or you inform the Surest Plan that you will be admitted to the inpatient hospital, Skilled Nursing Facility, long term acute care facility, inpatient rehabilitation facility, partial hospitalization, or Residential Treatment Facility. This notice is required in advance of being admitted for inpatient care for any type of non-Emergency admission and for partial hospitalization. All contracted facilities are required to provide Pre-Admission Notification to you.

**Pregnancy:** All of the following:

- Prenatal care
- Postnatal care
- Childbirth
- Any complications associated with the above.

**Prescription Drug Program:** The program that provides benefits for prescription drugs to individuals covered under the Surest options.

**Presumptive Drug Test:** Test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

**Primary Physician:** A Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

**Prior Authorization:** Pre-service, urgent care request, concurrent care benefit coverage decision for a service, procedure, or test that has been subject to an evidence-based review resulting in a Medical Necessity determination.

**Private Duty Nursing:** Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or an office/home setting when any of the following are true:

- Services exceed the scope of intermittent care in the home.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Participant by an independent nurse who is hired directly by the Participant or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

**Provider:** A health care professional, Physician, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide health care services to you. The term "Provider" refers to an In-Network Provider unless otherwise specified.

**Qualified Medical Child Support Order (QMCSO):** A judgment, decree, or order issued by a court that requires coverage under the Plan for an Eligible Employee's Eligible Dependent and that has been determined by the Plan Administrator to be qualified under ERISA. You may obtain a copy of the Plan's QMCSO administrative procedures, free of charge, from the Nokia QMCSO Administrator. See Section V., "Important Contacts," for information on how to contact the Nokia QMCSO Administrator.

**Qualified Status Change:** A change in status with respect to an Eligible Employee or the Eligible Employee's Eligible Dependents that permits certain changes in coverage under the Plan. See "Changing Your Coverage During the Plan Year" in Section C., "Eligibility and Enrollment," for more information.

**Recognized Amount:** The amount which the copayment is based on for the below Covered Health Services when provided by Out-of-Network Providers:

- Out-of-network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by Out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in

section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

1) An All Payer Model Agreement if adopted
2) State law; or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

**Reconstructive:** Surgery or procedure to restore or correct:

- A defective body part when such defect is incidental to or follows surgery resulting from illness, injury, or other diseases of the involved body part.
- A congenital disease or anomaly which has resulted in a functional defect as determined by a Physician.
- A physical defect that directly adversely affects the physical health of a body part, and the restoration or correction is determined by the Claim Administrator to be Medically Necessary.

**Residential Treatment:** Treatment in a facility, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services treatment. The facility must meet all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

**Residential Treatment Facility:** A facility that is licensed by the appropriate state agency, has, or maintains a written, specific, and detailed treatment program requiring full-time residence and

participation, and provides 24-hour-a-day care in a structured setting, supervision, food, lodging, rehabilitation, or treatment for an illness related to mental health and substance use related disorders.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

**Secretary:** As that term applied in the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260). This definition encompasses the secretary of HHS, DOL and Treasury.

**Semi-private Room:** A room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

**Sickness:** Physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

**Skilled Care:** Skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

**Skilled Nursing Facility:** A hospital or nursing facility that is licensed and operated as required by law. A Medicare licensed bed or facility (including an extended care facility, a long-term acute care facility, a hospital swing-bed, and a transitional care unit) that provides skilled care.

**Specialist:** A Physician who has a majority of their practice in areas other than those practicing in the areas of family practice, general medicine, internal medicine, obstetrics/gynecology or general pediatrics.

**Specialty Drugs:** Infusions, injectables and non-injectable prescription drugs, as determined by the Claim Administrator, which have one or more of the following key characteristics:

- Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes.
- Intensive patient training and compliance assistance are required to facilitate therapeutic goals.

- There is limited or exclusive product availability and/or distribution.
- There are specialized product handling and/or administration requirements.
- Are produced by living organisms or their products.

**Spinal Treatment:** Detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Spouse:** A person of the same or opposite gender or sex who is lawfully married to an Eligible Employee. You may not have more than one Spouse under the Plan.

**Substance-Related and Addictive Disorders Services:** Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

**Surrogate:** A female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg, the surrogate is biologically (genetically) related to the child

**Telehealth Visit:** Live, interactive audio with visual transmissions, and/or transmissions through federally compliant secure messaging applications of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Participant's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

**Transition of Care:** The option for a new Participant to request coverage from your current, Out-of-Network health care professional at In-Network rates for a limited time due to a specific medical condition, until the safe transfer to an In-Network health care professional can be arranged.

**Transitional Living:** Mental health services and substance-related and addictive disorder services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living

arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

**Unproven Services:** Services, including medications and devices regardless of *U.S. Food and Drug Administration (FDA)* approval, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not being allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

The Claims Administrator has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, the Claims Administrator issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice.

Please note: If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though Unproven, the service has significant potential as an effective treatment for that Sickness or condition.

**Urgent Care:** Care that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

**Urgent Care Center:** A facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

**USERRA:** An acronym for the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

**Utilization Management:** Utilization Management processes are conducted by Surest to ensure that certain services are Medically Necessary. Utilization Management processes include clinical, medical, pre-service review (e.g., Prior Authorization), concurrent review (e.g., during a hospital stay), and post-service review (review of Claims to ensure services were Medically Necessary).

**Virtual Care:** Virtual care is for Covered Health Services that include the diagnosis and treatment of medical and mental health conditions for Participants that can be appropriately managed

virtually through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health care Specialist, through use of interactive audio and video communications equipment or through federally compliant secure messaging applications outside of a medical facility (for example, from home or from work).

# Section C. Eligibility and Enrollment

**Who Is Eligible?**

If you are an Eligible Employee, coverage under the Plan is available to you and to your Eligible Dependents. (Your Eligible Dependents must be covered under the same Medical Plan option that you choose for yourself.)

Eligible Dependents who may be covered under the Plan are limited to:

- Your Spouse or Domestic or Civil Union Partner
- Your Child (through the end of the month in which such Child attains age 26)
- Your Adult Disabled Child
- The Child of your Domestic or Civil Union Partner (through the end of the month in which such Child attains age 26 and provided such Child lives with you).

Note: See Section B.,"Terms You Should Know," which sets forth the definitions for each type of "Eligible Dependent."

States sometimes pass laws that require employee benefit plans to provide benefits and/or coverage to individuals who otherwise are not eligible. For example, a state might require an employer to provide coverage to an ex-spouse or a child who exceeds the Medical Plan's age requirements and therefore is not eligible for benefits under the Company's Medical Plan. The federal law known as ERISA supersedes state law. As a result, the Plan only covers the individuals described in this SPD. See "Medical Plan Contributions" later in this section for information on imputed income if you cover a Domestic or Civil Union Partner or a Domestic or Civil Union Partnership Child.

**Enrolling in the Plan**

What you need to do to enroll in coverage under the Plan differs depending on whether you are:

- A newly hired (or newly eligible) employee
- Changing your existing coverage during an Annual Open Enrollment Period, or
- Changing your existing coverage during the year due to a Qualified Status Change (see "Changing Your Coverage During the Plan Year" later in this section).

**Declining Coverage**

You may decline coverage under the Plan. However, if you do, you will have to wait until the next Annual Open Enrollment Period if you want to enroll in the Plan--unless you have a Qualified Status Change. See "Changing Your Coverage During the Plan Year" later in this section.

**Plan Options and Coverage Categories**

The Plan offers different coverage options (plan design) and coverage categories (who is covered). Depending on the plan option and coverage category you choose, your cost of services covered under the Plan, and the amount of contributions required for such coverage, will differ.

The following coverage options are available under the "Surest Plan" options:

- Surest Enhanced option
- Surest Standard option.

To see the difference between the level of coverage offered under the Surest Enhanced option and the Surest Standard option, see Section F., "What's Covered Under the Surest Enhanced Option," and Section G., "What's Covered Under the Surest Standard Option."

You may select from one of the following coverage categories when enrolling yourself and your Eligible Dependents in the Plan:

- You only
- You + your Spouse/Domestic or Civil Union Partner
- You + your Children (including your Adult Disabled Children and, if applicable, the Children of your Domestic or Civil Union Partner)
- You + your Family (i.e., your Spouse/Domestic or Civil Union Partner and your Children, including your Adult Disabled Children, and, if applicable, the Children of your Domestic or Civil Union Partner).

*Newly Hired Employees*

If you are a full-time or part-time Eligible Employee (other than an Eligible Co-op Student) regularly scheduled to work 20 or more hours a week, you are assigned individual ("You only") coverage under the Medical Plan as of your first day of employment. You may add Eligible Dependents to your coverage provided you do so within 31 days of the date you are notified of your eligibility to enroll. If you are scheduled to work less than 20 hours a week, you must actively enroll. Contact the NBRC for information on how to actively enroll in the Medical Plan. See Section V., "Important Contacts," for information on how to contact the NBRC.

If you are an Eligible Co-op Student, you are not automatically assigned any coverage under the Plan. Instead, you must affirmatively enroll in the Plan by contacting the NBRC or logging onto YBR within 31 days of the date you are notified of your eligibility to enroll in the Plan. At the time of your enrolling in the Plan, you will also have the opportunity to enroll your Eligible Dependents.

Note: If you do not enroll in the Plan within the time period noted above, you may enroll in the Plan and add or drop Eligible Dependents only during the Plan's Annual Open Enrollment Period (or if you have a Qualified Status Change).

For all Eligible Employees: You must enroll your Eligible Dependents in the same medical plan option that you choose for yourself. If you enroll your Eligible Dependents at the same time you enroll yourself (or within 31 days of the date you are notified of your eligibility to enroll), coverage for those Eligible Dependents begins the same day your coverage begins.

You generally will receive an e-mail from the Nokia Benefits Resource Center pointing you to the Your Benefits Resources (YBR) website for more information about your coverage options, including the cost, how to enroll yourself and your Eligible Dependents, and the date by which you must make your elections (generally, within 31 days after you receive your enrollment information).

*If You Don't Enroll (New Hires)*

As a new hire, if you do not make any elections by the required date, here is what happens:

- If you are a regular full-time or a regular part-time Eligible Employee (other than an Eligible Co-op Student) scheduled to work 20 or more hours a week, you alone will continue to have coverage under the Surest Enhanced option. You may not add any Eligible Dependents until the next Annual Open Enrollment Period, unless you have a Qualified Status Change (see "Changing Your Coverage During the Plan Year" later in this section).

- If you are an Eligible Co-op Student or are scheduled to work fewer than 20 hours per week, you will not be assigned a coverage option. This means you and your Eligible Dependents cannot enroll in the Plan until the following Plan Year. You must wait until the next Annual Open Enrollment Period to enroll, unless you have a Qualified Status Change (see "Changing Your Coverage During the Plan Year" later in this section).

Note: Your Eligible Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse/Domestic or Civil Union Partner are both Eligible Employees, you may each be enrolled separately (as a covered Eligible Employee) or one of you may be covered as the Eligible Dependent of the other person, but not both. If you and your Spouse/Domestic or Civil Union Partner enroll separately, either parent (but not both) may enroll any eligible dependent child.

**Annual Open Enrollment Period**

During annual open enrollment each year, you will have the opportunity to select the coverage that best meets your needs for the coming year. This means that you may "add" or "cancel" coverage for yourself and your Eligible Dependents and/or change coverage options. Annual open enrollment is held once a year, usually in the fall. Elections made during annual open enrollment take effect on the first day of the next calendar year.

Before annual open enrollment, you will receive enrollment materials that will include information about the coverage options available to you under the Plan in the upcoming year. In most cases, if you are currently enrolled in the Plan and do not make any changes to your coverage, your current coverage elections will remain in effect unless a particular Plan option is being discontinued or replaced by another option.

If your Plan option is being discontinued and you do not select another Plan option, you will be enrolled in a default option.

**Changing Your Coverage During the Plan Year**

You may change your coverage under the Plan during the Plan Year **only** if you have a "qualified status change. In order to be able to make a change during the year, qualified status changes must be reported through YBR or to the Nokia Benefits Resource Center within 31 days of the event.

A "qualified status change" is an event that causes someone to become eligible for, or to no longer be eligible for, coverage under the Medical Plan or another employer's plan. These events are listed in the table below.

Please note: Your election change under the Medical Plan during the year must be due to and consistent with the type of qualified status change that has occurred. For example, if you legally adopt a child, you may enroll the newly adopted child in the Medical Plan. You may not, however, cancel coverage for your Spouse.

| Qualified Status Change | Description |
|---|---|
| **Change in Marital Status** | Your marriage, divorce, legal separation, the annulment of your marriage, or the death of your Spouse. |
| **Change in Domestic or Civil Union Partner Status** | The entering into of, or termination of, a Domestic or Civil Union Partner relationship. |
| **Change in the Number of Eligible Dependents** | The birth, death, legal adoption, or placement for legal adoption of one of your Eligible Dependents. |
| **Change in Employment Status, Work Schedule, or Worksite That Causes a Change in Eligibility** | You or Eligible Dependent:<br>• Becomes employed or loses employment<br>• Experiences a change in worksite, or<br>• Reduces or increases hours of employment, including a switch between part-time and full-time employment or the start of, or a return from, a leave of absence. |

| Qualified Status Change | Description |
|---|---|
| | Note: Without a corresponding change in your or your Eligible Dependent's eligibility under the Medical Plan, the above changes will not permit a mid-year change under the Medical Plan. |
| **Your Eligible Dependent Meets or No Longer Meets the Medical Plan's Eligibility Requirements** | An event that causes a dependent to meet or to no longer meet the Medical Plan's eligibility requirements, for example, your Child reaches the maximum age for coverage. |
| **Change in Place of Residence** | A change in residence for you or an Eligible Dependent that causes a gain or loss of eligibility for coverage. |
| **Significant Cost or Coverage Changes** | A significant change in the cost or coverage under the Plan (for example, if costs significantly increase mid-year, you may be eligible to drop coverage) or a significant change in cost or coverage under another employer's group health plan in which one of your Eligible Dependents participates. (For example, if costs significantly increase under your Spouse's plan mid-year, your Spouse may be able to disenroll from the other employer's plan and enroll in the Medical Plan.) |
| **Court-Ordered Coverage** | A change in your responsibility to provide healthcare coverage for a dependent Child as stipulated in a judgment, decree or court order resulting from a divorce, legal separation, annulment or change in legal custody (for example, a Qualified Medical Child Support Order). Documentation must be submitted. |

Note: The fact that another employer's plan has a different enrollment period than the Plan is not considered a qualified status change under the Plan. For example, if one plan's annual open enrollment period is in October and the other plan's annual open enrollment period is in November, you may not make changes to your coverage under the Plan as a result of the different timing of the enrollment periods.

**Special Enrollment Rights**

The Plan provides "special enrollment rights" for both Eligible Employees and their Eligible Dependents in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and also the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA). Special enrollment rights refer to the ability to enroll for coverage under the Plan outside the Plan's normal enrollment periods (e.g., when first becoming eligible for coverage or during an Annual

Open Enrollment Period) in certain limited circumstances, provided timely notice is provided to the Plan, as described below.

Under HIPAA, if you declined coverage under the Plan (either when you first became eligible for coverage or during a subsequent Annual Open Enrollment Period) because you had other health insurance or other group health plan coverage (for example, coverage available under a Spouse's plan), you may be able to enroll yourself and your Eligible Dependents in this Plan if you (or any of your Eligible Dependent(s)) lose eligibility for that other coverage or if, in the case of an employer-sponsored group health plan, the other employer stops contributing toward your or your dependents' other coverage. However, you must request enrollment in the Plan within 31 days plan after your or your Eligible Dependent's(s') other coverage ends (or within 31 days after the other employer stops contributing toward that other coverage).

Also under HIPAA, if you "gain" a new dependent during the Plan Year as a result of marriage, entering into a Domestic or Civil Union Partnership, or the birth, adoption, or placement for adoption of a child, you may be able to enroll yourself and your Eligible Dependents (both "new" Eligible Dependents and existing but unenrolled Eligible Dependents) in the Plan. However, you must request enrollment within 31 days after the event, i.e., the marriage, entering into such Domestic or Civil Union Partnership, birth, adoption, or placement for adoption.

If you timely request enrollment in the Plan due to a special enrollment event as described above, coverage will be effective as follows:

- If the event is the birth, adoption or placement for adoption of a child, coverage will be effective as of the date of birth, adoption or placement for adoption
- For all other events, coverage will be effective on the day first of the month following the month in which your request for enrollment is received.

In addition to the foregoing special enrollment rights under HIPAA, the Plan provides for special enrollment rights under CHIPRA. If you or your Eligible Dependent is eligible for but not enrolled in coverage under the Plan, you are eligible to enroll in the Plan outside of the Plan's Annual Enrollment Period if you meet either of the following conditions and you request enrollment with the Plan no later than the deadline described below:

- You or your Eligible Dependent loses eligibility for Medicaid or State Children's Health Insurance Program (CHIP) coverage
- You or your Eligible Dependent becomes eligible for premium assistance with respect to coverage under the Plan, due to coverage with Medicaid or CHIP.

In order to enroll in the Plan for any of those circumstances, you must request enrollment within 60 days of the event.

If you timely request enrollment in the Plan due to a CHIPRA special enrollment event as described above, coverage will be effective on the first day of the month following the month in which your request for enrollment is received.

For more information about your special enrollment rights under these laws, please contact the Nokia Benefits Resource Center.

# Section D. The Cost of Plan Coverage

**Employee Contributions**

The Plan is "self-insured" by the Company, meaning the Company is responsible for the cost of providing benefits due under the Plan as well as the cost of administering the Plan. You are required to contribute toward this cost. The amount you pay depends on the medical plan option you choose (e.g., Surest Enhanced vs. Surest Standard) and the Coverage Category (e.g., you only, you plus your Spouse/Domestic or Civil Union Partner, etc.). You are provided with information regarding the amount of contribution that you are required to pay at the time of enrollment. You can also find cost information for all the available options by visiting the YBR website or contacting the NBRC.

In most instances, your contributions are deducted from your paycheck on a pre-tax basis (that is, before taxes are deducted from your pay).

**Tax Treatment of Coverage for Domestic and Civil Union Partners and Their Children**

Most Eligible Dependents under the Plan are considered to be "Tax Dependents" of the Eligible Employee, meaning that covering such dependents under the Plan does not result in additional taxable income to the employee under state or federal tax law. You are not taxed on the value of your Plan benefits for Tax Dependents.

Nokia assumes all Covered Dependents are Tax Dependents, with the exception of Domestic or Civil Union Partners and their Children. If you are eligible to cover a Domestic or Civil Union Partner or a Child of your Domestic or Civil Union Partner (or some other person who is not a Tax Dependent), Nokia is required to report income for you that reflects the value of the coverage (minus any after-tax contributions) for tax reporting purposes. This is known as imputed income. You will receive a W-2 annually for the value of coverage for any Eligible Dependent who is not a Tax Dependent, and this additional taxable income is subject to both income tax and FICA withholding.

For more information about the tax implications of coverage for a Domestic or Civil Union Partner or Domestic or Civil Union Dependent under the Plan, please consult with your personal tax advisor. Neither the Company nor the Plan provides personal tax advice.

**Cost of COBRA Coverage**

"COBRA" coverage is continuation coverage that is available under the Plan in certain circumstances. See Section Q., "COBRA Continuation Coverage," for more information. There is

a difference between the contributions required for active employee coverage and coverage as COBRA continuant. Please contact the Nokia Benefits Resource Center or visit the YBR website or refer to your COBRA Enrollment Notice for details on the current cost of your coverage. See Section V., “Important Contacts,” for more information on how to contact the Nokia Benefits Resource Center.

## Section E. How the Surest Medical Plan Options Work

This section provides an overview of how to use the Surest medical options.

Notably, the Surest medical plan options--both the Surest Enhanced option and the Surest Standard option--include the following key features:

- The broad, national UnitedHealthcare Choice Plus network of doctors, clinics and hospitals
- $0 deductible
- No coinsurance
- Fixed copays or copay ranges for all services
- Both In-Network and Out-of-Network coverage.

The Surest options allow Participants to make informed choices about their health care, cost, and coverage needs — in advance of receiving care. With the Surest mobile app and the Benefits.Surest.com website, Participants can search for available care, cost, and coverage options in any geographic location and compare copays for tests, procedures or treatments to choose the best option for them prior to making an appointment. Participants can also call Surest Member Services for assistance navigating their coverage options.

With the Surest medical options:

- Copays are determined based on billions of claims, the UnitedHealthcare premium and quality designations, and Centers for Medicare & Medicaid Services (CMS) quality performance standards
- Lower copays assigned to providers reflect higher-value care and are based on quality, efficiency, cost and overall effectiveness of care.

With the Surest medical options, Participants can:

- Shop around and compare costs and care options on the Surest mobile app or Surest website. Check copayments for tests, procedures or treatments before making an appointment — and choose what works best for you.
- Shop by quality. Lower copays indicate higher-value care, based on quality, efficiency, cost and overall effectiveness.
- See different treatment options. Surest gives you the information to choose what makes the most sense for your health, lifestyle and budget — which gives you more control over improving your health while providing you with opportunities to save.

- Get answers to your questions. Contact Surest Member Services by chat, email or phone (1-866-683-6440).

In-Network Care

The Plan offers a provider network for health plan services, the UnitedHealthcare Choice Plus network, which means that UnitedHealthcare has negotiated agreements with certain healthcare providers and hospitals. The agreements are based on discounted rates for services, and the providers must accept those rates without billing an extra amount to patients (balance billing) in order to remain in the network. When you go to an in-network provider, you only pay the copay (a fixed dollar amount) shown on the Surest app or website for covered services. The Plan may pay additional amounts on top of what you owe, but the provider has agreed in advance to accept UnitedHealthcare's negotiated rate as payment in full.

Out-of-Network Care

If you voluntarily seek care from a doctor or other healthcare provider that is not contracted with UnitedHealthcare for the UnitedHealthcare Choice Plus network, this is called "out-of-network", and you will have to pay a larger portion of your medical bill. The Plan's copays and annual out-of-pocket maximums are greater for out-of-network care than they are for in-network care.

When you use an out-of-network provider, not only can that provider charge you whatever that provider wants, the provider can also bill you for whatever is left over after the Plan pays its part (i.e., up to the usual and customary limit) of the out-of-network bill. These extra costs above what the Plan allows, known as balance billing, do not count toward the Plan's out-of-pocket maximum.

Please note: You cannot be balance billed by providers who work at in-network hospitals, hospital outpatient centers, and ambulatory surgery centers and provide care in situations where you have no control over whether the treatment was received from an in-network or out-of-network provider, such as

- If you receive emergency care at an out-of-network facility or from an out-of-network provider, or

- If you receive elective non-emergency care at an in-network facility but unknowingly receive treatment from an out-of-network ancillary provider (such as a radiologist or anesthesiologist).

If your out-of-network provider wants to order a test or treatment that requires prior authorization under the Plan, sometimes the provider may obtain that prior authorization for you, but in most cases, you will be the one responsible for making sure you get that prior authorization. If you don't obtain the required prior authorization from an out-of-network provider, the Plan will not cover any of the cost. You will be fully financially responsible for any of the services or supplies requiring prior authorization.

You are covered at the out-of-network coverage level for emergency and non-emergency services while traveling outside of the United States for personal reasons. You must submit an out-of-network claim form to Surest to obtain reimbursement.

Advocacy Services

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

Before enrolling in a Surest medical option, you (and your Eligible Dependents) can test-drive Surest by visiting Benefits.Surest.com/Nokia. Enter access code "Nokia2026" to see how it works.

Once enrolled in a Surest option, Participants have three ways for getting the most from the Surest option:

- Download and register on the Surest mobile app, available on the App Store and Google Play. (Search for "Surest.")
- Visit Benefits.Surest.com.
- Call Surest Member Services if you still have questions about your coverage or costs. Customer support is available at 1-866-683-6440, from 7:00 a.m. to 10:00 p.m., ET, Monday through Friday.

To find our whether a provider is In-Network:

- Log in to Benefits.Surest.com/Nokia (pre-member website; use access code "Nokia2026") or Benefits.Surest.com (member website)

In the search field under "Search costs, coverage and practitioners," type in your provider's name, review the results, and select the desired copay amount for details

To look up coverage:

- Log in to Benefits.Surest.com/Nokia (pre-member website; use access code "Nokia2026") or

- Benefits.Surest.com (member website)
- Select “Search Coverage”
- Enter “Condition”
- Review result and then select any option for details.

## Section F. What's Covered Under the Surest Enhanced Option

Described below is information relating to covered health services under the Surest Enhanced option. For relevant limitations, see Section "H", "Exclusions and Limitations--What the Surest Options Do Not Cover."

| The Surest Enhanced Option | In-Network | Out-of-Network |
|---|---|---|
| **Deductible** | $0 | $0 |
| **Out-of-Pocket Maximum (per Plan Year)** | | |
| **Individual** | $4,000 | $8,000 |
| **Family** | $8,000 | $24,000 |

Notes:

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

| Ambulance Services | In-Network | Out-of-Network |
|---|---|---|
| | $210 copayment / transport | $210 copayment / transport |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Out-of-network Ambulance Services copayment applies to the In-Network out-of-pocket maximum.
- Ground or air ambulance, as the Claims Administrator determines appropriate. Air ambulance is medical transport by helicopter or airplane.
- Emergency ambulance services and transportation provided by a licensed ambulance service (either ground or air ambulance) to the nearest hospital that offers Emergency health services.

- Ambulance service by air is covered in an Emergency if ground transportation is impossible or would put your life or health in serious jeopardy.
- Non-Emergency ambulance transportation provided by a licensed ambulance service (either ground or air ambulance) between facilities only when the transport meets one of the following:
  - From an Out-of-Network hospital to the closest in-network hospital when Covered Health Services are required.
  - To the closest in-network Hospital that provides the required Covered Health Services that was not available at the original Hospital.
  - From a short-term acute care facility to the closest in-network long-term acute care facility (LTAC), in-network Inpatient Rehabilitation Facility, or other in-Network sub-acute facility where the required Covered Health Services can be delivered.
- For purposes of this Benefit, the following terms have the following meanings:
  - "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
  - "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden sickness, injury, or flare-up of a chronic sickness.
  - "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.
- Non-Emergency air ambulance services require Prior Authorization and Medical Necessity review.

| **Behavioral Health: Mental Health and Substance Use Disorder Services** | In-Network | Out-of-Network |
|---|---|---|
| **Mental Health Office Visit** | $20 copayment / visit | $40 copayment / visit |
| **Mental Health Telehealth Visit** | $20 copayment / visit | $40 copayment / visit |
| **Applied Behavioral Analysis (ABA) Therapy** | $20 copayment / visit | $160 copayment / visit |
| **Mental Health Biofeedback** | $20 copayment / visit | $160 copayment / visit |
| **Mental Health Habilitative, Cognitive, Occupational and Speech Therapy** | $15 copayment / visit | $45 copayment / visit |
| **Mental Health Physical Therapy** | $10 copayment / visit | $30 copayment / visit |
| **Electroconvulsive Therapy (ECT)** | $110 copayment / visit | $330 copayment / visit |
| **Intensive Outpatient Treatment Program (IOP)** | $60 copayment / visit | $180 copayment / visit |
| **Outpatient Alcohol and Drug Treatment Program** | $80 copayment / visit | $240 copayment / visit |
| **Partial Hospitalization (PHP)/Day Treatment** | $110 copayment / day | $330 copayment / day |
| **Substance Use Disorder Medication Therapy** | $35 copayment / visit | $90 copayment / visit |
| **Transcranial Magnetic Stimulation (TMS) Therapy** | $110 copayment / visit | $320 copayment / visit |
| **Residential Treatment Facility Care** | $1,600 copayment / stay | $4,800 copayment / stay |
| **Outpatient Mental Health** | $110 copayment / visit | $330 copayment / visit |
| **Inpatient Hospital** | $1,600 copayment / stay | $4,800 copayment / stay |
| **Virtual Care** | See Virtual Care section for details. | Not Applicable |

Notes:
- Refer to the Surest mobile app for additional coverage information.
- Benefits include:
  - Diagnostic evaluations, assessment, and treatment planning.
  - Other treatments and/or procedures.
  - Medication management and other associated treatments.
  - Methadone Maintenance.

- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Intensive Outpatient Treatment program (IOP) (a structured outpatient mental health or substance use treatment program at a freestanding or hospital-based facility and provides services for at least three hours per day, two or more days per week).
- Residential treatment.
- Partial hospitalization (PHP)/Day treatment (a structured ambulatory program that may be freestanding or hospital-based and provides services for at least 20 hours per week).
- Other Outpatient treatment.

- Biofeedback therapy is a non-drug treatment in which patients learn to control bodily processes that are normally involuntary, such as muscle tension, blood pressure, or heart rate.
- Returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- Mental Health Office Visit refers to a face-to-face visit with your Provider.
- Mental Health Telehealth Visit refers to a non-face-to-face visit with your Provider.
- Nutritional counseling for mental health or substance use disorder does not have visit limits.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.
- Inpatient residential and partial hospitalization services may require Prior Authorization and Medical Necessity review.
- Refer to the Gender Dysphoria Services section for additional coverage information.
- Mental Health Occupational Therapy is a visit for therapy focused on regaining daily life skills for a person with a mental health condition, such as autism.
- Mental Health Physical Therapy is a visit for therapy focused on regaining physical function for a person with a mental health condition, such as autism.
- Mental Health Speech Therapy is a visit for therapy focused on regaining speech and communication function for an individual with a mental health condition, such as autism.

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

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

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

| **Colonoscopy - Non-Screening** | In-Network | Out-of-Network |
|---|---|---|
| | $0 copayment / visit | $2,950 copayment / visit |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments may vary based on Provider and location.
- Benefits include Physician services and facility charges.

- Coverage is available for a non-screening colonoscopy received on an outpatient basis at a hospital, alternate facility, or in a Physician's office.
- A non-screening colonoscopy is a procedure performed to diagnose disease symptoms.
- Services for preventive screenings are provided under the Preventive Care Services section.

| **Complex Imaging** | In-Network | Out-of-Network |
|---|---|---|
| **MRI (Magnetic Resonance Imaging)** | $150 to $900 copayment / visit | $1,400 copayment / visit |
| **CT (Computed Tomography)** | $100 to $725 copayment / visit | $1,725 copayment / visit |
| **Nuclear Imaging** | $150 to $1,100 copayment / visit | $3,250 copayment / visit |
| **Pet Scan** | $150 to $900 copayment / visit | $1,400 copayment / visit |

Notes:

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

| **Dental and Oral Services** | In-Network | Out-of-Network |
|---|---|---|
| **Orthognathic (Jaw) Surgery** | $2,750 copayment / visit | $7,000 copayment / visit |
| **Temporomandibular Joint (TMJ) Dysfunction Surgery** | $800 copayment / visit | $2,400 copayment / visit |
| **Dental - Accidental and Medical Conditions:** | | |
| **Office Visit** | $20 to $105 copayment / visit | $220 copayment / visit |
| **Outpatient Hospital Visit** | $150 to $850 copayment / visit | $2,550 copayment / visit |
| **Inpatient Hospital** | $2,000 copayment / stay | $6,000 copayment / stay |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Dental Services visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from a visit with durable medical equipment, such as an oral appliance, may result in an additional copayment.
- Dental services are covered by the Plan when treatment is necessary because of accidental damage, dental services are received from a Doctor of Dental Surgery, "D.D.S." or a Doctor of Medical Dentistry; "D.M.D." and the dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

- The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to
  - Dental services related to medical transplant procedures.
  - Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system).
  - Direct treatment of acute traumatic Injury, cancer or cleft palate.
- Benefits are available only for treatment of a sound, natural tooth.
- The Physician or dentist must certify that the injured tooth was a virgin or unrestored tooth or a tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.
- Dental services for final treatment to repair the damage must be both of the following:
  - Started within three months of the accident or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan.
  - Completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.
- Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof, and floor of the mouth.
- The Surest Plan also covers dental services, limited to dental services required for treatment of an underlying medical condition such as a cleft palate or other congenital defect, oral reconstruction after invasive oral tumor removal, preparation for or as a result of radiation therapy for oral or facial cancer.
- Eligible Expenses for hospitalizations are those incurred by a Participant who: (1) is a child under age five; (2) is severely disabled; or (3) has a medical condition, unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a Physician, dentist, or dental Specialist.
- Accidental Dental Services may require Prior Authorization and Medical Necessity review.

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

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits or outpatient hospital visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Orthognathic and TMJ copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Includes orthodontic services and supplies, and surgical and non-surgical options for the treatment of TMJ. Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatments have failed.
- Returning home from a visit with durable medical equipment, such an oral appliance, may result in an additional copayment.
- Orthognathic surgery and select services for TMJ Disorder may require Prior Authorization and Medical Necessity review.

| **Dialysis Services** | In-Network | Out-of-Network |
|---|---|---|
| **Home Dialysis** | $70 copayment / visit | $210 copayment / visit |
| **Dialysis** | $40 to $270 Copayment / visit | $810 Copayment / visit |

Notes:

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

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

Notes:

Durable Medical Equipment (DME) and supplies are tiered based on average cost and allowed amount. Supplies such as tubing, syringes, and catheters are assigned to a lower tier and will result in a lower copayment. Equipment such as glucose monitors, pumps, and wheelchairs are assigned to a higher tier and will result in a higher copayment.

- Each piece of durable medical equipment and supplies are assigned to a tier, which corresponds to a copayment. A breakdown of the tiers and corresponding copayments can be found on Surest mobile app or Benefits.Surest.com website.
- Returning home from an appointment with a health care Provider or from the hospital with durable medical equipment, such as crutches, may result in an additional copayment. Copayments will be dependent on the tier the item falls into.
- For Enteral Nutrition administered at home, multiple copayments will apply (such as for formula, nursing visit and administration).

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

- Refer to the Surest mobile app for additional coverage and copayment information.
- This durable medical equipment and supplies list is subject to periodic review and modification (generally quarterly, but no more than six times per Plan Year).
- You may also view which tier a particular DME item has been assigned to by using the Surest mobile app or Benefits.Surest.com website or calling Surest Member Services for assistance.
- Coverage includes rental or purchase of DME if Medically Necessary, ordered or provided by a Physician for outpatient use primarily in a home setting, serves a medical purpose for the treatment of an illness or injury, and is not of use to a Participant in the absence of a disease or disability. If you need certain durable medical equipment for an extended period of time, there may be an option to rent. Length of rental may vary by DME item. The purchase copayment based on tier may be split over a period of time, at which point the DME may be considered "purchased" or coverage may end. Note that some equipment such as oxygen equipment, will be set to rental for the duration of time the equipment is needed. Surest generally follows Centers for Medicare and Medicaid Services (CMS) guidelines on rental vs purchase. Refer to Surest mobile app or Benefits.Surest.com website for additional information.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors, and masks).
- Cranial orthoses such as head shaping helmets and head reconstruction are a set of orthotic devices and services to reshape the head. They may be medically indicated for plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape).
- Scalp/cranial hair prostheses (wigs) are a Covered Health Service regardless of the reason for hair loss is limited to a maximum Benefit of one wig per Plan Year for In-Network and Out-of-Network Providers combined.
- Eyeglasses or contacts after cataract surgery or for aphakia is limited to one frame and one pair of lenses or one pair of contact lenses or a one-year supply of disposable contact lenses.
- Hearing aids are limited to $5,000 every 36 months for In-Network and Out-of-Network Providers combined. This limit applies to traditional hearing aids.
- Communication aids or devices; equipment to create, replace, or augment communication abilities, including but not limited to communication board or computer or electronic-assisted communication, speech processors, and receivers. Speech generating device, digitized speech, and using pre-recorded messages are eligible.
- Purchase of one standard breast pump, either manual or electric, per pregnancy. Participant may have to pay a surcharge to the Provider if they purchase enhanced models.
- Enteral Nutrition and low protein modified food products administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. The formula or product must be administered under the direction of a Physician or registered dietitian. (Example conditions

include, but are not limited to, metabolic disease such as phenylketonuria (PKU) and maple syrup urine disease, severe food allergies, and impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.)
- Shoes as prescribed by a Provider for a Participant. Limited to one pair per Plan Year.
- Coverage is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.
- Select Durable Medical Equipment (DME) may require Prior Authorization and Medical Necessity review.

| **Emergency Room Services** | In-Network | Out-of-Network |
|---|---|---|
| **Emergency Room Visit** | $350 copayment / visit | $350 copayment / visit |
| **Observation Stay** | $350 copayment / stay | $350 copayment / stay |

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

| **Fertility Preservation** | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $20 to $105 copayment / visit | $220 copayment / visit |
| **Iatrogenic In Vitro Fertilization** | $500 copayment / service | Not Covered |
| **Egg Retrieval for Iatrogenic Infertility** | $1,500 copayment / service | Not Covered |
| **Cryopreservation for Iatrogenic Infertility** | $500 copayment / service | Not Covered |
| **Storage for Iatrogenic Infertility** | $100 copayment / year | Not Covered |
| **Genetic Testing (PGT) for Iatrogenic Infertility** | $500 copayment / visit | Not Covered |

Notes:
- Refer to the Surest mobile app for additional coverage information.
- There is a combined lifetime maximum of $15,000 per Participant for covered medical fertility preservation and fertility services including prescription medications for fertility preservation and fertility services.

Fertility Preservation for Iatrogenic Infertility:
- Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:
  - Collection of sperm.
  - Cryo-preservation of sperm.
  - Ovarian stimulation, retrieval of eggs and fertilization.
  - Oocyte cryopreservation.

  - Embryo cryopreservation.
  - Storage up to one year.
- Benefits for medications related to the treatment of fertility preservation are provided as described under [your Outpatient Prescription Drug Rider or under] Pharmaceutical Products in this section.
- Benefits are not available for elective fertility preservation.
- Benefits are not available for embryo transfer.
- Benefits are not available for long-term storage costs (greater than one year).

Preimplantation Genetic Testing (PGT) and Related Services:

- Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:
  - PGT must be ordered by a Physician after Genetic Counseling.
  - The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
  - Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
    - Ovulation induction (or controlled ovarian stimulation).
    - Egg retrieval, fertilization and embryo culture.
    - Embryo biopsy.
    - Embryo transfer.
    - Cryo-preservation and short-term embryo storage (less than one year).
- Benefits are not available for long-term storage costs (greater than one year).
- Please refer to other sections of the SPD for Covered Health Services for diagnosis and treatment of underlying medical condition which may cause infertility such as surgical procedures: laparoscopy, lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty, and ovarian cystectomy.

| **Fertility Services** | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $20 to $105 copayment / visit | $220 copayment / visit |
| **Artificial insemination** | $100 copayment / service | Not Covered |
| **Egg Retrieval** | $1,500 copayment / service | Not Covered |
| **Embryo Transfer/Implantation** | $750 copayment / service | Not Covered |
| **Cryopreservation** | $500 copayment / service | Not Covered |
| **Storage** | $100 copayment / year | Not Covered |
| **Thawing** | $150 copayment / service | Not Covered |
| **Genetic Testing (PGT)** | $500 copayment / visit | Not Covered |
| **Donor Services (Egg)** | $1,200 copayment / service | Not Covered |
| **Donor Services (Sperm)** | $300 copayment / service | Not Covered |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Multiple copayments may apply if more than one service is performed during a visit.
- There is a combined lifetime maximum of $15,000 per Participant for covered medical fertility preservation and fertility services including prescription medications for fertility preservation and fertility services.

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

- Diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician.

- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Fertility Treatment copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Therapeutic services when provided under the direction of a Designated Provider are limited to the following procedures:
  - Assisted Reproductive Technologies (ART), including but not limited to:
    - In-Vitro fertilization (IVF).
    - Egg/oocyte retrieval.
    - Fresh or frozen embryo transfer.
    - Intracytoplasmic sperm injection (ICSI).
    - Gamete intrafallopian transfer (GIFT).
    - Pronuclear stage tubal transfer (PROST),
    - Tubal embryo transfer (TET),
    - Zygote intrafallopian transfer (ZIFT).
    - Assisted hatching.
    - Cryopreservation and storage of embryos for up to 12 months.
    - Embryo biopsy for PGT-M or PGT-SR (formerly known as PGD).
  - Frozen embryo transfer cycle including the associated cryopreservation and storage of embryos for up to 12 months.
  - Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
  - Ovulation induction (or controlled ovarian stimulation).
  - Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
  - Surgical Procedures, including but not limited to: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, ovarian cystectomy.
  - Electroejaculation.
  - Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.
- Treatment for the diagnosis and treatment of the underlying cause of Infertility is covered as described in other sections of this Booklet. Benefits for diagnostic tests are described under Laboratory Services, X-Rays, and Diagnostic Test – Outpatient, Office Visit and Diagnostic Visit.
- The medical Plan provides Benefits for certain prescription medications or products, including specialty medications, for the treatment of infertility that are administered by a medical Provider on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.
- Fertility Benefits for prescription medications or products for outpatient use that are filled by a prescription order or refill are described in Part III., "The Prescription Drug Program (PDP)" (see Section J., "Overview of the Prescription Drug Program," Section K., "Filling Prescriptions," and Section L., "Other Prescription-Drug-Related Services").

**Donor Coverage:**

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

| **Gender Dysphoria Services** | In-Network | Out-of-Network |
|---|---|---|
| **Mental Health Office Visit** | $20 copayment / visit | $40 copayment / visit |

| | | |
|---|---|---|
| **Gender Dysphoria Voice Therapy** | $15 copayment / visit | $45 copayment / visit |
| **Gender Dysphoria Surgery** | $110 to $1,600 copayment / visit | $330 to $4,800 copayment / visit |
| **Gender Dysphoria Reconstructive Services** | $20 to $110 copayment / stay | $40 to $330 copayment / stay |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Gender Dysphoria Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Select services for the treatment of Gender Dysphoria may require Prior Authorization and Medical Necessity review.
- Members must be 18 years of age or older for the surgical treatment of Gender Dysphoria.
- The following services are covered for Gender Dysphoria:
  - Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses.
  - Hormone therapy as appropriate to the patient's gender goals: Hormone therapy administered by a medical Provider (for example during an office visit). Hormone therapy dispensed from a pharmacy is provided as described in Part III., "The Prescription Drug Program (PDP)" (see Section J., "Overview of the Prescription Drug Program," Section K., "Filling Prescriptions," and Section L., "Other Prescription-Drug-Related Services").
  - Laboratory testing to monitor the safety of continuous hormone therapy as appropriate to the patient's gender goals.
  - Hair transplantation.
  - Dermatology.
  - Permanent hair removal for purposes of genital reconstruction.
  - Permanent face and neck hair removal or reduction, including electrolysis and laser treatment.
  - Voice lessons and voice therapy.
- Surgery treatment for Gender Dysphoria includes the surgeries listed below:
  - Abdominoplasty and body contouring.
  - Liposuction.
  - Genital surgeries:
    - Clitoroplasty (creation of clitoris).
    - Hysterectomy (removal of uterus).
    - Labiaplasty (creation of labia).
    - Metoidioplasty (creation of penis, using clitoris).
    - Orchiectomy (removal of testicles).
    - Penectomy (removal of penis).
    - Penile prosthesis.
    - Phalloplasty (creation of penis).
    - Salpingo-oophorectomy (removal of fallopian tubes and ovaries).
    - Scrotoplasty (creation of scrotum).
    - Testicular prosthesis.
    - Urethroplasty (reconstruction of female urethra).
    - Urethroplasty (reconstruction of male urethra).
    - Vaginectomy (removal of vagina).
    - Vaginoplasty (creation of vagina).
    - Vulvectomy (removal of vulva).
  - Chest surgeries:

- Bilateral mastectomy or breast reduction.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Pectoral implants.

– Face and neck surgeries:
- Blepharoplasty (eyelid lift).
- Brow lift.
- Forehead lift.
- Facial bone remodeling.
- Lip reshaping.
- Rhinoplasty (nose reshaping).
- Thyroid cartilage remodeling / thyroid chondroplasty / tracheal shave (remodeling of the Adam's apple).
- Face lift.
- Neck tightening.
- Voice modification surgery.

| **Home Health Services** | In-Network | Out-of-Network |
|---|---|---|
| **Home Health Care Visit** | $60 copayment / visit | $180 copayment / visit |
| **Private Duty Nursing** | $60 copayment / visit | $180 copayment / visit |

Notes:
- Refer to the Surest mobile app for additional coverage information.
- Home Health Care Visits are limited to 100 visits per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
- Private Duty Nursing does not have visit limits.
- Services received from a Home Health Agency (an organization authorized by law to provide health care services in the home) or independent Provider that are the following:
  – Ordered by a Physician.
  – Provided in your home by a registered nurse or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
  – Provided on a part-time, intermittent care schedule.
  – Provided when skilled care is required.
- For Enteral Nutrition administered at home, multiple copayments will apply (such as for formula, nursing visit and administration).
- Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, billed by the Home Health Agency, will apply to the Home Health Services visit limits.
- Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, not administered by a Home Health Agency will apply to the Rehabilitative/Habilitative Services visit limits.
- Select Home Health Services may require Prior Authorization and Medical Necessity review.

| **Hospice Care** | In-Network | Out-of-Network |
|---|---|---|
| **Home Hospice Visit** | $60 copayment / visit | $180 copayment / visit |
| **Inpatient Hospice Care** | $2,000 copayment / stay | $6,000 copayment / stay |

Notes:
- Refer to the Surest mobile app for additional coverage information.
- Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill.
- Hospice care can be provided in the home or an inpatient setting and includes physical, psychological, social, spiritual, and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Participant (terminally ill person) is receiving hospice care.

- Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.
- Inpatient Hospice Care may require Prior Authorization and Medical Necessity review.

| **Hospital Services - Other** | In-Network | Out-of-Network |
|---|---|---|
| **Outpatient Hospital Visit** | $150 to $850 copayment / visit | $2,550 copayment / visit |
| **Inpatient Hospital** | $2,000 copayment / stay | $6,000 copayment / stay |

Notes:

- Other Hospital Services: The above copayments apply for Covered Health Services not specifically listed in this SPD, Surest mobile app or Benefits.Surest.com website. Copayments may vary based on Provider and location.
- Refer to the Surest mobile app for additional coverage information.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Hospital Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Inpatient hospitalization/stay Benefits include:
  - Physician and non-Physician services, supplies, and medications received during an inpatient stay.
  - Facility charges, including room and board in a semi-private room (a room with two or more beds).
  - Physician services for lab tests, anesthesiologists, pathologists, radiologists, and Emergency room Physicians.
  - The Surest Plan will allow the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.
- If you are admitted to inpatient from the Emergency department or from observation, the Emergency room copayment or Observation Stay copayment will be waived, and you will be responsible for the Inpatient Hospital Services copayment.
- Outpatient hospital care includes radiation device placement, outpatient pulmonary function testing, esophageal dilation, and hip dysplasia treatment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as crutches, may result in an additional copayment.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.

| **Laboratory Services, X-Rays, and Diagnostic Tests - Outpatient** | In-Network | Out-of-Network |
|---|---|---|
| **Non-Routine Tests** | $20 to $1,250 copayment / visit | $150 to $2,500 copayment / visit |
| **Routine Diagnostic Laboratory Services / X-Rays / Ultrasounds** | $0 copayment / visit | $0 copayment / visit |

Notes:

- Refer to the Surest mobile app for additional coverage information and the copayment that has been assigned to your procedure/service.
- Copayments for Non-Routine Diagnostic Laboratory Services/X-ray/Ultrasounds may vary based on Provider, location, and procedure.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the facility service or surgery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Services for illness and injury-related diagnostic purposes, received on an outpatient basis at a hospital, alternate facility, or in a Physician's office include:

- Non-routine diagnostic testing including, but not limited to:
  - Angiography (Arteriography).
  - Cardiac Event Monitoring.
  - Coronary Calcium Score (Heart Scan).
  - Cystometrogram (CMG).
  - Diagnostic Hearing Exams and Testing.
  - Echocardiogram Exercise Stress Test.
  - EKG Exercise Stress Test.
  - Electroencephalogram (EEG).
  - Electromyography (EMG) and Nerve Conduction Studies (NCS).
  - Gastrointestinal Motility Testing.
  - Genetic Testing.
  - Home Sleep Test & Unattended Sleep Study.
  - Attended Sleep Study (Polysomnography).
  - Non-Cardiac Angiography, Arthrography and Myelography.
  - Pulmonary Function Tests.
  - Tilt Table Testing.
  - Transthoracic Echocardiogram (TTE).
- Routine diagnostic testing such as:
  - Diagnostic labs, pathology tests, and interpretation charges, such as blood tests, analysis of tissues, or liquids from the body.
  - Diagnostic ultrasounds and X-rays, such as fluoroscopic tests and interpretation.

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

| **Maternity Care and Delivery** | In-Network | Out-of-Network |
|---|---|---|
| **Routine Prenatal and Postnatal Office Visits, including Labs and Tests** | $0 copayment / visit | $160 copayment / visit |
| **Newborn Nursery Care** | $0 copayment / test | $0 copayment / test |
| **Amniocentesis** | $500 copayment / test | $1,500 copayment / test |
| **Chorionic Villus Sampling (CVS)** | $550 copayment / test | $1,650 copayment / test |
| **Inpatient Delivery** | $750 to $1,500 copayment / stay | $4,500 copayment / stay |
| **Home Birth/Delivery** | $750 copayment / visit | $2,700 copayment / visit |
| **Elective Abortion - Medical** | $90 copayment / visit | $270 copayment / visit |
| **Elective Abortion – Surgical** | $160 copayment / visit | $480 copayment / visit |
| **Therapeutic Medication Abortion (Medically Necessary)** | $90 copayment / visit | $270 copayment / visit |

| | | |
|---|---|---|
| **Therapeutic Surgical Abortion (Medically Necessary)** | $160 copayment / visit | $480 copayment / visit |
| **All Other Outpatient Services** | Based on place of services | Based on place of services |

Notes:

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

| **Medical Infusions, Injectables, and Chemotherapy** | In-Network | t-of-Network |
|---|---|---|
| **Cancer Chemotherapy** | $25 - $650 copayment / visit | $225 - 1,950 copayment / visit |
| **Provider Administered Drugs** | $40 to $2,600 copayment / visit | $450 to $7,000 copayment / visit |

Notes:

- Refer to the Surest mobile app for additional coverage information and for the copayment assigned to your procedure/service.
- Copayments may vary based on Provider and location.
- Benefits are available for certain medical infusions, injectables, and cancer chemotherapy administered on an outpatient basis in a hospital facility, alternate facility, in a Physician's office, or in the home. This includes intravenous chemotherapy or other intravenous infusion therapy.
- Covered Health Services include medical education services that are provided in an office, outpatient hospital, or alternate facility by appropriately licensed or registered health care professionals.
- The Medical Infusions and injectables require supervision and follow up with a medical professional. The Provider Administered Drugs will be dispensed and administered by a medical professional. Certain drugs are dispensed by a medical professional and may require special handling and storage. Certain drugs may require special handling and storage and are generally considered Specialty Drugs administered by a medical professional.
- Supportive drugs that are often unplanned for your diagnosis and treatment, such as IV fluids or antibiotic injections, have a $0 copayment.
- Provider Administered Drugs and Cancer Chemotherapy that are typically for planned administration have their own copayments when given in a non-emergent outpatient setting. If a mixture of drugs is needed for a chemotherapy visit, the copayment of the highest cost drug will apply to that visit.

- The copayments apply to specific drugs that must be administered in a medical setting or under medical supervision. Call Surest Member Services to learn which medical drug (e.g., infusions and injections) are subject to these copayments.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Medical Drug copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Select injectable drugs that can be safely self-administered may not be covered under the medical Benefit. These drugs or equivalent drugs are covered as described in Part III., "The Prescription Drug Program (PDP)" (see Section J., "Overview of the Prescription Drug Program," Section K., "Filling Prescriptions," and Section L., "Other Prescription-Drug-Related Services").
- Select Medical Infusions, Injectables, and Chemotherapy may require Prior Authorization and Medical Necessity review.

| **Office Visit and Diagnostic Visit** | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit (including Telehealth Visit)** | $20 to $105 copayment / visit | $220 copayment / visit |
| **Mental Health Office Visit** | $20 copayment / visit | $40 copayment / visit |
| **Mental Health Telehealth Visit** | $20 copayment / visit | $40 copayment / visit |
| **Allergy Injection Visit** | $0 copayment / visit | $160 copayment / visit |
| **Allergy Testing and Treatment** | $110 copayment / visit | $330 copayment / visit |
| **Convenience Care / Retail Visit** | $25 copayment / visit | Not Covered |
| **E-Visit and Telephone Consult with Your Physician** | $20 copayment / visit | $220 copayment / visit |
| **Outpatient Anticoagulant Management** | $20 copayment / visit | $60 copayment / visit |
| **Virtual Care** | See Virtual Care section for details. | Not Applicable |

**Notes:**

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

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

| **Palliative Care** | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $20 to $105 copayment / visit | $220 copayment / visit |

| | | |
|---|---|---|
| **Home Health Care Visit** | $60 copayment / visit | $180 copayment / visit |
| **Outpatient Hospital Visit** | $150 to $850 copayment / visit | $2,550 copayment / visit |

Notes:

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

| **Prescription Drugs** | In-Network | Out-of-Network |
|---|---|---|
| | Covered under the Medical Plan's Prescription Drug Program. See Part III., "The Prescription Drug Program (PDP)" (see Section J., "Overview of the Prescription Drug Program," Section K., "Filling Prescriptions," and Section L., "Other Prescription-Drug-Related Services"). | |

| **Preventive Care Services** | In-Network | Out-of-Network |
|---|---|---|
| | $0 copayment / visit | $160 copayment / visit |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Preventive Care Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Services include evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, Bright Futures, Health Resources and Services Administration, and Advisory Committee on Immunization Practices.
- Examples include:
  - Pediatric preventive care services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations up to age 18.
  - Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once-a-year visits from 24 months to age six.
  - Routine physical exams.
  - Routine screenings for certain cancers and other conditions. This includes mammography, breast ultrasounds and breast MRIs.
  - Routine screening colonoscopy is covered as preventive with a diagnosis of family history.
  - Routine immunizations. Age limits may apply.
  - Routine lab tests, pathology, and radiology.
  - Hearing and vision screening limited to one exam per Plan Year for children up to age of 21.
  - Routine pre-natal and post-natal services.
  - One routine postnatal care exam provided during the period immediately after childbirth that includes a health exam, assessment, education, and counseling.
  - Preventive contraceptive methods and counseling for women.

- Includes certain approved contraceptive methods for women with reproductive capacity, including contraceptive drugs, devices, and delivery methods.

- For Prescription Drug Coverage, see Part III., "The Prescription Drug Program (PDP)" (see Section J., "Overview of the Prescription Drug Program," Section K., "Filling Prescriptions," and Section L., "Other Prescription-Drug-Related Services").
- Low-dose CT Scan (LDCT) for lung cancer screening may require Prior Authorization and Medical Necessity review.

| **Radiation Therapy and Other High Intensity Therapy** | In-Network | Out-of-Network |
|---|---|---|
| | $40 to $2,100 copayment / visit | $210 to $6,300 copayment / visit |

Notes:

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

| **Reconstructive Surgery** | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $20 to $105 copayment / visit | $220 copayment / visit |
| **Outpatient Hospital** | $150 to $850 copayment / visit | $2,550 copayment / visit |
| **Inpatient Hospital** | $2,000 copayment / stay | $6,000 copayment / stay |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits or outpatient hospital may vary based on Provider and location.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Reconstructive Surgery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.

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

| **Rehabilitative/Habilitative Services and Other Low Intensity Therapy** | In-Network | Out-of-Network |
|---|---|---|
| **Acupuncture Visit** | $50 copayment / visit | $150 copayment / visit |
| **Aural Therapy – Post Cochlear Implant** | $20 to $140 copayment / visit | $220 copayment / visit |
| **Biofeedback** | $70 copayment / visit | $210 copayment / visit |
| **Cardiac Rehabilitation Therapy** | $60 copayment / visit | $180 copayment / visit |
| **Chiropractic Visit** | $25 copayment / visit | $75 copayment / visit |
| **Cognitive Therapy** | $15 to $105 copayment / visit | $185 copayment / visit |
| **Occupational Therapy** | $15 to $105 copayment / visit | $185 copayment / visit |
| **Physical Therapy** | $10 to $75 copayment / visit | $225 copayment / visit |
| **Speech Therapy** | 15 to $105 copayment / visit | $185 copayment / visit |
| **Pulmonary Rehabilitation Therapy** | $80 copayment / visit | $240 copayment / visit |
| **Vision Therapy** | $20 copayment / visit | $220 copayment / visit |

Notes:
Rehabilitative and habilitative services must be performed by a Physician or by a licensed therapy Provider. Benefits include services provided in a Physician's office or on an outpatient basis at a hospital, or alternate facility. Services provided in your home are provided as described under the Home Health Care section.

- Refer to the Surest mobile app for additional coverage and copayment information.

- The copayments for certain therapies may vary based on Provider and location (e.g., aural, cognitive, occupational, physical, and speech therapy).
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Rehabilitative/Habilitative Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- Acupuncture is limited to 30 visits or services per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
- Aural Therapy does not have visit limits.
- Biofeedback therapy is a non-drug treatment in which patients learn to control bodily processes that are normally involuntary, such as muscle tension, blood pressure, or heart rate.
- Cardiac Rehabilitation does not have visit limits.
- Chiropractic Visits are limited to 30 visits or services, per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
  - Chiropractic Services are limited to manipulative services including chiropractic care and osteopathic manipulation rendered to diagnose and treat acute neuromuscular-skeletal conditions.
- Occupational and Cognitive therapy visits are limited to 100 visits per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
  - Cognitive rehabilitation therapy following traumatic brain injury or cerebral vascular accident is covered when Medically Necessary.
- Physical therapy is limited to 100 visits per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
- Pulmonary Rehabilitation does not have visit limits.
- Speech therapy is limited to 100 visits per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
- Vision therapy does not have visit limits.
- Note that Occupational Therapy and Physical Therapy are different types of service and the copayment varies based on how the claim is billed.
- Therapies provided in the home will be assigned the home health care visit copayment. See Home Health Services for coverage notes.
- Therapies related to the treatment of a mental health condition, such as autism disorder, are provided under Behavioral Health – Mental Health and Substance Use Disorder services section and do not apply to limits in this section.

| **Skilled Nursing Facility Services** | In-Network | Out-of-Network |
|---|---|---|
| **Skilled Nursing Facility** | $1,600 copayment / stay | $4,800 copayment / stay |
| **Inpatient Rehabilitation Facility** | $1,500 copayment / stay | $4,500 copayment / stay |

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

- Refer to the Surest mobile app for additional coverage information.
- Skilled Nursing Facility stays are limited to 100 days per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Skilled Nursing Facility Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.

- An Inpatient Rehabilitation Facility, such as a long-term acute rehabilitation center, a hospital, or a special unit of a hospital designated as an inpatient rehabilitation facility, that provides occupational therapy, physical therapy, and/or speech therapy as authorized by law.
- Benefits include:
  - Facility services for an inpatient stay in a Skilled Nursing Facility or inpatient rehabilitation facility.
  - Supplies and non-Physician services received during the inpatient stay.
  - Room and board in a semi-private room (a room with two or more beds).
  - Physician services for anesthesiologists, pathologists, and radiologists.
  - Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or inpatient rehabilitation facility for treatment of an illness or injury that would have otherwise required an inpatient stay in a hospital.
- Benefits are available only if both of the following are true:
  - The initial confinement in a Skilled Nursing Facility or inpatient rehabilitation facility was or will be a cost-effective alternative to an inpatient stay in a hospital.
  - You will receive skilled care services that are not primarily Custodial Care.
- Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:
  - Services must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
  - Services are ordered by a Physician.
  - Services are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair.
  - Services require clinical training in order to be delivered safely and effectively.
- You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Participants who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.
- The Surest Plan does not provide Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician
- Returning home from a Skilled Nursing Facility or Inpatient Rehabilitation Facility stay with durable medical equipment, such as a walker, may result in an additional copayment.
- All Skilled Nursing Facility and Inpatient Rehabilitation Facility admissions require Prior Authorization and Medical Necessity review.
- See Hospital Services for other coverage notes.

| **Transplant Services** | In-Network | Out-of-Network |
|---|---|---|
| **Bone Marrow and Solid Organ Transplant** | $2,100 copayment / visit | Not Covered |
| **Corneal Transplant** | $2,200 copayment / visit | Not Covered |
| **Cellular and Gene Therapy** | $2,100 copayment / visit | Not Covered |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for outpatient hospital may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Transplant Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Transplants for which Benefits are available include bone marrow (including CAR T-cell therapy for malignancies), heart, heart/lung, lung, kidney, kidney/pancreas, pancreas, liver, liver/intestine, intestine, and cornea.
- Benefits are also available for cellular and gene therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility.

- Surest has identified quality designated providers for transplant services (except for corneal transplant) that are accessible through Transplant Resource Services (see Section I., "Clinical Programs and Resources," for additional information). Transplant services (except for corneal transplant) must be rendered at a designated provider.
- All Participants undergoing transplant services (except for corneal transplant) must enroll in Transplant Resource Services, which is a care coordination program for patients undergoing transplants.
- Benefits are available to the donor and the recipient when the recipient is covered under the Surest Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage.
- Surest has specific guidelines regarding Benefits for transplant services. Contact Surest Member Services at the number on your member ID card for information about these guidelines.
- The Surest Plan provides Benefits for expenses for travel and lodging. See Section I. "Clinical Programs and Resources" for more information.

| **Treatment / Tests / Therapies – Go to Surest mobile app or Benefits.Surest.com website for additional information** | In-Network | Out-of-Network |
|---|---|---|
| • **Level 1:** Generally, minor procedures or treatments that are typically performed in an outpatient office setting (e.g., needle biopsy, pain management procedures, etc.) | $35 to $2,850 copayment / visit | $210 to $7,000 copayment / visit |
| • **Level 2:** Generally, minor procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting (e.g., bronchoscopy, etc.) | $0 to $2,950 copayment / visit | $620 to $7,000 copayment / visit |
| • **Level 3:** Generally, major procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting but may be performed in an inpatient hospital setting (e.g., thyroid surgery, prostate surgery, etc.) | $170 to $3,000 copayment / visit/stay | $1,500 to $7,000 copayment / visit/stay |
| • **Level 4:** Generally, major procedures, surgeries, or treatments that are typically performed in an inpatient hospital but may be performed in an outpatient hospital setting (e.g., colon surgery, small bowel surgery, etc.) | $300 to $3,000 copayment / visit/stay | $6,000 to $7,000 copayment / visit/stay |
| • **Level 5:** Generally, major procedures, surgeries, or treatments that require intensive monitoring and are performed in an inpatient hospital setting (e.g., bone marrow and solid organ transplant, brain tumor surgery, coronary artery bypass graft surgery, etc.) | $1,100 to $3,000 copayment / visit/stay | $6,300 to $7,000 copayment / visit/stay |
| **Other Treatments/Tests/Therapies:** refer to the Surest mobile app or Benefits.Surest.com website for coverage and copayment information or call Surest Member Services. Copayments may vary based on Provider, location and treatment, test, or therapy. | | |
| • **Office Visits** | $20 to $105 copayment / visit | $220 copayment / visit |
| • **Outpatient Hospital Visit** | $150 to $850 copayment / visit | $2,550 copayment / visit |

| | | |
|---|---|---|
| • **Inpatient Hospital** | $2,000 copayment / stay | $6,000 copayment / stay |

Notes:

- Refer to the Surest mobile app for additional coverage information and for the copayment assigned to your procedure/service.
- The copayments above apply unless a Benefit is specified in another section of this SPD, Surest mobile app or Benefits.Surest.com website.
- Copayments for outpatient hospital may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Treatment / Tests / Therapies copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Treatment, tests, and therapies have been tiered based on type and level (minor vs. major) of care. Some minor treatments or procedures are either included in the office visit copayment or may have a specific copayment based on the Provider and location selected. Some surgical procedures also have specific copayments based on the Provider or location selected.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Copayments for Procedures in Level 1 – Level 5 may vary based on Provider and location. Refer to the Surest mobile app, or call Surest Member Services to determine the copayment assigned to your procedure/service.
  - Level 1 is a category of minor procedures typically performed in an outpatient office setting.
  - Level 2 is a category of minor surgeries and procedures, or services typically performed in an outpatient hospital setting.
  - Level 3 is a category of major surgeries and procedures typically performed in an outpatient hospital setting.
  - Level 4 is a category of major surgeries and procedures typically performed in an inpatient hospital setting.
  - Level 5 is a category of major surgeries and procedures that require intensive monitoring and typically performed in an inpatient hospital setting. Transplant services must be rendered at a location specified as a designated provider.
- Copayments for office visits or outpatient hospital visits may vary based on Provider and location. Refer to the Surest mobile app, or call Surest Member Services to determine the copayment assigned to your procedure/service.
- Inpatient hospitalization/stay Benefits include:
  - Physician and non-Physician services, supplies, and medications received during an inpatient stay.
  - Facility charges, including room and board in a semi-private room (a room with two or more beds).
  - Physician services for lab tests, anesthesiologists, pathologists, radiologists, and Emergency room Physicians.
  - The Surest Plan will allow the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.
- If you are admitted to inpatient from the Emergency department or from observation, the Emergency room copayment or Observation Stay copayment will be waived, and you will be responsible for the Inpatient Hospital Services copayment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as a walker, may result in an additional copayment.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.
- Select office-based and outpatient procedures may require Prior Authorization and Medical Necessity review.

| **Urgent Care** | In-Network | Out-of-Network |
|---|---|---|
| **Urgent Care Visit** | $75 copayment / visit | $225 copayment / visit |

Notes:

- Refer to the Surest mobile app for additional coverage information.

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

| **Virtual Care – Designated Provider** | In-Network | Out-of-Network |
|---|---|---|
| **Virtual Primary and Urgent Care** | $0 copayment / visit | Not Covered |
| **Virtual Mental Health & Substance Use Disorder Care** | $20 to $60 copayment / visit | Not Covered |
| **Virtual Specialty Care** | $0 to $105 copayment / visit | Not Covered |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Please see the Behavioral Health and Office Visit sections for additional information on Telehealth Visits with your Provider.
- Virtual care is for Covered Health Services that include the diagnosis and treatment of medical and mental health conditions for Participants that can be appropriately managed virtually within the scope of practice of the virtual providers, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner. Virtual care provides communication of medical information between the patient and Provider, through use of interactive audio and video communications equipment or through federally compliant secure messaging applications outside of a medical facility (for example, from home or from work).
- Copayments will vary based on Provider. If you choose a Provider that is not a Designated Virtual Network Provider, see Office Visit section for additional Telehealth Visit copayment information. Benefits are available only when services are delivered through a Designated Virtual Network Provider that are specified by your Surest Plan.
- Please visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services to locate a Designated Virtual Network Provider.
- No virtual care coverage for Out-of-Network Providers.
- Please note that not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which in-person Physician contact is needed.

## Section G. What's Covered Under the Surest Standard Option

Described below is information relating to covered health services under the Surest Standard option. For relevant limitations, see Section "H", "Exclusions and Limitations--What the Surest Options Do Not Cover."

| The Surest Standard Option | In-Network | Out-of-Network |
|---|---|---|
| **Deductible** | $0 | $0 |
| **Out-of-Pocket Maximum (per Plan Year)** | | |
| **Individual** | $6,000 | $12,000 |
| **Family** | $12,000 | $36,000 |

Notes:

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

| Ambulance Services | In-Network | Out-of-Network |
|---|---|---|
| | $330 copayment / transport | $330 copayment / transport |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Out-of-network Ambulance Services copayment applies to the In-Network out-of-pocket maximum.
- Ground or air ambulance, as the Claims Administrator determines appropriate. Air ambulance is medical transport by helicopter or airplane.

- Emergency ambulance services and transportation provided by a licensed ambulance service (either ground or air ambulance) to the nearest hospital that offers Emergency health services.
- Ambulance service by air is covered in an Emergency if ground transportation is impossible or would put your life or health in serious jeopardy..
- Non-Emergency ambulance transportation provided by a licensed ambulance service (either ground or air ambulance) between facilities only when the transport meets one of the following:
  - From an Out-of-Network hospital to the closest in-Network hospital when Covered Health Services are required.
  - To the closest in-network Hospital that provides the required Covered Health Services that was not available at the original Hospital.
  - From a short-term acute care facility to the closest in-network long-term care acute facility (LTAC), in-network Inpatient Rehabilitation Facility, or other in-Network sub-acute facility where the Required Covered Health Services can be delivered.
- For the purposes of this Benefit, the following terms have the following meanings:
  - "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
  - "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden sickness, injury, or flare-up of a chronic sickness.
  - "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.
- Non-Emergency air ambulance services require Prior Authorization and Medical Necessity review.

| **Behavioral Health: Mental Health and Substance Use Disorder Services** | In-Network | Out-of-Network |
|---|---|---|
| **Mental Health Office Visit (including Telehealth Visit)** | $40copayment / visit | $80 copayment / visit |
| **Mental Health Telehealth Visit** | $40 copayment / visit | $80 copayment / visit |
| **Applied Behavioral Analysis (ABA) Therapy** | $40 copayment / visit | $220 copayment / visit |
| **Mental Health Biofeedback** | $40 copayment / visit | $220 copayment / visit |
| **Mental Health Habilitative, Cognitive, Occupational, Physical, and Speech Therapy** | $20 copayment / visit | $60 copayment / visit |
| **Electroconvulsive Therapy (ECT)** | $180 copayment / visit | $540 copayment / visit |
| **Intensive Outpatient Treatment Program (IOP)** | $100 copayment / visit | $300 copayment / visit |
| **Outpatient Alcohol and Drug Treatment Program** | $110 copayment / visit | $245 copayment / visit |
| **Partial Hospitalization (PHP)/Day Treatment** | $180 copayment / day | $4540 copayment / day |
| **Substance Use Disorder Medication Therapy** | $45 copayment / visit | $90 copayment / visit |
| **Transcranial Magnetic Stimulation (TMS) Therapy** | $170 copayment / visit | $320 copayment / visit |
| **Residential Treatment Facility Care** | $2,700 copayment / stay | $8,100 copayment / stay |
| **Outpatient Mental Health** | $180 copayment / visit | $540 copayment / visit |
| **Inpatient Hospital** | $2,700 copayment / stay | $8,100 copayment / stay |
| **Virtual Care** | See Virtual Care section for details. | Not Applicable |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Benefits include:
  - Diagnostic evaluations, assessment, and treatment planning.
  - Other treatments and/or procedures.

- Medication management and other associated treatments.
- Methadone Maintenance
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

  - Intensive Outpatient Treatment program (IOP) (a structured outpatient mental health or substance use treatment program at a freestanding or hospital-based facility and provides services for at least three hours per day, two or more days per week).
  - Residential treatment.
  - Partial hospitalization (PHP)/Day treatment (a structured ambulatory program that may be freestanding or hospital-based and provides services for at least 20 hours per week).
  - Other Outpatient treatment.
- Biofeedback therapy is a non-drug treatment in which patients learn to control bodily processes that are normally involuntary, such as muscle tension, blood pressure, or heart rate.
- Returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- Mental Health Office Visit refers to a face-to-face visit with your Provider.
- Mental Health Telehealth Visit refers to a non-face-to-face visit with your Provider.
- Nutritional counseling for mental health or substance use disorder does not have visit limits.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.
- Inpatient residential and partial hospitalization services may require Prior Authorization and Medical Necessity review.
- Refer to the Gender Dysphoria Services section for additional coverage information.
- Mental Health Occupational Therapy is a visit for therapy focused on regaining daily life skills for a person with a mental health condition, such as autism.
- Mental Health Physical Therapy is a visit for therapy focused on regaining physical function for a person with a mental health condition, such as autism.
- Mental Health Speech Therapy is a visit for therapy focused on regaining speech and communication function for an individual with a mental health condition, such as autism.

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

  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others, property, or impairment in daily functioning.
  - Provided by a Board-Certified Applied Behavior Analyst (BCBA) or other qualified Provider under the appropriate supervision.
- Intensive Behavioral Therapy (IBT) is outpatient behavioral care services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors, and improve the mastery of functional age-appropriate skills in Participants with Autism Spectrum Disorder.
- These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.
- Visit limits do not apply to therapies provided for a mental health condition, such as autism disorders.
- Applied Behavioral Analysis for Autism Spectrum Disorder services may require Prior Authorization and Medical Necessity review.

| **Colonoscopy - Non-Screening** | In-Network | Out-of-Network |
|---|---|---|
| | $0 copayment / visit | $2,950 copayment / visit |

Notes:

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

- Benefits include Physician services and facility charges.
- Coverage is available for a non-screening colonoscopy received on an outpatient basis at a hospital, alternate facility, or in a Physician's office.
- A non-screening colonoscopy is a procedure is performed to diagnose disease symptoms, a copayment applies.
- Services for preventive screenings are provided under the Preventive Care Services section.

| **Complex Imaging** | In-Network | Out-of-Network |
|---|---|---|
| **MRI (Magnetic Resonance Imaging)** | $250 to $1,250 copayment / visit | $1,550 copayment / visit |
| **CT (Computed Tomography)** | $150 to $1,050 copayment / visit | $1,700 copayment / visit |
| **Nuclear Imaging** | $250 to $1,550 copayment / visit | $3,250 copayment / visit |
| **Pet Scan** | $250 to $1,250 copayment / visit | $1,550 copayment / visit |

Notes:

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

| **Dental and Oral Services** | In-Network | Out-of-Network |
|---|---|---|
| **Orthognathic (Jaw) Surgery** | $4,000 copayment / visit | $11,000 copayment / visit |
| **Temporomandibular Joint (TMJ) Dysfunction Surgery** | $1,000 copayment / visit | $3,000 copayment / visit |
| | | |
| **Dental - Accidental and Medical Conditions:** | | |
| **Office Visit** | $40 to $150 copayment / visit | $220 copayment / visit |
| **Outpatient Hospital Visit** | $350 to $1,200 copayment / visit | $3,250 copayment / visit |
| **Inpatient Hospital** | $3,500 copayment / stay | $10,500 copayment / stay |

**Notes:**

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Dental Services visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from a visit with durable medical equipment, such as an oral appliance, may result in an additional copayment.
- Dental services are covered by the Plan when treatment is necessary because of accidental damage, dental services are received from a Doctor of Dental Surgery, "D.D.S." or a Doctor of Medical Dentistry; "D.M.D." and the dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

- The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to
  - Dental services related to medical transplant procedures.
  - Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system).
  - Direct treatment of acute traumatic Injury, cancer or cleft palate.
- Benefits are available only for treatment of a sound, natural tooth.
- The Physician or dentist must certify that the injured tooth was a virgin or unrestored tooth or a tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.
- Dental services for final treatment to repair the damage must be both of the following:
  - Started within three months of the accident or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan.
  - Completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.
- Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof, and floor of the mouth.
- The Surest Plan also covers dental services, limited to dental services required for treatment of an underlying medical condition such as a cleft palate or other congenital defect, oral reconstruction after invasive oral tumor removal, preparation for or as a result of radiation therapy for oral or facial cancer.
- Eligible Expenses for hospitalizations are those incurred by a Participant who: (1) is a child under age five; (2) is severely disabled; or (3) has a medical condition, unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a Physician, dentist, or dental Specialist.
- Accidental Dental Services may require Prior Authorization and Medical Necessity review.

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

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits or outpatient hospital visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Orthognathic and TMJ copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Includes orthodontic services and supplies, and surgical and non-surgical options for the treatment of TMJ. Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatments have failed.
- Returning home from a visit with durable medical equipment, such an oral appliance, may result in an additional copayment.
- Orthognathic surgery and select services for TMJ Disorder may require Prior Authorization and Medical Necessity review.

| **Dialysis Services** | In-Network | Out-of-Network |
|---|---|---|
| **Home Dialysis** | $120 copayment / visit | $335 copayment / visit |
| **Dialysis** | $125 to $500 Copayment / visit | $1,500 Copayment / visit |

Notes:

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

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

Notes:

- Durable Medical Equipment (DME) and supplies are tiered based on average cost and allowed amount. Supplies such as tubing, syringes, and catheters are assigned to a lower tier and will result in a lower copayment.

Equipment such as glucose monitors, pumps, and wheelchairs are assigned to a higher tier and will result in a higher copayment.

- Each piece of durable medical equipment and supplies are assigned to a tier, which corresponds to a copayment. A breakdown of the tiers and corresponding copayments can be found on Surest mobile app or Benefits.Surest.com website.
- Returning home from an appointment with a health care Provider or from the hospital with durable medical equipment, such as crutches, may result in an additional copayment. Copayments will be dependent on the tier the item falls into.
- For Enteral Nutrition administered at home, multiple copayments will apply (such as for formula, nursing visit and administration).

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

- Refer to the Surest mobile app for additional coverage and copayment information.
- This durable medical equipment and supplies list is subject to periodic review and modification (generally quarterly, but no more than six times per Plan Year).
- You may also view which tier a particular DME item has been assigned to by using the Surest mobile app or Benefits.Surest.com website or calling Surest Member Services for assistance.
- Coverage includes rental or purchase of DME if Medically Necessary, ordered or provided by a Physician for outpatient use primarily in a home setting, serves a medical purpose for the treatment of an illness or injury, and is not of use to a Participant in the absence of a disease or disability. If you need certain durable medical equipment for an extended period of time, there may be an option to rent. Length of rental may vary by DME item. The purchase copayment based on tier may be split over a period of time, at which point the DME may be considered "purchased" or coverage may end. Note that some equipment such as oxygen equipment, will be set to rental for the duration of time the equipment is needed. Surest generally follows Centers for Medicare and Medicaid Services (CMS) guidelines on rental vs purchase. Refer to Surest mobile app or Benefits.Surest.com website for additional information.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors, and masks).
- Cranial orthoses such as head shaping helmets and head reconstruction are a set of orthotic devices and services to reshape the head. They may be medically indicated for plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape).
- Scalp/cranial hair prostheses (wigs) are a Covered Health Service regardless of the reason for hair loss is limited to a maximum Benefit of one wig per Plan Year for In-Network and Out-of-Network Providers combined.
- Eyeglasses or contacts after cataract surgery or for aphakia is limited one frame and one pair of lenses or one pair of contact lenses or a one-year supply of disposable contact lenses.
- Hearing aids are limited to $5,000 every 36 months for In-Network and Out-of-Network Providers combined. This limit applies to traditional hearing aids.
- Communication aids or devices; equipment to create, replace, or augment communication abilities, including but not limited to communication board or computer or electronic-assisted communication, speech processors, and receivers. Speech generating device, digitized speech, and using pre-recorded messages are eligible.
- Purchase of one standard breast pump, either manual or electric, per pregnancy. Participant may have to pay a surcharge to the Provider if they purchase enhanced models.
- Enteral Nutrition and low protein modified food products administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. The formula or product must be administered under the direction of a Physician or registered dietitian. (Example conditions include, but are not limited to, metabolic disease such as phenylketonuria (PKU) and maple syrup urine disease

severe food allergies, and impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.)

- Shoes as prescribed by a Provider for a Participant. Limited to one pair per Plan Year.
- Coverage is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.
- Select Durable Medical Equipment (DME) may require Prior Authorization and Medical Necessity review.

| **Emergency Room Services** | In-Network | Out-of-Network |
|---|---|---|
| **Emergency Room Visit** | $550 copayment / visit | $550 copayment / visit |
| **Observation Stay** | $550 copayment / stay | $550 copayment / stay |

Notes:

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

| **Fertility Preservation** | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $40 to $150 copayment / visit | $220 copayment / visit |
| **Latrogenic In Vitro Fertilization** | $500 copayment / service | Not Covered |
| **Egg Retrieval for Iatrogenic Infertility** | $1,500 copayment / service | Not Covered |
| **Cryopreservation for Iatrogenic Infertility** | $500 copayment / service | Not Covered |
| **Storage for Iatrogenic Infertility** | $100 copayment / year | Not Covered |
| **Genetic Testing (PGT) for Iatrogenic Infertility** | $500 copayment / visit | Not Covered |

**Notes:**

- Refer to the Surest mobile app for additional coverage information.
- There is a combined lifetime maximum of $15,000 per Participant for covered medical fertility preservation and fertility services including prescription medications for fertility preservation and fertility services.

Fertility Preservation for Iatrogenic Infertility:

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

- Benefits are not available for long-term storage costs (greater than one year).

Preimplantation Genetic Testing (PGT) and Related Services:

- Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:
  - PGT must be ordered by a Physician after Genetic Counseling.
  - The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
  - Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
    - Ovulation induction (or controlled ovarian stimulation).
    - Egg retrieval, fertilization and embryo culture.
    - Embryo biopsy.
    - Embryo transfer.
    - Cryo-preservation and short-term embryo storage (less than one year).
- Benefits are not available for long-term storage costs (greater than one year).
- Please refer to other sections of the SPD for Covered Health Services for diagnosis and treatment of underlying medical condition which may cause infertility such as surgical procedures: laparoscopy, lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty, and ovarian cystectomy.

| **Fertility Services** | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $40 to $150 copayment / visit | $220 copayment / visit |
| **Artificial insemination** | $100 copayment / service | Not Covered |
| **Egg Retrieval** | $1,500 copayment / service | Not Covered |
| **Embryo Transfer/Implantation** | $750 copayment / service | Not Covered |
| **Cryopreservation** | $500 copayment / service | Not Covered |
| **Storage** | $100 copayment / year | Not Covered |
| **Thawing** | $150 copayment / service | Not Covered |
| **Genetic Testing (PGT)** | $500 copayment / visit | Not Covered |
| **Donor Services (Egg)** | $1,200 copayment / service | Not Covered |
| **Donor Services (Sperm)** | $300 copayment / service | Not Covered |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Multiple copayments may apply if more than one service is performed during a visit
- There is a combined lifetime maximum of $15,000 per Participant for covered medical fertility preservation and fertility services including prescription medications for fertility preservation and fertility services.

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

- Diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Fertility Treatment copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Therapeutic services when provided under the direction of a Designated Provider are limited to the following procedures:
  - Assisted Reproductive Technologies (ART), including but not limited to:

  - InVitro fertilization (IVF).
  - Egg/oocyte retrieval.
  - Fresh or frozen embryo transfer.
  - Intracytoplasmic sperm injection (ICSI).
  - Gamete intrafallopian transfer (GIFT).
  - Pronuclear stage tubal transfer (PROST),
  - Tubal embryo transfer (TET),
  - Zygote intrafallopian transfer (ZIFT).
  - Assisted hatching.
  - Cryopreservation and storage of embryos for up to 12 months.
  - Embryo biopsy for PGT-M or PGT-SR (formerly known as PGD).
- Frozen embryo transfer cycle including the associated cryopreservation and storage of embryos for up to 12 months.
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures, including but not limited to: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, ovarian cystectomy.
- Electroejaculation.
- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.

- Treatment for the diagnosis and treatment of the underlying cause of Infertility is covered as described in other sections of this Booklet. Benefits for diagnostic tests are described under Laboratory Services, X-Rays, and Diagnostic Test – Outpatient, Office Visit and Diagnostic Visit.
- The medical Plan provides Benefits for certain prescription medications or products, including specialty medications, for the treatment of infertility that are administered by a medical Provider on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.
- Fertility Benefits for prescription medications or products for outpatient use that are filled by a prescription order or refill are described under Section 13 (Attachment I – Outpatient Prescription Drugs).

**Donor Coverage:**

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

| **Gender Dysphoria Services** | In-Network | Out-of-Network |
|---|---|---|
| **Mental Health Office Visit** | $25 copayment / visit | $50 copayment / visit |
| **Gender Dysphoria Voice Therapy** | $20 copayment / visit | $60 copayment / visit |
| **Gender Dysphoria Surgery** | $180 to $2,700 copayment / visit | $540 to $8,100 copayment / visit |
| **Gender Dysphoria Reconstructive Services** | $40 to $180 copayment / stay | $80 to $540 copayment / stay |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Gender Dysphoria Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Members must be 18 years of age or older for the surgical treatment of Gender Dysphoria.
- Select services for the treatment of Gender Dysphoria may require Prior Authorization and Medical Necessity review.
- The following services are covered for Gender Dysphoria:
  - Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses.
  - Hormone therapy as appropriate to the patient's gender goals: Hormone therapy administered by a medical Provider (for example during an office visit). Hormone therapy dispensed from a pharmacy is provided as described in Part III., "The Prescription Drug Program (PDP)" (see Section J., "Overview of the Prescription Drug Program," Section K., "Filling Prescriptions," and Section L., "Other Prescription-Drug-Related Services").
  - Laboratory testing to monitor the safety of continuous hormone therapy as appropriate to the patient's gender goals.
  - Hair transplantation.
  - Dermatology.
  - Permanent hair removal for purposes of genital reconstruction.
  - Permanent face and neck hair removal or reduction, including electrolysis and laser treatment.
  - Voice lessons and voice therapy.
- Surgery treatment for Gender Dysphoria, includes the surgeries listed below:
  - Abdominoplasty and body contouring.
  - Liposuction.
  - Genital surgeries:
    - Clitoroplasty (creation of clitoris).
    - Hysterectomy (removal of uterus).
    - Labiaplasty (creation of labia).
    - Metoidioplasty (creation of penis, using clitoris).
    - Orchiectomy (removal of testicles).
    - Penectomy (removal of penis).
    - Penile prosthesis.
    - Phalloplasty (creation of penis).
    - Salpingo-oophorectomy (removal of fallopian tubes and ovaries).
    - Scrotoplasty (creation of scrotum).
    - Testicular prosthesis.
    - Urethroplasty (reconstruction of female urethra).

- Urethroplasty (reconstruction of male urethra).
- Vaginectomy (removal of vagina).
- Vaginoplasty (creation of vagina).
- Vulvectomy (removal of vulva).

– Chest surgeries:
- Bilateral mastectomy or breast reduction.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Pectoral implants.

– Face and neck surgeries:
- Blepharoplasty (eyelid lift).
- Brow lift.
- Forehead lift.
- Facial bone remodeling.
- Lip reshaping.
- Rhinoplasty (nose reshaping).
- Thyroid cartilage remodeling / thyroid chondroplasty / tracheal shave (remodeling of the Adam's apple).
- Face lift.
- Neck tightening.
- Voice modification surgery.

| **Home Health Services** | In-Network | Out-of-Network |
|---|---|---|
| **Home Health Care Visit** | $80 copayment / visit | $240 copayment / visit |
| **Private Duty Nursing** | $80 copayment / visit | $240 copayment / visit |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Home Health Care Visits are limited to 100 visits per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
- Private Duty Nursing does not have visit limits.
- Services received from a Home Health Agency (an organization authorized by law to provide health care services in the home) or independent Provider that are the following:
  - Ordered by a Physician.
  - Provided in your home by a registered nurse or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
  - Provided on a part-time, intermittent care schedule.
  - Provided when skilled care is required.
- For Enteral Nutrition administered at home, multiple copayments will apply (such as for formula, nursing visit and administration).
- Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, billed by the Home Health Agency, will apply to the Home Health Services visit limits.
- Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, not administered by a Home Health Agency will apply to the Rehabilitative/Habilitative Services visit limits.
- Select Home Health Services may require Prior Authorization and Medical Necessity review.

| **Hospice Care** | In-Network | Out-of-Network |
|---|---|---|
| **Home Hospice Visit** | $80 copayment / visit | $240 copayment / visit |

| | | |
|---|---|---|
| **Inpatient Hospice Care** | $3,500 copayment / stay | $10,500 copayment / stay |

Notes:

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

| **Hospital Services - Other** | In-Network | Out-of-Network |
|---|---|---|
| **Outpatient Hospital Visit** | $350 to $1,200 copayment / visit | $3,250 copayment / visit |
| **Inpatient Hospital** | $3,500 copayment / stay | $10,500 copayment / stay |

Notes:

- Other Hospital Services: The above copayments apply for Covered Health Services not specifically listed in this SPD, Surest mobile app or Benefits.Surest.com website. Copayments may vary based on Provider and location.
- Refer to the Surest mobile app for additional coverage information.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Hospital Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Inpatient hospitalization/stay Benefits include:
  - Physician and non-Physician services, supplies, and medications received during an inpatient stay.
  - Facility charges, including room and board in a semi-private room (a room with two or more beds).
  - Physician services for lab tests, anesthesiologists, pathologists, radiologists, and Emergency room Physicians.
  - The Surest Plan will allow the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.
- If you are admitted to inpatient from the Emergency department or from observation, the Emergency room copayment or Observation Stay copayment will be waived, and you will be responsible for the Inpatient Hospital Services copayment.
- Outpatient hospital care includes radiation device placement, outpatient pulmonary function testing, esophageal dilation, and hip dysplasia treatment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as crutches, may result in an additional copayment.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.

| **Laboratory Services, X-Rays, and Diagnostic Tests - Outpatient** | In-Network | Out-of-Network |
|---|---|---|
| **Non-Routine Tests** | $35 to $1,800 copayment / visit | $170 to $2,950 copayment / visit |
| **Routine Diagnostic Laboratory Services / X-Rays / Ultrasounds** | $0 copayment / visit | $0 copayment / visit |

Notes:

- Refer to the Surest mobile app for additional coverage information and the copayment that has been assigned to your procedure/service.
- Copayments for Non-Routine Diagnostic Laboratory Services/X-ray/Ultrasounds may vary based on Provider, location, and procedure.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the facility service or surgery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Services for illness and injury-related diagnostic purposes, received on an outpatient basis at a hospital, alternate facility, or in a Physician's office include:
  - Non-routine diagnostic testing including, but not limited to:
    - Angiography (Arteriography).
    - Cardiac Event Monitoring.
    - Coronary Calcium Score (Heart Scan).
    - Cystometrogram (CMG).
    - Diagnostic Hearing Exams and Testing.
    - Echocardiogram Exercise Stress Test.
    - EKG Exercise Stress Test.
    - Electroencephalogram (EEG).
    - Electromyography (EMG) and Nerve Conduction Studies (NCS).
    - Gastrointestinal Motility Testing.
    - Genetic Testing.
    - Home Sleep Test & Unattended Sleep Study.
    - Attended Sleep Study (Polysomnography).
    - Non-Cardiac Angiography, Arthrography and Myelography.
    - Pulmonary Function Tests.
    - Tilt Table Testing.
    - Transthoracic Echocardiogram (TTE).
  - Routine diagnostic testing such as:
    - Diagnostic labs, pathology tests, and interpretation charges, such as blood tests, analysis of tissues, or liquids from the body.
    - Diagnostic ultrasounds and X-rays, such as fluoroscopic tests and interpretation.
- If more than one type of imaging occurs, such as an x-ray and ultrasound, on the same date of service, more than one copayment may apply.
- If more than one type of diagnostic testing occurs, such as an EKG exercise stress test and an electroencephalogram (EEG), on the same date of service, more than one copayment may apply.
- The following categories of Genetic Testing services are covered:
  - Genetic tests for cancer susceptibility.
  - Genetic tests for hereditary diseases.
  - Unspecified molecular pathology.
  - Fetal aneuploidy testing.
- Select Laboratory services and Diagnostic Testing may require Prior Authorization and Medical Necessity review.

| **Maternity Care and Delivery** | In-Network | Out-of-Network |
|---|---|---|

| | | |
|---|---|---|
| **Routine Prenatal and Postnatal Office Visits, including Labs and Tests** | $0 copayment / visit | $220 copayment / visit |
| **Newborn Nursery Care** | $0 copayment / test | $0 copayment / test |
| **Amniocentesis** | $900 copayment / test | $2,700 copayment / test |
| **Chorionic Villus Sampling (CVS)** | $950 copayment / test | $2,850 copayment / test |
| **Inpatient Delivery** | $1,500 to $3,000 copayment / stay | $9,000 copayment / stay |
| **Home Birth/Delivery** | $1,500 copayment / visit | $4,500 copayment / visit |
| **Elective Abortion - Medical** | $170 copayment / visit | $510 copayment / visit |
| **Elective Abortion – Surgical** | $275 copayment / visit | $825 copayment / visit |
| **Therapeutic Medication Abortion (Medically Necessary)** | $170 copayment / visit | $510 copayment / visit |
| **Therapeutic Surgical Abortion (Medically Necessary)** | $275 copayment / visit | $825 copayment / visit |
| **All Other Outpatient Services** | Based on place of services | Based on place of services |

Notes:

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

| **Medical Infusions, Injectables, and Chemotherapy** | In-Network | Out-of-Network |
|---|---|---|
| **Cancer Chemotherapy** | $70 - $700 copayment / visit | $290 - $2,100 copayment / visit |
| **Provider Administered Drugs** | $75 to 3,900 copayment / visit | $510 to $11,000 copayment / visit |

Notes:

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

| **Office Visit and Diagnostic Visit** | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit (including Telehealth Visit)** | $40 to $150 copayment / visit | $220 copayment / visit |
| **Mental Health Office Visit (including Telehealth Visit)** | $40 copayment / visit | $80 copayment / visit |
| **Allergy Injection Visit** | $0 copayment / visit | $220 copayment / visit |
| **Allergy Testing and Treatment** | $200 copayment / visit | $595 copayment / visit |
| **Convenience Care / Retail Visit** | $45 copayment / visit | Not Covered |
| **E-Visit and Telephone Consult with Your Physician** | $40 copayment / visit | $220 copayment / visit |
| **Outpatient Anticoagulant Management** | $30 copayment / visit | $90 copayment / visit |
| **Routine eye care (Adult) (limited to one exam for detection of an underlying medical condition, per person per plan year.** | $0 copayment / exam | $375 copayment / exam |

| | | |
|---|---|---|
| **Virtual Care** | See Virtual Care section for details | Not Applicable |

**Notes:**

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

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Office Visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Office Visit refers to face-to-face visit or Telehealth visit with your Provider.
- Multiple copayments may apply if a treatment or procedure is also performed during a visit.
- Hearing Services – Assessments with your Provider.
- Mental Health Office Visit refers to a face-to-face visit with your Provider.
- Mental Health Telehealth Visit refers to a non-face-to-face visit with your Provider.
- Nutritional Counseling that is not for preventive or mental health purposes does not have visit limits.
- Virtual Care refers to a visit with a Designated Virtual Network Provider such as Doctor on Demand, K Health. See Virtual Care Section for details.
- Convenience Care/Retail Clinics are walk-in clinics in retail stores, supermarkets, and pharmacies that treat uncomplicated minor illnesses and injuries, and provide preventive care services.
- Routine eye care (Adult) is limited to one exam for detection of an underlying medical condition, per person per plan year for In-Network and Out-of-Network Providers combined.
- If your Provider refers you for a test or service within a hospital or other facility, the Outpatient Hospital copayment may apply.
- Returning home from a visit with durable medical equipment (e.g., crutches) may result in an additional copayment.

| **Palliative Care** | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $40 to $150 copayment / visit | $220 copayment / visit |
| **Home Health Care Visit** | $80 copayment / visit | $240 copayment / visit |
| **Outpatient Hospital Visit** | $350 to $1,200 copayment / visit | $3,250 copayment / visit |

Notes:

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

| **Prescription Drugs** | In-Network | Out-of-Network |
|---|---|---|
| | Covered under the Medical Plan's Prescription Drug Program. See Part III., "The Prescription Drug Program (PDP)" (see Section J., "Overview of the Prescription | |

| | |
|---|---|
| | Drug Program," Section K., "Filling Prescriptions," and Section L., "Other Prescription-Drug-Related Services"). |

| **Preventive Care Services** | In-Network | Out-of-Network |
|---|---|---|
| | $0 copayment / visit | $220 copayment / visit |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Preventive Care Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Services include evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, Bright Futures, Health Resources and Services Administration, and Advisory Committee on Immunization Practices.
- Examples include:
  - Pediatric preventive care services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations up to age 18.
  - Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once-a-year visits from 24 months to age six.
  - Routine physical exams.
  - Routine screenings for certain cancers and other conditions. This includes mammography, breast ultrasounds, and breast MRIs.
  - Routine screening colonoscopy is covered as preventive with a diagnosis of family history.
  - Routine immunizations. Age limits may apply.
  - Routine lab tests, pathology, and radiology.
  - Hearing and vision screening limited to one exam per Plan Year for children up to age of 21.
  - Routine pre-natal and post-natal services.
  - One routine postnatal care exam provided during the period immediately after childbirth that includes a health exam, assessment, education, and counseling.
  - Preventive contraceptive methods and counseling for women.
    - Includes certain approved contraceptive methods for women with reproductive capacity, including contraceptive drugs, devices, and delivery methods.
- For Prescription Drug Coverage see Part III., "The Prescription Drug Program (PDP)" (see Section J., "Overview of the Prescription Drug Program," Section K., "Filling Prescriptions," and Section L., "Other Prescription-Drug-Related Services").
- Low-dose CT Scan (LDCT) for lung cancer screening may require Prior Authorization and Medical Necessity review.

| **Radiation Therapy and Other High Intensity Therapy** | In-Network | Out-of-Network |
|---|---|---|
| | $90 to $3,700 copayment / visit | $335 to $11,000 copayment / visit |

Notes:

- The Surest Plan provides Benefits for services received on an outpatient basis at a hospital, alternate facility, or in a Physician's office.

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

| **Reconstructive Surgery** | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $40 to $150 copayment / visit | $220 copayment / visit |
| **Outpatient Hospital** | $350 to $1,200 copayment / visit | $3,250 copayment / visit |
| **Inpatient Hospital** | $3,500 copayment / stay | $10,500 copayment / stay |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits or outpatient hospital may vary based on Provider and location.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Reconstructive Surgery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as a walker, may result in an additional copayment.
- Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an illness, injury, or congenital anomaly. The primary result of the procedure is not a changed or improved physical appearance.
- Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.
- Benefits for Reconstructive procedures include breast reconstruction following a mastectomy and Reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Surest Plan if the initial breast implant followed a mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications,

are provided in the same manner and at the same level as those for any other Covered Health Services. You can contact Surest Member Services at the number on your member ID card for more information about Benefits for mastectomy-related services.

- There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered Cosmetic procedures. An example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive procedure. In other cases, if improvement in appearance is the primary intended purpose, this would be considered a Cosmetic procedure. The Surest Plan does not provide Benefits for Cosmetic services or procedures.
- The fact that a Participant may suffer psychological consequences or socially avoidant behavior as a result of an illness, injury, or congenital anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as Reconstructive procedures.
- Reconstructive Surgery may require Prior Authorization and Medical Necessity review.

| **Rehabilitative/Habilitative Services and Other Low Intensity Therapy** | In-Network | Out-of-Network |
|---|---|---|
| **Acupuncture Visit** | $70 copayment / visit | $175 copayment / visit |
| **Aural Therapy – Post Cochlear Implant** | $30 to $200 copayment / visit | $250 copayment / visit |
| **Biofeedback** | $90 copayment / visit | $270 copayment / visit |
| **Cardiac Rehabilitation Therapy** | $100 copayment / visit | $300 copayment / visit |
| **Chiropractic Visit** | $35 copayment / visit | $80 copayment / visit |
| **Cognitive Therapy** | $20 to $155 copayment / visit | $195 copayment / visit |
| **Occupational Therapy** | $20 to $155 copayment / visit | $195 copayment / visit |
| **Physical Therapy** | $20 to $110 copayment / visit | $230 copayment / visit |
| **Speech Therapy** | $20 to $155 copayment / visit | $195 copayment / visit |
| **Pulmonary Rehabilitation Therapy** | $110 copayment / visit | $330 copayment / visit |
| **Vision Therapy** | $40 copayment / visit | $220 copayment / visit |

Notes:
Rehabilitative and habilitative services must be performed by a Physician or by a licensed therapy Provider. Benefits include services provided in a Physician's office or on an outpatient basis at a hospital, or alternate facility. Services provided in your home are provided as described under the Home Health Care section.

- Refer to the Surest mobile app for additional coverage and copayment information.
- The copayments for certain therapies may vary based on Provider and location (e.g., aural, cognitive, occupational, physical, and speech therapy).
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Rehabilitative/Habilitative Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- Acupuncture is limited to 30 visits or services per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
- Aural Therapy does not have visit limits.

- Biofeedback therapy is a non-drug treatment in which patients learn to control bodily processes that are normally involuntary, such as muscle tension, blood pressure, or heart rate.
- Cardiac Rehabilitation does not have visit limits.
- Chiropractic Visits are limited to 30 visits or services, per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
  - Chiropractic Services are limited to manipulative services including chiropractic care and osteopathic manipulation rendered to diagnose and treat acute neuromuscular-skeletal conditions.
- Occupational and Cognitive therapy visits are limited to 100 visits per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
  - Cognitive rehabilitation therapy following traumatic brain injury or cerebral vascular accident is covered when Medically Necessary.
- Physical therapy is limited to 100 visits per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
- Pulmonary Rehabilitation does not have visit limits.
- Speech therapy is limited to 100 visits per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
- Vision therapy does not have visit limits.
- Note that Occupational Therapy and Physical Therapy are different types of service and the copayment varies based on how the claim is billed.
- Therapies provided in the home will be assigned the home health care visit copayment. See Home Health Services for coverage notes.
- Therapies related to the treatment of a mental health condition, such as autism disorder, are provided under Behavioral Health – Mental Health and Substance Use Disorder services section and do not apply to limits in this section.

| **Skilled Nursing Facility Services** | In-Network | Out-of-Network |
|---|---|---|
| **Skilled Nursing Facility** | $2,700 copayment / stay | $8,100 copayment / stay |
| **Inpatient Rehabilitation Facility** | $2,750 copayment / stay | $8,250 copayment / stay |

Notes:

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

- Refer to the Surest mobile app for additional coverage information.
- Skilled Nursing Facility stays are limited to 100 days per Participant per Plan Year for In-Network and Out-of-Network Providers combined.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Skilled Nursing Facility Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- An Inpatient Rehabilitation Facility, such as a long-term acute rehabilitation center, a hospital, or a special unit of a hospital designated as an inpatient rehabilitation facility, that provides occupational therapy, physical therapy, and/or speech therapy as authorized by law.
- Benefits include:
  - Facility services for an inpatient stay in a Skilled Nursing Facility or inpatient rehabilitation facility.
  - Supplies and non-Physician services received during the inpatient stay.
  - Room and board in a semi-private room (a room with two or more beds).
  - Physician services for anesthesiologists, pathologists, and radiologists.

  - Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or inpatient rehabilitation facility for treatment of an illness or injury that would have otherwise required an inpatient stay in a hospital.
- Benefits are available only if both of the following are true:
  - The initial confinement in a Skilled Nursing Facility or inpatient rehabilitation facility was or will be a cost-effective alternative to an inpatient stay in a hospital.
  - You will receive skilled care services that are not primarily Custodial Care.
- Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:
  - Services must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
  - Services are ordered by a Physician.
  - Services are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair.
  - Services require clinical training in order to be delivered safely and effectively.
- You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Participants who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.
- The Surest Plan does not provide Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician.
- Returning home from a Skilled Nursing Facility or Inpatient Rehabilitation Facility stay with durable medical equipment, such as a walker, may result in an additional copayment.
- All Skilled Nursing Facility and Inpatient Rehabilitation Facility admissions require Prior Authorization and Medical Necessity review.
- See Hospital Services for other coverage notes.

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

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for outpatient hospital may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Transplant Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Transplants for which Benefits are available include bone marrow (including CAR T-cell therapy for malignancies), heart, heart/lung, lung, kidney, kidney/pancreas, pancreas, liver, liver/intestine, intestine, and cornea.
- Benefits are also available for cellular and gene therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility.
- Surest has identified quality designated providers for transplant services (except for corneal transplant) that are accessible through Transplant Resource Services, see Section I., "Clinical Programs and Resources," for additional information. Transplant services (except for corneal transplant) must be rendered at a designated provider.

- All Participants undergoing transplant services (except for corneal transplant) must enroll in Transplant Resource Services, which is a care coordination program for patients undergoing transplants.
- Benefits are available to the donor and the recipient when the recipient is covered under the Surest Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage.
- Surest has specific guidelines regarding Benefits for transplant services. Contact Surest Member Services at the number on your member ID card for information about these guidelines.
    - The Surest Plan provides Benefits for expenses for travel and lodging. See Section I. "Clinical Programs and Resources" for more information.

| **Treatment / Tests / Therapies** – Go to Surest mobile app **or** Benefits.Surest.com website for additional information | In-Network | Out-of-Network |
|---|---|---|
| • **Level 1:** Generally, minor procedures or treatments that are typically performed in an outpatient office setting (e.g., biofeedback, needle biopsy, pain management procedures, etc.) | $40 to $4,300 copayment / visit | $270 to $11,000 copayment / visit |
| • **Level 2:** Generally, minor procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting (e.g., bronchoscopy, etc.) | $0 to $4,400 copayment / visit | $620 to $11,000 copayment / visit |
| • **Level 3:** Generally, major procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting but may be performed in an inpatient hospital setting (e.g., thyroid surgery, prostate surgery, etc.) | $300 to $4,500 copayment / visit/stay | $2,175 to $11,000 copayment / visit/stay |
| • **Level 4:** Generally, major procedures, surgeries, or treatments that are typically performed in an inpatient hospital but may be performed in an outpatient hospital setting (e.g., colon surgery, small bowel surgery, etc.) | $600 to $4,500 copayment / visit/stay | $10,200 to $911,000 copayment / visit/stay |
| • **Level 5:** Generally, major procedures, surgeries, or treatments that require intensive monitoring and are performed in an inpatient hospital setting (e.g., bone marrow and solid organ transplant, brain tumor surgery, coronary artery bypass graft surgery, etc.) | $2,150 to $4,500 copayment / visit/stay | $10,800 to $11,000 copayment / visit/stay |
| **Other Treatments/Tests/Therapies:** refer to the Surest mobile app or Benefits.Surest.com website for coverage and copayment information or call Surest Member Services. Copayments may vary based on Provider, location and treatment, test, or therapy. | | |
| • **Office Visits** | $40 to $150 copayment / visit | $220 copayment / visit |
| • **Outpatient Hospital Visit** | $350 to $1,200 copayment / visit | $3,250 copayment / visit |
| • **Inpatient Hospital** | $3,500 copayment / stay | $10,500 copayment / stay |

Notes:

- Refer to the Surest mobile app for additional coverage information and for the copayment assigned to your procedure/service.
- The copayments above apply unless a Benefit is specified in another section of this SPD, Surest mobile app or Benefits.Surest.com website.
- Copayments for outpatient hospital may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Treatment / Tests / Therapies copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Treatment, tests, and therapies have been tiered based on type and level (minor vs. major) of care. Some minor treatments or procedures are either included in the office visit copayment or may have a specific copayment based on the Provider and location selected. Some surgical procedures also have specific copayments based on the Provider or location selected.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Copayments for Procedures in Level 1 – Level 5 may vary based on Provider and location. Refer to the Surest mobile app, or call Surest Member Services to determine the copayment assigned to your procedure/service.
  - Level 1 is a category of minor procedures typically performed in an outpatient office setting.
  - Level 2 is a category of minor surgeries and procedures, or services typically performed in an outpatient hospital setting.
  - Level 3 is a category of major surgeries and procedures typically performed in an outpatient hospital setting.
  - Level 4 is a category of major surgeries and procedures typically performed in an inpatient hospital setting.
  - Level 5 is a category of major surgeries and procedures that require intensive monitoring and typically performed in an inpatient hospital setting. Transplant services must be rendered at a location specified as a designated provider.
- Copayments for office visits or outpatient hospital visits may vary based on Provider and location. Refer to the Surest mobile app, or call Surest Member Services to determine the copayment assigned to your procedure/service.
- Inpatient hospitalization/stay Benefits include:
  - Physician and non-Physician services, supplies, and medications received during an inpatient stay.
  - Facility charges, including room and board in a semi-private room (a room with two or more beds).
  - Physician services for lab tests, anesthesiologists, pathologists, radiologists, and Emergency room Physicians.
  - The Surest Plan will allow the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.
- If you are admitted to inpatient from the Emergency department or from observation, the Emergency room copayment or Observation Stay copayment will be waived, and you will be responsible for the Inpatient Hospital Services copayment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as a walker, may result in an additional copayment.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.
- Select office-based and outpatient procedures may require Prior Authorization and Medical Necessity review.

| **Urgent Care** | In-Network | Out-of-Network |
|---|---|---|
| **Urgent Care Visit** | $125 copayment / visit | $375 copayment / visit |

Notes:

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

| **Virtual Care – Designated Provider** | In-Network | Out-of-Network |
|---|---|---|
| **Virtual Primary and Urgent Care** | $0 copayment / visit | Not Covered |
| **Virtual Mental Health & Substance Use Disorder Care** | $40 to $100 copayment / visit | Not Covered |
| **Virtual Specialty Care** | $0 to $150 copayment / visit | Not Covered |

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Please see the Behavioral Health and Office Visit sections for additional information on Telehealth Visits with your Provider.
- Virtual visits are Covered Health Services that include the diagnosis and treatment of medical and mental health conditions for Participants that can be appropriately managed virtually within the scope of practice of the virtual providers, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner. Virtual care provides communication of medical information between the patient and Provider, through use of interactive audio and video communications equipment or through federally compliant secure messaging applications outside of a medical facility (for example, from home or from work).
- Copayments will vary based on Provider. If you choose a Provider that is not a Designated Virtual Network Provider (Other Virtual Provider), see Office Visit section for additional Virtual or Telehealth Visit copayment information. Benefits are available only when services are delivered through a Designated Virtual Network Provider that are specified by your Surest Plan.
- Please visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services to locate a Designated Virtual Provider.
- No virtual visit coverage for Out-of-Network Providers.
- Please note that not all medical conditions can be treated through virtual visits. The Designated Virtual Provider will identify any condition for which in-person Physician contact is needed.

## Section H. Exclusions and Limitations--What the Surest Options Do Not Cover and Prior Authorization and Pre-Admission Notification Requirements

The Surest options under the Medical Plan do not provide Benefits for the following services, treatments, or supplies (including items or services that are related to the services, treatments, or supplies listed below, but which are not specifically listed below) even if they are recommended or prescribed by a Provider or are the only available treatment for your condition, unless specifically described or listed in Section F., "What's Covered Under the Surest Enhanced Option," or Section G., "What's Covered Under the Surest Standard Option" (as applicable). Select services also require Prior Authorization or Pre-Admission Notification to be covered. See the final section of this Section H for details.

Please note that, in listing services or examples in this Section H, the words "this includes" and "including but not limiting to" are not intended to reflect or imply a limit to the exclusion (i.e., to the description of the excluded services or to the examples). Where the Surest options do provide a limit to a list of services or examples, this Section H specifically states that the list "is limited to."

**Alternative Treatments**

1. Aromatherapy.

2. Art therapy, dance therapy, horseback therapy, music therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.

3. Health care services ordered or rendered by Providers or para-professionals unlicensed by the appropriate regulatory agency.

4. Holistic medicine and services, including dietary supplements.

5. Homeopathic or naturopathic medicine, including dietary supplements.

6. Hypnotism.

7. Massage therapy that is not physical therapy or prescribed by a licensed Provider as a component of a multi-modality rehabilitation treatment plan.

8. Rolfing.

9. Vocational therapy.

**Appliances**

See Devices, Appliances, Supplies and Prosthetics.

**Behavioral Health: Mental Health/Substance Use Disorder**

10. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

11. Inpatient or intermediate or outpatient care services that were not pre-authorized.

12. Investigational therapies for treatment of Autism Spectrum Disorders.

13. Non-medical 24-hour withdrawal management which is an organized residential service, including those defined in the American Society of Addiction Medicine (ASAM) criteria providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

14. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association.

15. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, and paraphilic disorders.

16. Outside of initial assessment, unspecified disorders for which the Provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association.

17. School-based Intensive Behavioral Therapies (IBT) service or services that are otherwise covered under the Individuals with Disabilities Education Act (IDEA).

18. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association.

19. Transitional living services.

20. Tuition for or services that are school based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.

21. Intense Early Intervention Using Behavioral Therapy (IEIBT) and Lovaas. This exclusion does not apply when required for the treatment of Autism Spectrum Disorders.

22. Vagus nerve stimulator treatment for the treatment of depression and quantitative electroencephalogram treatment of behavioral health conditions.

23. Wilderness, adventure, camping, outdoor, or other similar programs.

**Custodial Care**

See Types of Care

**Dental**

24. Dental braces (orthodontics).

25. Dental care (which includes dental X-rays, supplies, and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental and Medical in Sections F., "What's Covered Under the Surest Enhanced Option," and Section G, "What's Covered Under the Surest Standard Option". This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition or as the result of an accident for which Benefits are available under the Plan.

26. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

27. Dental implants, bone grafts, and other implant-related procedures.

28. Endodontics, periodontal surgery, and restorative treatments are excluded.

29. Preventive care, diagnosis, and treatment of or related to the teeth, jawbones, or gums.

30. Oral surgery and anesthesia for removal of impacted teeth, removal of a tooth root without removal of the whole tooth, and root canal therapy.

31. Mandibular staple implant provided the procedure is not done to prepare the mouth for dentures.

32. Facility Provider and anesthesia services rendered in a Provider facility setting in conjunction with non-covered dental procedures when determined by the Claims Administrator to be Medically Necessary and appropriate due to your age and/or medical condition.

33. The correction of a non-dental physiological condition which has resulted in a severe functional impairment.

34. Removal of erupted or impacted teeth (unless required as the result of an accident or medical condition).

35. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a congenital anomaly.

**Devices, Appliances, Supplies and Prosthetics**

36. Birthing tub.

37. Cranial banding except when Medically Necessary for the treatment of plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape).

38. Devices and computers to assist in communication and speech, except as described in Section F., "What's Covered Under the Surest Enhanced Option," or Section G., "What's Covered Under the Surest Standard Option" (as applicable). Examples of not covered items include iPads and Android tablets

39. Devices used specifically as safety items or to affect performance in sports-related activities.

40. Disposable supplies for home use such as, but not limited to Ace-type bandages, antiseptics, bandages, diapers, dressings, incontinence supplies, gauze, and tape.

41. Home testing devices and monitoring equipment except as specifically provided in Section F., "What's Covered Under the Enhanced-Surest Option," or Section G., "What's Covered Under the Standard-Surest Option" (as applicable).

42. Household equipment, household fixtures, and modifications to the structure of the home, escalators or elevators, hot tubs and saunas, ramps, swimming pools, whirlpools, wiring, plumbing, or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, hypo-allergenic pillows, mattresses, water purifiers, or waterbeds.

43. Oral appliances for snoring.

44. Orthotic appliances and devices that straighten or re-shape a body part. Examples of excluded orthotic appliances and devices include but are not limited to some types of braces, and arch supports, and include orthotic braces available over the counter.

45. Over-the-counter medical equipment or supplies such as saturation monitors, prophylactic knee braces, and bath chairs that can be purchased without a prescription even if a prescription has been ordered.

46. Repairs to prosthetic devices due to misuse, malicious damage, or gross neglect.

47 Replacement of prosthetic devices due to misuse, malicious damage, or gross neglect or to replace lost or stolen items.

48. Shoes. This exclusion does not apply to therapeutic, custom-molded shoes when prescribed by a Physician.

49. Shoe orthotics. This exclusion does not apply to therapeutic shoe orthotics when prescribed by a Physician.

50. Supplies, equipment, and similar incidentals for personal comfort. Examples include air conditioners, air purifiers, exercise equipment, humidifiers, Jacuzzis, recliners, saunas, and vehicle modifications such as van lifts.

51. Vehicle/car or van modifications including, but not limited to, car carriers, handbrakes, and hydraulic lifts.

**Domiciliary Care**

See Types of Care.

**Drugs (under the medical plan)**

52. Charges for giving injections that can be self-administered.

53. Drugs dispensed by a Physician or Physician's office for outpatient use.

54. Investigational or non-FDA-approved drugs.

55. Non-prescription supplies.

56. Over-the-counter drugs, except as specified in Part III., "The Prescription Drug Program (PDP)" (see Section J., "Overview of the Prescription Drug Program," Section K., "Filling Prescriptions," and Section L., "Other Prescription-Drug-Related Services").

57. Certain new prescription medications or products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

This exclusion does not apply if you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening sickness or condition, under such circumstances, Benefits may be available for the new prescription medications or product to the extent provided in Section F., "What's Covered Under the Surest Enhanced Option," or Section G., "What's Covered Under the Surest Standard Option" (as applicable).

58. A pharmaceutical product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product. Such determinations may be made up to six times during a calendar year.

59. A pharmaceutical product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product. Such determinations may be made up to six times during a calendar year.

60. A pharmaceutical product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product. For the purpose of this exclusion a "biosimilar" is a biological pharmaceutical product approved based on showing that it is highly similar to a reference product (a biological pharmaceutical product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

61. Selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects.

62. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Participants for self-administration

63. Vitamin or dietary supplements, except as specified in Part III., “The Prescription Drug Program (PDP)” (see Section J., “Overview of the Prescription Drug Program,” Section K., “Filling Prescriptions,” and Section L., “Other Prescription-Drug-Related Services”).

**Experimental or Investigational or Unproven Services**

64. Intracellular micronutrient testing.

65. Services that are considered Experimental or Investigational as determined by Surest are excluded. The fact that an Experimental or Investigational treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational in the treatment of that particular condition. To find out additional information, call Surest Member Services.

**Foot Care**

66. Routine foot care. Examples include:

a) Cutting or removal of corns and calluses.

b) Nail trimming, nail cutting, or nail debridement.

c) Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.

67. Treatment of flat feet.

68. Treatment of subluxation of the foot.

69. Shoes. This exclusion does not apply to therapeutic, custom-molded shoes when prescribed by a Physician.

70. Shoe orthotics. This exclusion does not apply to therapeutic shoe orthotics when prescribed by a Physician.

71. Shoe inserts.

72. Arch supports.

**Gender Dysphoria Services**

73. Cosmetic procedures related to a diagnosis of Gender Dysphoria, including:

a) Buttock lift.

b) Calf implants/augmentation.

c) Chemical peels.

d) Dermabrasion.

e) Ear reduction (Otoplasty).

f) Fertility preservation services.

g) Gluteal augmentation.

h) Laser or electrolysis hair removal not related to genital reconstruction.

i) Neurotoxins.

j) Piercing.

k) Scalp tissue transfer (scalp advancement).

l) Treatment for hair growth.

m) Wrinkle removal.

**Hearing**

See Vision, Hearing and Voice.

**Infertility**

See Reproduction.

**Mental Health**

See Behavioral Health: Mental Health/Substance Use Disorder.

**Nutrition**

74. Enteral feedings and other nutritional and electrolyte formulas, including infant formula, blenderized food, and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under Enteral Nutrition in Section F., "What's Covered Under the Surest Enhanced Option," or Section G., "What's Covered Under the Surest Standard Option" (as applicable).

75. Nutritional or Cosmetic therapy using high-dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high-protein foods and low-carbohydrate foods).

**Physical Appearance**

76. Breast reduction surgery that is determined to be a Cosmetic procedure except as required by the Women's Health and Cancer Rights Act of 1998.

77. Cosmetic procedures such as:

a) Hair removal or replacement by any means, except for hair removal as part of a genital reconstruction procedure by a physician for the treatment of Gender Dysphoria.

b) Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under Reconstructive Procedures in Section F., "What's Covered Under the Surest Enhanced Option," or Section G., "What's Covered Under the Surest Standard Option" (as applicable).

c) Pharmacological regimens, nutritional procedures, or treatments.

d) Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures).

e) Skin abrasion procedures performed as a treatment for acne.

f) Treatments for hair loss.

g) Treatments for skin wrinkles or any treatment to improve the appearance of the skin.

h) Treatment for spider veins of the lower extremities when it is considered Cosmetic.

i) Varicose vein treatment of the lower extremities when it is considered Cosmetic.

78. Excision or removal of hanging skin on any part of the body, unless determined to be Medically Necessary. Examples include plastic surgery procedures called abdominoplasty, brachioplasty, and panniculectomy.

79. Physical conditioning programs such as athletic training, bodybuilding, diversion or general motivation, exercise, fitness, flexibility, health club memberships and programs, and spa treatments.

80. Reconstructive surgery where there is another more appropriate covered surgical procedure or when the proposed Reconstructive surgery offers minimal improvement in your appearance. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

81. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic procedure.

82. Treatment of benign gynecomastia (abnormal breast enlargement in males) unless deemed to be medically necessary.

83. Weight loss programs, whether or not they are under medical supervision or for medical reasons, even if for morbid obesity, except as described in Section I., “Clinical Programs and Resources.”

**Procedures and Treatments**

84. Chelation therapy, except to treat heavy metal toxicity and overload conditions.

85. Helicobacter pylori (H. pylori) serologic testing.

86. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

87. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain injury or cerebral vascular accident.

88. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

89. Rehabilitation services and manipulative treatment to improve general physical condition and not therapeutic in nature that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term, or maintenance/preventive treatment.

90. Rehabilitation services for speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, congenital anomaly, or Autism Spectrum Disorder.

91. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care Providers specializing in smoking cessation and may include a psychologist, social worker, or other licensed or certified professional. The programs usually include behavior modification techniques, intensive psychological support, and medications to control cravings.

**Prosthetics**

See Devices, Appliances, Supplies and Prosthetics.

**Providers**

92. Services ordered or delivered by a Christian Science practitioner.

93. Services performed by a Provider who is a family member by birth or marriage, including your spouse, domestic partner, brother, sister, parent, or child. This includes any service the Provider may perform on himself or herself.

94. Services performed by a Provider with your same legal residence.

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

**Reproduction**

96. The following fertility treatment-related services, except as described in Section F., "What's Covered Under the Surest Enhanced Option," or Section G., "What's Covered Under the Surest Standard Option" (as applicable):

a) All charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to, fees for laboratory tests.

b) All costs associated with surrogate parenting including, but not limited to, donor oocytes (eggs), donor sperm and host uterus.

c) Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

c) Cloning.

d) Cryopreservation and other forms of preservation of reproductive materials except as described under Fertility Treatment. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described under Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services in Section 5.1 (Covered Health Services).

e) Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.

f) Donor services and non-medical costs of oocyte or sperm donation (e.g., donor agency fees).

g) Embryo or oocyte accumulation, defined as a fresh oocyte (egg) retrieval prior to the depletion of previously banked frozen embryos or oocytes (eggs).

h) Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.

i) Ovulation predictor kits.

j) Reversal of voluntary sterilization.

k) Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).

l) Infertility treatment following unsuccessful reversal of voluntary sterilization.

m) Infertility Treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

n) Pre-implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer in order to increase the chance for conception.

o) Services for partners, spouses, and the maternity expenses of gestational carriers not covered by the Surest Plan.

p) Treatments considered Experimental by the American Society of Reproductive Medicine.

q) Services and supplies furnished by an out-of-network Provider.

**Services Provided Under Another Plan**

97. Services for which coverage is available:

a) For treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you.

b) Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

c) Under another medical plan, except for Eligible Expenses, or Recognized Amount when applicable, payable as described in this SPD.

d) Under Workers' Compensation or similar legislation if you could elect it or could have it elected for you.

e) While on active military duty.

f) Under Nokia's Global Business Travel Insurance and the related local policy.

**Substance Abuse**

See Behavioral Health: Mental Health/Substance Use Disorder.

**Substance Use Disorder**

See Behavioral Health: Mental Health/Substance Use Disorder.

**Supplies**

See Devices, Appliances, Supplies and Prosthetics.

**Transplants**

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

99. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's medical coverage.)

**Travel**

100. Travel or transportation expenses, even if ordered by a Physician, except as identified under "Travel and Lodging Expenses" in Section I., "Clinical Programs and Resources." This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Sections F and G, "What's Covered Under the Surest Enhanced Option" and "What's Covered Under the Surest Standard Option".

**Types of Care**

101. Custodial Care.

102. Domiciliary Care.

103. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

104. Respite care, except as defined under Hospice Care in Section F., "What's Covered Under the Surest Enhanced Option," or Section G., "What's Covered Under the Surest Standard Option" (as applicable).

105. Rest cures.

106. Services of personal care attendants.

107. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

**Vision, Hearing and Voice**

108. Routine eye exam including refraction.

109. Implantable lenses used only to correct a refractive error such as radial keratotomy or related procedure, and artificial retinal devices or retinal implants.

110. Refractive surgery (e.g., Lasik) for ophthalmic conditions that are correctable by contact lenses or glasses.

111. Eyeglasses, contact lenses and any fittings associated with them except as identified in Section F., "What's Covered Under the Surest Enhanced Option," or Section G., "What's Covered Under the Surest Standard Option" (as applicable).

112. Surgery and other related treatment that is intended to correct farsightedness, nearsightedness, presbyopia, and astigmatism, including but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

113. Bone-anchored hearing aids except when either of the following applies:

a) For Participants with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

b) For Participants with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

The Plan will not pay for more than one bone-anchored hearing aid per Participant who meets the above coverage criteria during the entire period of time the Participant is enrolled in the Plan. In addition, repairs and/or replacement for a bone-anchored hearing aid for Participants who meet the above coverage are not covered, other than for malfunctions.

114. Any type of communicator, electronic voice producing machine, voice enhancement, voice prosthesis, or any other language assistive devices.

**Voice**

See Vision, Hearing and Voice.

**All Other Exclusions**

115. Autopsies and other coroner services and transportation services for a corpse.

116. Charges for:

a) Completion of Claim forms.

b) Missed appointments.

c) Record processing.

d) Room or facility reservations.

117. Charges prohibited by federal anti-kickback or self-referral statutes.

118. Direct-to-consumer retail genetic tests.

119. Expenses for health services and supplies:

a) For which the Participant has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.

b) That are received after the date the Participant's coverage ends, including health services for medical conditions which began before the date the Participant's coverage ends.

c) That are received as a result of war or any act of war, whether declared or undeclared, or caused during services in the armed forces of any country. This exclusion

does not apply to Participants who are civilians injured or otherwise affected by war, any act of war, or terrorism in a non-war zone.

d) That exceed Eligible Expenses, or the Recognized Amount when applicable, or any specified limitation in this SPD.

120. Foreign language and sign language services.

121. Health care services that Surest determines are not Medically Necessary.

122. Long-term (more than 30 days) storage of blood, umbilical cord, or other material (e.g., cryopreservation of tissue, blood, and blood products).

123. Over-the-counter self-administered home diagnostic tests (except direct-to-consumer/home-based tests), including but not limited to HIV, ovulation, and pregnancy tests.

124. Physical, psychiatric, or psychological exams, testing, and all forms of vaccinations and immunizations, or treatments when:

a) Conducted for purposes of medical research.

b) Related to judicial or administrative proceedings or orders, unless determined to be Medically Necessary.

c) Required solely for purposes of adoption, career or employment, education, insurance, marriage, sports or camp, travel, or as a result of incarceration.

d) Required to obtain or maintain a license of any type.

125. Health care services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services that would otherwise be determined to be a Covered Health Service if the service treats complications that arise from the non-Covered Health Service. For the purpose of this exclusion a “complication” is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition.

126. In the event an Out-of-Network Provider waives, does not pursue, or fails to collect, copayments or other amount owed for a particular health care service, no Benefits are provided for the health care service when the copayments are waived, not pursued, or not collected.

**Prior Authorization and Pre-Admission Notification**

Select services require Prior Authorization or Pre-Admission Notification. Prior Authorization is required by service type, regardless of whether the service is rendered by in-network or out-of-network Providers.

In-network Providers are responsible for obtaining Prior Authorization for select Covered Health Services and are responsible for Pre-Admission Notification for planned inpatient admissions and post-admission notification at least 24 hours of admission of Emergency inpatient admissions. Prior Authorization is not required for flexible coverages; however, if the procedure is being performed in an inpatient setting, the Provider is responsible for Pre-Admission Notification at least 24 hours prior to admission. Inpatient stays will be reviewed for Medical Necessity, length of stay, and level of care. All acute inpatient rehabilitation (AIR) admissions, long-term acute care (LTAC) admissions, and Skilled Nursing Facility (SNF) admissions are subject to Medical Necessity review pre-admission. If you have questions about Prior Authorization or Pre-Admission Notification, please contact Surest Member Services.

If you are using an out-of-network Provider, you are responsible for ensuring that any necessary Prior Authorizations and Pre-Admission Notifications have been obtained or the services may not be covered by the Surest Plan. Contact Surest Member Services prior to obtaining services to determine whether Prior Authorization is required or ask your Provider to contact the pre-certification number on your member ID card.

If your Prior Authorization or Pre-Admission Notification is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request expedited review). This information can also be found in Section 8 (What Do I Do If My Claim Is Denied).

The Prior Authorization list is subject to change without notice. The most current information can be obtained by having your Provider contact the pre-certification number on your member ID card or call Surest Member Services.

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

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

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

# Section I. Clinical Programs and Resources

**Overview**

The Medical Plan offers the following clinical programs and resources for participants:

- Diabetes Reversal (Virta)
- Kaia Health
- Maternity Support Program
- Ardynn
- Real Appeal
- Surest Care Management
- Surest Digital Health Solutions
- Transplant Resource Services
- Travel and Lodging Expenses, and
- Transition of Care and Continuity of Care.

Each of these is described below.

**Diabetes Reversal (Virta)**

Surest offers a personalized virtual diabetes control clinic focused on nutritional changes, medication changes, and biomarker feedback with the goal of helping implement lifestyle changes to reverse diabetes. The program is for Type-2 diabetics who meet certain criteria. To find out additional information, visit the Surest mobile app or Benefits.Surest.com website, call Surest Member Services, or go to https://www.virtahealth.com/join/surest.

**Kaia Health**

Kaia is a digital therapy app for various fitness levels and lifestyles. Kaia offers a personalized therapy program that addresses both the causes and symptoms of pain. Surest has partnered with Kaia to offer you and your dependents access to Kaia at no additional cost. When you sign up with Kaia, you'll immediately gain access to their clinically validated therapy, including:

- Personalized exercises.
- One-on-one coaching.
- Whole-person mind-body training.
- Wellness education.
- Advanced motion analysis technology.

Learn more about Kaia and sign up at startkaia.com/surest.

**Maternity Support Program**

Surest offers a maternity support program with round-the-clock access to maternity nurses, lactation consultants, and early childhood experts. To find out additional information, visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services, or go to https://www.pacify.com/surest/.

**Ardynn**

Ardynn, powered by PotentiaMetrics, is a decision support service that helps people and their families understand survival statistics and the likely outcomes of different treatment options for a cancer diagnosis. Ardynn's big data platform leverages the largest cancer outcomes dataset of its kind to help cancer patients find answers to questions about cancer that can affect their quality of life. In addition, Ardynn advocates are trained to identify and help resolve common frustrations and can help guide members throughout their cancer experience. For additional information, visit the Surest mobile app, Benefits.Surest.com website, call Surest Member Services, or go to www.ardynn.com/surest.

**Real Appeal**

The Real Appeal weight loss program is a step-by-step, guided program personalized to each member. The program provides tools, information and ongoing support and guidance aimed at helping members achieve their weight loss goals. For those who qualify, the program is free of charge. Enrollment and participation in the program are accessible via Real Appeal.

**Incentives Available to You**

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

**Surest Care Management**

Surest Care Management offers support to help you use your Benefits under the Medical Plan's Surest options, improve your health, and achieve an optimal quality of life.

Surest Care Management's care managers act as an advocate for you and your family by:

- Assisting you in making important health care decisions.
- Coordinating your care with your health care Providers.
- Helping you develop self-management skills.

- Identifying available treatment options.
- Offering personalized coaching to help you live better with an illness or recover from an acute condition.
- Researching resources, such as Care Model Digital Health Solutions (see below), support groups, and financial assistance.

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

It is your choice to participate in Surest Care Management. There are no extra charges for these services, and you can end your participation at any time, for any reason. Participation in this program will not affect your Benefits. Contact Surest Member Services if you think you can use this support. See Section V., "Important Contacts," for information on how to contact Surest Member Services.

**Surest Digital Health Solutions**

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

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

**Transplant Resource Services**

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

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

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

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

**Travel and Lodging Expenses**

Travel and lodging assistance is only available for you or your covered Eligible Dependents if you meet the qualifications for the benefit. The benefit only applies for transplant services. The Plan covers expenses for travel and lodging for the patient, provided the patient is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles (unless otherwise noted) from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- An annual maximum of $2,000 and a lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures and care.
- Services must be received either through an In-Network provider or at an out of network provider approved through a gap exception prior to receiving care. Services must be received at the nearest available designated provider in order to be eligible.
- The Claims Administrator must receive valid receipts for such charges before you will be reimbursed after travel has taken place. Reimbursement is as follows:

*Lodging*

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

  Examples of items that are not covered:
  - Groceries.
  - Alcoholic beverages.
  - Personal or cleaning supplies.
  - Meals.
  - Over-the-counter dressings or medical supplies.
  - Deposits.

- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

*Transportation*

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

**Transition of Care and Continuity of Care**

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

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

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

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

- **Transition of Care**: You are newly eligible for the Surest Plan and currently receiving care for a Covered Health Service by an In-Network Provider and your Provider is no longer In-Network under the Surest Plan.

- **Continuity of Care**: You are currently enrolled in the Surest Plan and actively receiving care for a Covered Health Services by an In-Network Provider, who subsequently leaves the network and becomes an Out-of-Network Provider.

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

- **Inpatient and Residential Care:** If you are actively receiving inpatient or residential care at a Provider that was In-Network and becomes Out-of-Network, you may qualify for Transition of Care or Continuity of Care Benefits to cover the duration of the inpatient or residential care stay.
- **Recent Major Surgery:** If you have had a recent surgery or procedure with an In-Network provider who becomes out-of- network, are in the acute phase and follow-up period (generally six to eight weeks after surgery) you may qualify for Transition of Care or Continuity of Care.
- **Scheduled Surgery/Procedure:** If you are scheduled to undergo a nonelective surgery or procedure with an In-Network Provider who becomes Out-of-Network, you may qualify for Transition of Care or Continuity of Care Benefits.
- **Pregnancy:** If you are pregnant and receiving care from a Provider who was In-Network and becomes Out-of-Network, you may qualify for Transition of Care or Continuity of Care Benefits.
- **Serious Chronic Condition:** If you are actively being treated for a serious chronic medical condition which may persist or worsen if care is delayed and are receiving care from a Provider who was In-Network and becomes Out-of-Network, you may qualify for Transition of Care or Continuity of Care Benefits.
- **Terminal Illness:** If you have an incurable or irreversible condition that has a probability of causing death within one year or less and are receiving care from a Provider who was In-Network and becomes Out-of-Network, you may qualify for Transition of Care or Continuity of Care Benefits.
- **Transplant:** If you are a transplant candidate or the recipient of an organ transplant and in need of ongoing care due to complications associated with the transplant and are receiving care from a Provider who was In-Network and becomes Out-of-Network, you may qualify for Transition of Care or Continuity of Care Benefits.

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

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

# Section J. Overview of the Prescription Drug Program

## About the Prescription Drug Program Generally

If you enroll in the Surest Enhanced or Surest Standard medical option, you are automatically covered under the Prescription Drug Program, which is administered separately by CVS Caremark.

Note: There are certain words and phrases that have specific meanings under the Medical Plan, including the Prescription Drug Program. These terms are printed in initial capital letters and are defined in Section B., "Terms You Should Know."

## What's Covered Under the Prescription Drug Program

*Overview*

Generally, the Prescription Drug Program covers:

- Drugs prescribed by a Physician and provided by a pharmacist (but see below, "What's Not Covered", for exceptions)
- Birth control medications and contraceptive devices (including oral contraceptives, implants and injections)
- Insulin
- Disposable supplies ordered by a Physician for a diabetic patient, including needles and syringes
- Blood and urine testing supplies,
- Seasonal, non-seasonal and travel vaccines offered under the broad retail vaccination network,
- Prescription (not over-the-counter) smoking deterrents (including nicotine products such as inhalers and nasal sprays), and
- Certain weight-loss drugs with prior authorization.

*Prescription-Drug Formulary*

The Prescription Drug Program uses the CVS Caremark formulary. A formulary is a list of commonly prescribed medications that have been shown to be clinically effective as well as cost effective. If your doctor prescribes formulary medications, you can help control rising health care costs while still maintaining high-quality care. The Formulary Drug List is available online at www.caremark.com or by calling CVS Customer Care at 1-800-240-9623.

The CVS Caremark formulary is reviewed and updated on a quarterly basis. Additionally, Products with egregious cost inflation that have readily available, clinically appropriate and more cost-effective alternatives may be evaluated and potentially removed from the formulary at additional times.

Because the formulary is subject to change, you should consult CVS Caremark before filling a prescription to ensure you have the most current information.

If you choose to purchase a brand medication not on the formulary, referred to as a Nonpreferred Brand, you will be responsible for paying a higher copayment or coinsurance, as applicable. If there is a clinical reason why you cannot take the formulary (Preferred Brand) medication, you can request an appeal through CVS Caremark by calling Customer Care at 1-800-240-9623. If the appeal is approved, you will only be charged the Preferred Brand copayment or coinsurance. This approval is valid for one year.

Under the Prescription Drug Program, there may be times when you use a participating pharmacy and are filling a prescription with a Nonpreferred brand-name drug. The pharmacist will receive a message stating the status of the medication is non-formulary (or Nonpreferred). Your retail pharmacist may decide to discuss with your physician whether an alternative drug listed on the formulary might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative drug. If you prefer to have the originally prescribed medication, you have the option to refuse the alternative medication before it is filled and to request the pharmacist fill the prescription as it was originally written. However, you will be responsible for paying the higher, Nonpreferred Brand copayment or coinsurance.

When you order through the mail-order program, the pharmacist may also decide to discuss with your physician whether an alternative medication listed on the formulary might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative medication and a confirmation letter will be sent to you and your physician explaining the change.

Let your physician know if you have any questions about a change in prescription. Your physician always makes the final decision about what medication to prescribe for you.

*Drugs Requiring Authorization*

Certain medications must be authorized for specific conditions before they are eligible for coverage. CVS Caremark will work with you, your pharmacist and your Physician to secure the necessary confirmation. The list of these drugs changes from time to time as new drugs are approved, new clinical guidelines for appropriate use are developed or problems are identified. Visit the CVS Caremark Web site or call CVS Caremark for a list of medications requiring authorization.

*Drugs Subject to Quantity Limits*

Some medications are subject to quantity limits. Visit the CVS Caremark Web site or call CVS Caremark for a list of medications that are subject to quantity limits.

*Specialty Medications*

Complex conditions, such as the following, are treated with specialty medications:

- Anemia
- Cancer
- Growth hormone deficiency
- Hepatitis C
- Multiple sclerosis, and
- Rheumatoid arthritis.

Specialty medications are often injectable medications administered either by the individual or a healthcare professional. These medications require special handling.

If you are using specialty medications, you receive them through CVS Caremark's specialty care pharmacy — CVS Specialty®. This specialty care pharmacy also provides customer support related to complex conditions. CVS Caremark's specialty care pharmacy can be reached at 1-800-237-2767.

**What's Not Covered Under the Prescription Drug Program**

The Prescription Drug Program does not cover, and will not pay any benefits for:

- Drugs and medicines provided (or that can be obtained) without a prescription from a Physician
- Non-federal legend drugs
- Prescription drugs with an over-the-counter (OTC) equivalent
- OTC contraceptives, jellies, creams, foams, and devices
- Plan B/Plan B One-Step through age 17 and older
- Diabetic blood testing monitors
- Isopropyl alcohol solution
- Insulin pumps
- Kutapressin
- Ostomy supplies
- Foreign drugs
- Mifeprex (but this might be covered under the Enhanced-Surest or Standard-Surest options or other medical portion of the Plan)
- Therapeutic devices or appliances
- Drugs used solely to promote hair growth for cosmetic purposes only
- Immunization agents, vaccines or biologicals (except if listed as covered)
- Allergy sera (serums)

- Blood or blood plasma (except if listed as covered)
- Patch, kit and most compounds
- Drugs labeled "Caution — limited by federal law to investigational use" or Experimental Drugs even if you are charged for those drugs
- Drugs used for Experimental or Investigational purposes
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or local governmental agency or any drug or medical service furnished at no cost to the covered individual
- Medication provided to a covered individual while a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility (for example, a Skilled Nursing Facility), convalescent Hospital, nursing home, Home Health Care Agency or similar institution that has a facility for dispensing pharmaceuticals on its premises
- Prescriptions filled in excess of the refill number specified by the Physician or any refill dispensed one year after the original prescription
- Charges for the administration or injection of any drug
- Nutritional dietary supplements
- Any drug or medicine not Medically Necessary to treat the condition, and
- Prescriptions filled through the mail that exceed the 90-day limit.

**Cost Sharing**

Your cost varies depending on how you choose to fill your prescription as well as by the three levels of Copayments/Coinsurance available under the Prescription Drug Program:

- Generic
- Preferred Brand, and
- Nonpreferred Brand.

*Separate Out-of-Network Annual Deductible*

The Prescription Drug Program Out-of-Network annual Deductible is separate from any Deductible you may be required to pay under your medical option. After you meet the program's annual Deductible, you'll be responsible for the Copayment/Coinsurance calculated on the Allowable Amount for covered medications. You'll be reimbursed for the remaining amount.

*Separate Out-of-Pocket Maximum*

The Out-of-Pocket Maximum applies to Copayments/Coinsurance for prescription drugs filled through Network Retail Pharmacies or the mail service. It doesn't apply to prescriptions filled at non-network pharmacies.

The Prescription Drug Program Out-of-Pocket Maximum is separate from the Out-of-Pocket Maximum under your medical option.

Once your Copayments/Coinsurance for prescriptions filled through Network Retail Pharmacies or the mail service total the Out-of-Pocket Maximum amount in a calendar year, you won't be required to pay any additional Copayments/Coinsurance for prescriptions filled through Network Retail Pharmacies or the mail service for the rest of that calendar year.

For information about specific Copayment/Coinsurance amounts, refer to Appendix 2.

## Section K. Filling Prescriptions

**How to Fill a Prescription**

Prescriptions may be filled under the Prescription Drug Program in any of the following ways:

- At any CVS retail pharmacy
- At any Costco Pharmacy
- At any Network Pharmacy, or
- Through the CVS Caremark® Mail Service Pharmacy.

Use a CVS retail pharmacy and any Network Pharmacy (including a Costco Pharmacy) for short-term prescriptions, i.e., prescriptions of up to 30 days (90 days for insulin).

If you need to take a medication on an ongoing basis (maintenance medications such as those that are taken regularly for conditions like diabetes, high blood pressure, asthma, etc.), you can receive refills of 90-day supplies at a time by using the Mail Service Pharmacy or a CVS retail pharmacy or any Costco Pharmacy. Note: Unless a state exception applies (see below), prescription drug copays for 30-day supplies of maintenance medications will double after the third time you receive such a 30-day supply at a retail pharmacy.; for cost savings, use the Mail Service Pharmacy (or a CVS retail pharmacy or a Costco Pharmacy). Note: this doubling of copays is modified for certain states as follows:

- **Florida:** Participants residing in Florida can also obtain 90-day supplies of medications taken on an ongoing basis at any Network retail pharmacy that fills 90-day supplies.
- **Minnesota:** Participants residing in Minnesota also have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find a Network participating pharmacy.
- **Oklahoma:** Participants residing in or filling their prescriptions in Oklahoma can also obtain 90-day supplies of medications taken on an ongoing basis at any Network retail pharmacy that fills 90-day supplies.
- **Tennessee:** Participants residing in Tennessee also have access to an expanded list of pharmacies from which to obtain 90-day supplies of

medications they take on an ongoing basis. Sign into Caremark.com to find an in-network participating pharmacy.

- **West Virginia:** Participants residing in West Virginia also have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find a participating pharmacy.

The above state-exception rules are subject to modification from time to time. Also, other states may be added to this list. For a complete list of participating pharmacies, go to www.Caremark.com/PharmacyLocator.

**Network Retail Pharmacies**

When you go to a Network Retail Pharmacy, give the pharmacist your Prescription Drug Program ID card, which you should have received in the mail from CVS Caremark when you first enrolled. (If you have misplaced your ID card or need additional ones for your dependents, you may print them from the CVS Caremark website.) The pharmacist will charge you the appropriate Copayment/Coinsurance for your prescription. That is the only amount you will pay.

If you do not have your Prescription Drug Program ID card with you at the time of your prescription purchase, be sure to identify yourself as a Participant. You or your pharmacist can contact CVS Caremark for verification of your eligibility. If you do not use your Prescription Drug Program ID card or cannot otherwise prove your eligibility, you will be responsible for paying the full cost of the prescription upfront and must file a claim form (claim forms are available on the CVS Caremark Web site at www.caremark.com for reimbursement). In addition, you may have to pay more out of your pocket because benefits may not be based on the lower Network prescription drug cost, but on the non-discounted price of the prescription and will be reimbursed based on the Allowable Amount.

To find a Network Retail Pharmacy near you:

- Call CVS Caremark at 1-800-240-9623
- Contact CVS Caremark directly through their Web site at www.caremark.com, or
- Ask your local pharmacy if it is a CVS Caremark network pharmacy.

**Out-of-Network Retail Pharmacies**

You may fill your prescription at an Out-of-Network retail pharmacy. However, when you use such a pharmacy, you pay the entire cost at the time of purchase. Then you file a claim with CVS Caremark for reimbursement. (See “Cost Sharing”, below.)

Claim forms are available on the CVS Caremark Web site or by calling CVS Caremark.

**Mail Service Pharmacy**

The CVS Caremark Mail Service Pharmacy is a great way to fill prescriptions if you regularly take the same medication on an ongoing basis. Up to a 90-day supply is available.

- To order a prescription online, log on to at www.caremark.com
- To have your Physician fax your prescription, have your Physician call 1-800-240-9623
- To order a prescription by mail, download a home delivery order envelope on the CVS Caremark Web site. Follow the instructions and enclose the appropriate Copayment/Coinsurance. Your prescription will be filled and sent to your home within 7-10 days of the date you mailed the prescription to CVS Caremark.

Refills are even easier. You can order a refill online, by mail or by calling the number on your refill sticker. Use your credit card to pay.

**Prescription Drug Coverage Management Programs**

*Retail Refill Allowance*

For prescriptions you take on an ongoing basis (90 days or more), you may use a retail pharmacy for your initial prescription and up to two refills (for a total of three fills), for up to a 30-day supply each time. If you remain on that medication, you must order subsequent refills through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy. Otherwise, you will be required to pay twice the retail Copayment at the non-CVS retail pharmacy.

*Member Pays the Difference Program (DAW Program)*

You will pay the generic Copayment, plus the difference in cost between the brand-name and generic drug, if you purchase a brand-name drug when a generic equivalent is available.

**The Caremark.com App**

The Caremark.com app allows you access to most of the same functionality that is available on the web site, including check drug cost, request refills or renewals, check order status, show/print your member ID card, pharmacy locator and check drug interactions. The app is available on both iOS and Android operating systems.

## Section L. Other Prescription-Drug-Related Services

### Cost Saver

Through the Caremark® Cost Saver™ program, members will have automatic access to GoodRx's prescription pricing to allow them to pay lower prices, when available, on generic medications in a seamless experience at the retail pharmacy counter. The amount paid will automatically be applied to any deductible and out-of-pocket thresholds (if applicable). You (or your Covered Dependent(s)) only need to show their CVS ID card at their preferred in-network pharmacy to obtain the lowest price for their generic medication. No action is required by the plan member.

### Drug Utilization Review

Prescriptions filled through the Prescription Drug Program become part of a computerized database that alerts the Network Retail Pharmacy or the CVS Specialty® Pharmacy pharmacists to potential drug interactions each time you have a prescription filled.

### PrudentRx Solution for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug program for you and your Covered Dependent(s), the Prescription Drug Program includes a special, called the PrudentRx Solution, for certain specialty medications. The PrudentRx Solution assists you and/or your Covered Dependent(s) by helping with enrollment in manufacturer copay assistance programs. Medications that are on the PrudentRx Program Drug List are subject to a 30% co-insurance, after satisfaction of any applicable Plan deductible. However, if you or your Covered Dependent(s) (as applicable) participate in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, you or your Covered Dependent(s) (as applicable) will have a $0 out-of-pocket responsibility for prescriptions covered under the PrudentRx Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient Member Cost Share for select medications--in particular, specialty medications. The PrudentRx Solution will assist you and your Covered Dependent(s) in obtaining copay assistance from drug manufacturers to reduce your or their cost share for eligible medications, thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs; be assured that this is done in compliance with HIPAA.

If you or your Covered Dependent(s) currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that

provides information about the PrudentRx Solution as it pertains to such medication. You (or your Covered Dependent(s)) must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for a covered specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx will contact you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call 1-800-578-4403. Eligible participants who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking a medication covered under the PrudentRx Solution but will start taking one soon, you can reach out to PrudentRx, or they will proactively contact you, so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 1-800- 578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your or a Covered Dependent's behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution, will not count toward your plan deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you (or your Covered Dependent(s)) for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act (ACA), will not count toward your deductible or ACA out-of-pocket maximum (if any), unless otherwise required by law. A list of specialty medications that are not considered to be "essential health benefits" under the Affordable Care Act is available by calling PrudentRx at 1-800- 578-4403. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

**Zerigo Skin Health Program**

Psoriasis and eczema can significantly impact your quality of life. The Zerigo Skin Health Program – a no-cost[1] home-based phototherapy treatment program - has helped hundreds of people find relief and improve their skin's appearance.

How it works:

1. **Get a prescription**: Schedule a brief, no-cost[1] telehealth visit with a Zerigo Health partner clinician, or schedule with your own doctor or dermatologist (co-pays may apply).

2. **Receive your device**: Once the prescription is generated, Zerigo Health will ship your home phototherapy device directly to you.

3. **Start your treatment**: Your dedicated Care Guide will help you set up your device and complete your first treatment. Care Guides are available to support you at any time.

With Zerigo Health, most members:
- Manage their chronic skin condition more effectively
- Reduce the frequency and severity of flares
- Improve their overall quality of life

*[1] The Zerigo Skin Health Program is available through your healthcare benefits as a value-added service. You may have to pay a copay or coinsurance if you see your personal doctor to get a prescription for phototherapy. Prescriptions issued by a CirrusMD clinician, during Zerigo Health's enrollment process, typically have no copay.*

**Toll-Free Prescription Drug Customer Service**

CVS Caremark maintains a toll-free customer service number (1-800-240-9623) to help you with:

- General questions about the Prescription Drug Program
- Locating an In-Network Retail Pharmacy
- Obtaining an order form/envelope for the mail service or a claim form for a prescription filled at an Out-of-Network Pharmacy
- Emergency pharmacist consultations, 24 hours a day, seven days a week
- Large print or Braille labels on medications filled through the mail service, upon request, and
- Telephone numbers for hearing impaired employees (1-800-759-1089) and overseas employees (1-972-915-6698) weekdays from 8:00 a.m. to 12 midnight, Eastern Time and on Saturdays from 8:00 a.m. to 6:00 p.m., Eastern Time.

## Section M. The Employee Assistance Program (EAP)

Need help coping with stress, family pressures, money issues or work demands?

The Medical Plan includes an Employee Assistance Program (EAP). The EAP offers you and your household members free, confidential, 24/7 assistance for a wide range of behavioral health issues, such as emotional difficulties, alcoholism, drug abuse, marital or family concerns, and other personal and life issues. Enrollment in the EAP is not required, nor do you need to be enrolled in Nokia's medical plan in order to access the Medical Plan's EAP coverage. To speak with a counselor, call Magellan at 1-800-327-7348 or visit Member.MagellanHealthcare.com.

# Section N. Coordination of Benefits (COB); Subrogation, Overpayment and Reimbursement

**Coordination of Benefits**

***Benefits When You Have Coverage under More than One Plan***

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

***When Does Coordination of Benefits Apply?***

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

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

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

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

***Definitions***

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

A. **Plan**. A Plan is any of the following that provides Benefits or services for medical, pharmacy, or dental care or treatment. If separate contracts are used to provide coordinated coverage for Participants of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.
   1. Plan includes group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans, or other forms of group or group-type coverage (whether insured or uninsured); medical care components

of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

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

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

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

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

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

E. **Closed Panel Plan.** Closed Panel Plan is a Plan that provides health care benefits to Participants primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other Providers, except in cases of Emergency or referral by a panel member.
F. **Custodial Parent.** Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year, excluding any temporary visitation.

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

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

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

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

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

D. Each Plan determines its order of benefits using the first of the following rules that apply:
   1. **Non-Dependent or Dependent**. The Plan that covers the person as an employee, Participant, 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 an employee, Participant, policyholder, subscriber, or a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, Participant, policyholder, subscriber, or retiree is the Secondary Plan and the other Plan is the Primary Plan.
   2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, Plans covering a dependent child shall determine the order of benefits as follows:
      a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
         (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan.
         (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
      b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
         (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's Plan is the Primary Plan. This shall not apply with respect to any Plan Year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
         (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
         (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
         (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            (a) The Plan covering the custodial parent.

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

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

d) (i) For a dependent child who has coverage under either or both parents' Plans and also has their own coverage as a dependent under a spouse's Plan, the rule in paragraph (5) applies.
(ii) In the event the dependent child's coverage under the spouse's Plan began on the same date as the dependent child's coverage under either or both parents' Plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.**
   a) The Plan that covers a person as an active employee (i.e., an employee who is neither laid off nor retired), is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 2(d)(i) above can determine the order of benefits.
   b) If you are actively employed and Medicare eligible (or if you are the spouse of an active employee who is Medicare eligible), the Medical Plan will pay benefits first and Medicare will pay benefits second if you are enrolled in Medicare. The same rule applies to your Covered Dependents who become Medicare eligible except for those with end-stage renal disease beyond 30 months. Medicare is primary after 30 months.

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

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

### *Effect on the Benefits of This Plan*

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

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

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

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

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

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

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

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

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

### *Right to Receive and Release Needed Information*

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

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

### *Payments Made*

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

### *Does This Plan Have the Right of Recovery?*

If the amount of the payments Surest made is more than Surest should have paid under this COB provision, Surest may recover the excess from one or more of the persons Surest paid or for whom Surest paid; or any other person or organization that may be responsible for the

benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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

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

**Subrogation and Refund**

A Participant may incur medical expenses due to illness or injuries that may be caused by the act or omission of a Third Party. Also, a Third Party (such as an insurance company) may be responsible for payment on account of the actions of another person or entity. In such circumstances, the Participant may have a claim against the Third Party for payment of medical expenses. Accepting Benefits under a Surest option for those incurred medical expenses automatically assigns to the Plan any rights the Participant may have to Recoveries from any Third Party up to the full amount of such Benefits. This Subrogation right allows the Plan to pursue any claim that the Participant has against any Third Party, whether or not the Participant chooses to pursue that claim. The Plan may make a claim directly against the Third Party, but in any event, the Plan has an equitable lien on any amount of the Recovery of the Participant whether or not designated as payment for medical expenses. In addition, each Participant agrees to hold Recoveries in a constructive trust for the benefit of the Plan. The equitable lien and constructive trust shall remain in effect until the Plan is repaid in full. In the event that the Participant(s) dies as a result of their injuries and a wrongful death or survivor claim is asserted against a Third Party, the Plan's Subrogation and Refund rights shall still apply.

**Assignment of Interest and the Plan's Recovery Right**

The Participant:

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

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

**Make Whole and Common Fund Doctrines Inapplicable**

The Plan expressly disavows and repudiates the make whole doctrine, which, if applicable, would prevent the Plan from receiving a Recovery unless a Participant has been "made whole" with regard to illness or injury that is the responsibility of a Third Party. The Plan also expressly disavows and repudiates the common fund doctrine, which, if applicable, would require the Plan

to pay a portion of the attorney fees and costs expended in obtaining a Recovery. These doctrines have no application to the Plan since the Plan's Refund rights apply to the first dollars payable by a Third Party.

**Duty to Cooperate**

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

- To cooperate with the Plan, or any representatives of the Plan, in protecting the Plan's rights, including discovery, attending depositions, and/or cooperating at trial.
- To provide prompt notice to the Plan when a claim is made against a party for illness or injury.
- To provide the Plan with pertinent information regarding the illness, disease, disability, or injury, including accident reports, settlement information, and any other requested additional information.
- To take such action and execute such documents as the Plan may require to facilitate enforcement of its Subrogation and reimbursement rights.
- To do nothing to prejudice the Plan's rights of Subrogation and Refund.
- To promptly reimburse the Plan when a Recovery through settlement, judgment, award, or other payment is received.
- Not to settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have Recovery rights against any Third Party.

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

**Conditions Precedent to Coverage**

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

**Other Coverage**

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

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

**Offset**

Failure by a Participant and/or his/her attorney to comply with any of the requirements described in this section may, at the Plan's discretion, result in a forfeiture of payment by the Plan of future medical Benefits, and any funds or Benefits otherwise payable under the Plan to or on behalf of the Participant may be withheld until the Participant satisfies his or her obligation.

**Defined Terms**

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

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

**Erroneous Payments**

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

**Excess Insurance**

Except as otherwise provided above under Coordination of Benefits, the following rule applies:

- If there is available, or potentially available, any coverage (including coverage resulting from a judgment at law or settlements), the Benefits under the Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for above under Coordination of Benefits.
- The Plan's Benefits shall be excess to:
  - The responsible party, its insurer, or any other sources on behalf of that party.
  - Any first party insurance through medical payment coverage, personal injury protection, no-fault auto insurance coverage, uninsured or underinsured motorist coverage.
  - Any policy of insurance from any insurance company or guarantor of a Third Party.
  - Worker's compensation or other liability insurance company.
  - Any other source, including crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

**Separation of Funds**

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

**Severability**

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

## Section O. When Coverage Ends

### When Employee Coverage Ends

Your coverage under the Plan ends on the last day of the month in which any of the following events occurs:

- Your employment with a Participating Company terminates or you otherwise cease to be an Eligible Employee
- You do not make a required contribution toward coverage under the Plan
- You request that your coverage be canceled, or you decline coverage, when permitted
- The company you work for ceases to be a Participating Company, or
- The Plan is terminated.

When your coverage ends, you may be able to continue coverage under certain circumstances. See Section Q., "COBRA Continuation Coverage," for more information.

### When Dependent Coverage Ends

Your Eligible Dependent's(s') coverage under the Plan will end as follows:

- If your coverage ends, your Eligible Dependent's(s') coverage will end on the same day.
- If your Eligible Dependent Child attains age 26, such Child's coverage will end on the last day of the month in which the Eligible Dependent Child reaches age 26.

***Please note**: If your Dependent Child is an Adult Disabled Child within the meaning of the Plan, he or she may be able to continue his or her coverage regardless of age. This coverage is not automatic. The Medical Plan Claims Administrator must certify that the child is eligible for coverage. To apply for coverage, contact the Medical Plan Claims Administrator and notify the Nokia Benefits Resource Center of your intention to seek this coverage.*

If your Eligible Dependent's coverage ends for any other reason, coverage for the Dependent will end on the last day of the month in which the event occurs.

- If you and your Spouse divorce, your Spouse's coverage will end on the last day of the month in which the divorce becomes final.

- If your Domestic or Civil Union Partnership ends (or you and your Domestic or Civil Union Partner no longer satisfy the Plan's eligibility criteria for Domestic or Civil Union Partnership), your Domestic or Civil Union Partner's coverage, and coverage for any enrolled Child(ren) of your Domestic or Civil Union Partner, will end on the last day of the month in which the Domestic or Civil Union Partnership ends (or in which the eligibility criteria are no longer satisfied).

# Section P. Employment-Related Events

## If You Terminate Employment

Your coverage under the Plan ends on the last day of the month in which your employment ends. You may, however, be eligible for coverage under the group healthcare plan that the Company maintains for retired employees, provided you meet the eligibility criteria of that plan. The benefits provided by the group healthcare plan for retired employees may differ from the benefits provided for active Eligible Employees under this Plan. This Plan and the plan for retired employees are subject to amendment, modification, or termination by the Company at any time, including before or during your retirement.

When coverage under this Plan ends, you may be eligible to continue coverage for yourself and your eligible Covered Dependents under COBRA. For more information, see Section Q., "COBRA Continuation Coverage."

## If You Transfer Employment to Another Nokia Group Company

If you transfer employment to another Nokia Group company, whether your coverage will continue depends on whether the other company is also a Participating Company with respect to this Plan. If you transfer employment to a Participating Company, your participation in the Medical Plan will not be affected. If, however. you transfer employment to a non-Participating Company, you will be treated as having had a termination of employment for purposes of the Plan and will no longer have coverage under the Plan. However, you may be eligible to continue coverage for yourself and your eligible Covered Dependents through COBRA. For more information, see Section Q., "COBRA Continuation Coverage."

## If You Leave Nokia and Are Later Rehired by a Participating Company or If You Transfer Employment to Another Nokia Group Company and You Later Transfer Back to a Participating Company

If you leave Nokia and are later rehired by a Participating Company (after a break in service), you will be treated as a new-hire for purposes of the Plan; you will automatically be enrolled in coverage under the Plan as of your first day of active employment upon your return. For more information, see Section C., "Eligibility and Enrollment."

## If You Become Disabled

If you are absent due to a disability, but still employed with a Participating Company, then your coverage under the Plan continues (provided you are still an Eligible Employee).

## If You Take an Approved Leave of Absence

If you take an approved leave of absence--including, but not limited to, absence due to disability, leave under FMLA, and qualified military leave under USERRA--you can continue Plan coverage for yourself and your Covered Dependents. In some instances, you might have to pay the full cost of Plan coverage.

## State and Local Leave Laws

To the extent continued Plan coverage is required by state and/or local leave laws and is not otherwise preempted by federal law, the Plan will comply.

# Section Q. COBRA Continuation Coverage

**Overview**

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to offer "qualified beneficiaries" (certain covered employees and certain of their covered dependents) the opportunity to continue their group health benefit coverage at their own expense for a limited period of time if they lose coverage due to a "qualifying event".

Note: Domestic or Civil Union Partners and their children are not typically eligible for continuation coverage under federal law, as they do not meet the definition of "qualified beneficiary" under COBRA. However, the Plan provides COBRA-like rights to covered Domestic or Civil Union Partners and to the Child(ren) of Domestic or Civil Union Partners as outlined in this section of the SPD. While not legally applicable in all cases, references herein to "COBRA" and to "qualified beneficiary" includes, respectively, "COBRA-like" coverage and Domestic or Civil Union Partners and the Child(ren) of Domestic or Civil Union Partners.

**Qualifying Events**

In order to become eligible for continuation coverage under the Plan's COBRA continuation of coverage provisions, you (or your Covered Dependents) must face a loss of Plan coverage due to a "qualifying event". The following constitute qualifying events under the Plan:

- Termination of your employment for any reason (other than for gross misconduct)
- A reduction in your work hours
- Your divorce or legal separation from your Spouse or the termination of your Domestic or Civil Union Partnership
- A child's loss of eligibility under the terms of the Plan (e.g., your Child turns age 26)
- Your death.

The qualifying event is deemed to occur on the date that coverage under the Plan would be lost due to the occurrence of the event. For example, because coverage under the Plan continues until the end of the month in which you experience an involuntary termination of employment, this qualifying event is considered to occur on the first day of the following month.

**Notice Requirement**

It is your or your qualified beneficiary's responsibility to notify the Nokia Benefits Resource Center of a qualifying event (other than your termination of employment, reduction in hours of employment, or death, or your Covered Dependent child turns age 26) that makes you or your

Covered Dependent(s) eligible for COBRA continuation coverage. The deadline for providing such notice is 60 days from the end of the calendar month in which the qualifying event occurs. For example, if you become legally separated from your Spouse on May 15, your Spouse and covered dependents (or you on their behalf) will have until July 31 (60 days from the first day of the month immediately following the month in which this event occurs) to notify the Nokia Benefits Resource Center of this event.

The individual eligible for COBRA continuation coverage must respond by the date on the notice of COBRA rights to be eligible for COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouses/Domestic or Civil Union Partners, and parents may elect COBRA continuation coverage on behalf of their children.

**Maximum Period of Continuation Coverage**

The table below shows the maximum period of continuation coverage available under the Plan's COBRA continuation-of-coverage provisions:

| **If This Qualifying Event Occurs…** | **COBRA Continuation Coverage Can Last for…** |
|---|---|
| • Termination of your employment for any reason other than gross misconduct; or<br>• A reduction in your work hours. | Up to 18 months (for you and your Covered Dependents)<br>**Note:** If you become entitled to Medicare while you are an active employee and, less than 18 months later, you experience a qualifying event that is a termination of your employment (for any reason other than gross misconduct) or a reduction in your work hours, COBRA continuation coverage for your Covered Dependents can last for up to 36 months (rather than 18 months) |
| • Your divorce or legal separation<br>• Termination of your Domestic or Civil Union Partnership | Up to 36 months (for your Covered Dependents) |
| • Your death | Up to 36 months (for your Covered Dependents). Note: your surviving Spouse/Domestic or Civil Union Partner who elected COBRA continuation coverage can, at the end of this 36-month period (or upon becoming eligible for Medicare, if sooner), enroll in the Family Security Program ("FSP"), a program available under the Nokia Medical |

| If This Qualifying Event Occurs… | COBRA Continuation Coverage Can Last for… |
|---|---|
| | Expense Plan for Retired Employees (the "Retiree Medical Plan"), a component of the Nokia Retiree Welfare Benefits Plan. Your surviving Spouse/Domestic or Civil Union Partner can also enroll your Covered Dependents who were enrolled in the Plan immediately before your death and who elected COBRA continuation coverage. Under the FSP, Company-provided group health plan coverage for your Spouse/Domestic or Civil Union Partner can continue until death, and coverage for any such Covered Dependents can continue until death or until they cease to be eligible dependents within the meaning of the Retiree Medical Plan. (If your eligible Spouse/Domestic or Civil Union Partner and an eligible dependent drops coverage under the FSP, they can never re-enroll in it.) Information regarding the FSP will be provided shortly before the end of your surviving Spouse's/Domestic Partner's original 36-month COBRA continuation period. **Note:** The FSP is not "lifetime coverage"; it may be modified or terminated by the Company at any time. |
| • Your Child's loss of eligibility under the Plan | Up to 36 months (for your covered Child) |
| • You or your Covered Dependent becoming disabled at any time during the first 60 days of the COBRA continuation coverage period and such disability lasting at least until the end of the initial 18-month period of COBRA continuation coverage. | The continuation-of-coverage period may be extended from 18 months to up to 29 months (for the disabled qualified beneficiary).<br><br>To be eligible for the additional period of coverage, the disabled person must call the Nokia Benefits Resource Center before the end of the initial 18-month period and within 60 days of receiving notice of disability from the Social Security Administration.<br><br>The individual must also notify the Nokia Benefits Resource Center within 30 days after the Social Security Administration determines that he or she is no longer disabled. |

*How COBRA Continuation Coverage Is Affected by Multiple Qualifying Events*

A qualified beneficiary (other than you--the Eligible Employee or former employee) may be eligible for an additional period of COBRA continuation coverage, not to exceed a total of 36 months from the initial qualifying event, if there is a second qualifying event because of your death, the divorce or legal separation of you and your Spouse, the termination of your Domestic or Civil Union Partnership, or your child losing eligibility under the Plan. The second event can be a second qualifying event only if it would have caused a loss of coverage under the Plan in the absence of the first qualifying event.

For example, suppose you terminate employment on December 31, 2025, and you are eligible to continue coverage for up to 18 months (i.e., until June 30, 2027). Your Child, who is a Covered Dependent on December 31, 2025, reaches age 26 (a second qualifying event) on December 31, 2026. Your child is then eligible for up to an additional 18 months of COBRA continuation coverage from the date of the original qualifying event. In this case, your child is eligible to continue coverage through December 31, 2028, which is 36 months from December 31, 2025, the date of your termination of employment (the original qualifying event).

To be eligible for extended coverage after a second qualifying event, you or your qualified beneficiary must notify the Nokia Benefits Resource Center within 60 days of the date of the second qualifying event.

**Adding a Newborn or Newly Adopted Dependent During a Period of Continuation Coverage**

If, while you are enrolled in COBRA continuation coverage, you have a baby, legally adopt a child or a child is placed with you for legal adoption and the child meets the Plan's rules for being an Eligible Dependent, the child will be a considered a "qualified beneficiary" and will be eligible for COBRA continuation coverage. The maximum coverage period for such a child will be the remainder of the maximum coverage period for that qualifying event.

**Electing COBRA Continuation Coverage**

Complete details about COBRA continuation coverage, including information about election and cost, are automatically sent to your preferred address if you (the employee):

- Terminate employment with a Participating Company,
- Experience a reduction in work hours, or
- Die,

or if your Covered Dependent child turns age 26.

For certain qualifying events, information regarding COBRA coverage is not automatically sent. It is your or your qualified beneficiary's responsibility to notify the Nokia Benefits Resource Center of the occurrence of the following qualifying events:

- Divorce from a Spouse
- Legal separation from a Spouse

- Termination of a Domestic or Civil Union Partnership, or
- A Child no longer satisfying the Plan's eligibility criteria, other than turning age 26.

You and/or your qualified beneficiaries must notify the Nokia Benefits Resource Center within 60 days of the occurrence of the qualifying event.

**What Does COBRA Coverage Cost?**

COBRA participants must pay monthly contributions for coverage.

Generally, monthly contributions are based on the full cost per covered person, set at the beginning of the year, plus two percent for administrative costs. Covered Dependents making separate elections must contribute at the same rate as the former employee. If your COBRA continuation coverage is extended to 29 months due to a qualifying disability, you may be required to pay the full cost of COBRA continuation coverage plus a 50 percent administrative fee for each month beyond 18 months.

Where the initial qualifying event is the employee's death, Covered Dependents electing COBRA continuation coverage pay the active-employee rate for the first six months of continuation coverage and the regular COBRA rate, as described above, thereafter. (The active-employee rate only applies where the initial qualifying event is due to death and does not apply where the death occurs later, i.e., during a previously elected COBRA continuation period.)

Payment is due at enrollment, but there is a 45-day grace period from the date you (or your Covered Dependents) elect coverage to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s).

Ongoing monthly payments are due on the 10th of each month, but there is a 45-day grace period (for example, the June payment is due June 10th, but will be accepted if postmarked up to 45 days after that).

**Termination of COBRA Continuation Coverage Before the End of the Maximum Period of Continuation Coverage**

COBRA continuation coverage will end before the end of the maximum continuation period if one of the following occurs:

- You or your Covered Dependent does not make timely premium payments or contributions as required
- The Company stops providing medical and prescription drug benefits to its employees, or
- You or any of your Covered Dependents become covered under another group healthcare plan not offered by a Nokia Group Company.

Continuation coverage also may be terminated for any reason where the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (for example, in the case of fraud).

## Section R. Claims and Appeals

The Plan maintains claims and appeals procedures designed to afford you a fair and timely review of any claim you might have relating to the Plan. Generally, you are legally required to pursue all your claim and appeal rights on a timely basis before seeking any other legal recourse, including litigation.

For information regarding how to contact parties referenced in this section, see Section V., "Important Contacts."

**Overview**

Disagreements about eligibility to participate in the Plan (or in one of the Plan's programs) or about benefits provided under the Plan can and do arise. To resolve these disagreements, the Plan provides for a formal claims and appeals process.

Note: You must exhaust the claim and appeal procedures as described in this SPD before filing any legal action (whether in state or federal court) regarding your Plan dispute.

The Plan has separate claims and appeals procedures depending on whether you have:

- An eligibility claim
- A benefit claim under the Surest Enhanced, Surest Standard or HMO option
- A benefit claim relating to the Prescription Drug Program.

An eligibility claim is a claim by you (or your dependent) concerning the right to participate in the Plan. For example, you may believe an error was made during Annual Open Enrollment that resulted in your (or your dependent) being assigned incorrect coverage, or you may believe you (or your dependent) experienced a "qualified status change" that entitles you (or your dependent) to make a change in Plan coverage during the year, but you are being told to wait until the next Annual Open Enrollment to make the change. Another example of an eligibility claim is a claim to be included as a participant in the Plan (e.g., there is a disagreement regarding your employment status that affects your eligibility for Plan coverage). Eligibility claims do not address whether a particular treatment or benefit is covered under the Plan.

In contrast to eligibility claims, benefit claims (whether under the Surest Enhanced, Surest Standard, or HMO option or the Prescription Drug Program) concern the question of benefits provided under the Plan. Such claims can include, for example, whether a procedure or course of

treatment is covered under the terms of the Plan, the amount of Copays payable under the Plan with respect to a particular service, or the extent to which Plan limits or other restrictions apply to the service at issue.

The claim and appeal procedures for eligibility claims, for benefit claims under the Surest Enhanced and Surest Standard options, and for benefit claims under the Prescription Drug Program are described separately below. (References to "you" refer to any claimant, including the authorized representative of any claimant.) Contact your HMO for information about its benefit claim and appeal procedures. (See Section V., "Important Contacts," for information on how to contact the Plan's HMOs.) To the extent you have a claim that does not neatly fall into one of these categories, address your claim using the Plan's eligibility claims procedures.

**Decision-Making Authority**

The authority to adjudicate claims and appeals has been assigned to different entities—for eligibility claims, to the Nokia Benefits Review Team (the "NBRT") and then to the Nokia Employee Benefits Committee (the "EBC"); for benefit claims under the Surest Enhanced, Surest Standard or HMO option, to the Claims Administrator for those Options; and for benefits claims under the Prescription Drug Program, to the Claims Administrator for that program. (For contact information for each of these entities, see Section V., "Important Contacts.") Each of these entities (NBRT, EBC, and Claims Administrators) is a fiduciary under ERISA and is required to review and decide your claim in accordance with the Plan's terms (the documents and instruments governing the Plan) and these procedures. In this regard, the Plan grants to each of these entities (as applicable) sole and complete discretionary authority to determine conclusively for all parties, and in accordance with such documents and instruments, any and all questions arising from administration of the Plan and interpretation of all Plan provisions, determination of all questions relating to participation in the Plan and eligibility for Plan benefits, determination of all relevant facts, determination of the amount and type of benefits payable under the Plan, and construction of all Plan terms. In the case of an appeal, the EBC's and the Claims Administrator's decisions are final and binding on all parties to the full extent permitted under applicable law, unless the claimant later proves that the decision was an abuse of administrator discretion.

**Eligibility Claims and Appeals**

In instances where you are required to file a claim form (as opposed to the automatic submission with some benefit-related claims), you should submit claims within 60 days of the date the medical service is provided. If it is not reasonably possible to submit a claim within this time frame, an extension of up to 12 months from the date of such service will be allowed. However, no benefits will be paid for claims submitted more than 12 months after the date the services were rendered.

### *Submitting an Eligibility Claim*

If you have an eligibility claim, contact the Nokia Benefits Resource Center and request an eligibility claim form ("Claim Initiation Form" or "CIF"). Your eligibility claim is not filed until you complete and mail your CIF, including any supporting documentation to:

Claims and Appeals Management
Dept 07544
PO Box 299107
Lewisville, TX 75029-9107

If your eligibility claim is coupled with a claim for benefits, follow the benefits Claims Administrator's process, but also include a copy of the benefits claim information with your CIF. You should indicate on your CIF whether the benefits claim is a post-service claim, pre-service claim, an urgent (pre-service) claim, or a concurrent care claim.

### *When You Can Expect to Receive a Decision with Respect to Your Eligibility Claim*

Since the vast majority of eligibility claims are post-service, you will receive a response within 30 days from the date that your CIF is received. The NBRT may extend the period for making the claim decision by 15 days if it determines that an extension is necessary and notifies you, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision. If your eligibility claim is being submitted in conjunction with a benefit claim, see the timing applicable to your "type" of claim or appeal in the *Benefit Claims and Appeals—Surest Enhanced and Surest Standard Options* section or *Benefit Claims and Appeals--Prescription Drug Program* section, as applicable, of this SPD.

*Special Rule:* If you do not provide sufficient information to allow the NBRT to make a decision with respect to your eligibility claim, you will be notified of the need for the information. You will have at least 45 days from receipt of the notice to provide the specified information. In such an instance, the NBRT's deadline for rendering a decision is suspended from the date on which it sends notice of the need for necessary information until the date on which you provide the information. For example, if the NBRT notifies you on Day 10 of the initial 30-day review period that additional information is required, you will have 45 days from your receipt of the notice to provide the necessary information. If the NBRT then receives that information on, for example, Day 30 of your 45-day response time, the time within which the NBRT is required to decide your claim picks up as if it were Day 11 of its initial 30-day review period.

### *What You Will Be Told if Your Eligibility Claim Is Denied*

If your claim is **denied**, in whole or in part, your written denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.

- Any additional material or information you may need to submit to complete the claim and an explanation as to why it is necessary.
- Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request).
- A description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following your appeal.

### *Eligibility Appeals Procedure and Deadline to Submit Your Appeal*

If your eligibility claim is denied and you wish to have it re-reviewed, you must file an appeal. You must file your appeal within **180 days** from the date on the claim denial letter. To file an appeal, you must write to:

Nokia
Employee Benefits Committee ("EBC")
600–700 Mountain Avenue
Room 6C-402A
Murray Hill, NJ 07974

You should include a copy of your initial claim denial notification, the reason(s) for the appeal, and relevant documentation with your appeal request.

You may request access, free of charge, to all documents relating to your appeal. Your appeal will be reviewed "de novo," which means you get a "start fresh" to establish the merits of your claim and the EBC will not place deference upon the original decision. The EBC is a fiduciary who is not the individual who made the initial decision and who is not the subordinate of the initial reviewer.

### *When You Can Expect to Receive a Decision with Respect to Your Eligibility Appeal*

You will be notified of the decision by the EBC within 60 days after receipt of your appeal. If special circumstances cause the EBC to need additional time to make a decision, a representative of the Committee will notify you in writing within the initial 60-day review period and explain why such additional time is needed. An additional 60 days—for a total of 120 days— may be taken if the EBC sends this notice.

***Please Note:*** *If your eligibility appeal is coupled with a non-urgent pre-service benefits appeal, urgent pre-service benefits appeal, or concurrent care benefits appeal, as the case may be, an effort will be made to decide your eligibility appeal within the time frames applicable to the benefits claim.*

### *What You Will Be Told if Your Eligibility Appeal Is Denied*

If your eligibility claim is denied on appeal, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial
- The Plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim
- Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request)
- A statement about your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) and a statement about voluntary alternative dispute resolution options.

The decision on your appeal is final. Upon denial by the EBC, you have the right to bring a civil action in federal court. This option is available to you only after you have exhausted all the administrative remedies available to you through the Plan's claims and appeals process as described in this section.

**Benefit Claims and Appeals—Surest Enhanced and Surest Standard Options**

***Claims Procedures***

When you receive In-Network services under the Surest options, the Provider will generally collect your Copayment from you at the time of your treatment and send a medical Claim to Surest for payment. Sometimes Out-of-Network Providers will do the same. Other times, Out-of-Network Providers might bill you for the total cost of your treatment, and you will need to submit the medical Claim to Surest to be reviewed for Benefits eligibility. Whether you pay out-of-pocket, or your Provider bills Surest directly, you are still entitled to the same Benefits.

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

If you would like more details about medical Claims procedures and your rights and responsibilities, contact Surest. (For contact information for Surest, see Section V., "Important Contacts".)

*Regular Post-Service Medical Claims*

Post-service medical Claims are non-urgent medical Claims processed after you have received treatment. (Pre-Service and Urgent Care Request for Benefits are described below under "What Do I Do If My Claim Is Denied.") Generally, you do not need to file a medical Claim for services from In-Network Providers; the Provider will handle the filing of the medical Claim. For Out-of-Network Providers that do not file medical Claims or if you receive Emergency or non-Emergency care while traveling outside the United States and are seeking reimbursement from the Surest Plan, you can submit a medical Claim using this procedure.

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

- The name and birth date of the Participant or Covered Dependent who received the care.
- The Participant ID listed on the Surest member ID card.
- An itemized bill from the Provider, which should include:
  - The Provider's name, address, tax identification number, NPI number, and license number (if available).
  - The date(s) the Participant or Covered Dependent received care.
  - The diagnosis and procedure codes for each service provided.
  - The charges for each service provided.
- Information about any other health coverage the Participant or Covered Dependent has.

Note: Proof of payment may be requested to substantiate your medical Claim but is not required upon initial submission to Surest.

*Other General Claims Procedures*

Your medical Claim must be submitted within one year from the date you received the health care services. If your Claim relates to an inpatient stay, the date you were discharged counts as the date you received the health care service for Claims purposes.

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

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

If a medical Benefits Claim is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents (without charge) relevant (as defined in applicable regulations) to the decision, and to appeal any denial, all within certain time schedules.

*Notice of Adverse Claim Determination*

If your medical Claim is denied in whole or in part, you will receive a written notice of denial. The notice will be written in an understandable and will include all of the following:

- Information sufficient to identify the medical Claim involved (including the date of service, the health care Provider, and the medical Claim amount [if applicable]); you can also request from the Claims Administrator the diagnosis and treatment codes, and their explanation.

- The specific reason or reasons for the denial, the denial code and its meaning and a description of the Plan standard, if any, that was used in denying the Claim and a discussion of the decision.
- The specific reference to the relevant Plan provision on which the decision is based.
- A description of additional information needed to support your medical Claim and an explanation of why it is needed.
- Information about how to appeal your Claim and any time limits, should you want to pursue it further and your right to bring a civil action under ERISA if your appeal is denied.
- A statement about available external review processes, including information on how to initiate the review.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either a copy of the document or a statement that such a document was relied on and that a copy will be provided (free of charge) upon request.
- Either an explanation of the scientific or clinical judgment for the decision (applying the Plan terms to your medical circumstances) or a statement that such an explanation was relied on and that a copy will be provided (free of charge) upon request, if the decision was based on a limit (for example, a decision that the proposed service is not Medically Necessary).
- A description of the expedited review process in the case of a denial concerning a Claim involving urgent care. If Surest tells you about its decision orally within the timeframes required, Surest will follow up within three business days with a written or electronic notice.
- A statement about the availability of contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.
- A description of any voluntary processes the Plan offers.

*Payment of Benefits*

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to “third parties” include references to Providers as well as any collection agencies or third parties that have purchased accounts receivable from Providers or to whom accounts receivable have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a Provider.

Any such payment to a Provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, the Claims Administrator, the Plan Administrator, or the EBC from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a Provider as a convenience to you, the Claims Administrator will treat you, rather than the Provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a Provider by any amounts that the Provider owes the Plan.

*Form of Payment of Benefits*

Payment of Benefits under the Plan, including payment of any Benefit Amount, shall be in cash, in cash equivalents, or in such other form of consideration as the Claims Administrator in its discretion determines to be adequate.

What Do I Do If My Claim Is Denied?

*If Your Medical Claim is Denied*

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

To submit an appeal:

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

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

*Review of an Appeal*

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

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

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

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

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

Surest adheres to the following review practices:

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

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

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

*Access to New or Additional Information*

If you ask, Surest will give you the identification of any medical expert who gave an opinion – whether or not Surest used that opinion to decide your Claim. Any Participant will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required, with: (i) any new or additional evidence

considered, relied upon, or generated by the Surest Plan in connection with the Claim; and (ii) a reasonable opportunity for any Participant to respond to such new evidence or rationale.

*Pre-Service and Urgent Care Request for Benefits*

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

If your pre-service or urgent care request for Benefits is denied, you will receive an explanation of why it was denied and 3how you can appeal (including how to request an expedited review).

*Timing of Appeals Determinations*

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

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

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

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

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

## *Urgent Care Request for Benefits and Appeal**

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

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

## *Pre-Service Request for Benefits and Appeal**

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

| Appeals (Pre-Service) | Appeals Timing |
|---|---|
| Surest must notify you of the first-level appeal decision within: | **15 days** after receiving a complete first-level appeal |
| You must appeal the first-level appeal (file a second-level appeal) within: | **60 days** after receiving the first-level appeal decision |
| Surest must notify you of the second-level appeal decision within: | **15 days** after receiving a complete second-level appeal |

*Post-Service Claim Request for Benefits and Appeal**

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

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

*Concurrent Care Request for Benefits*

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

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

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

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

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

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

*Notice of Claim Denial on Appeal*

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

- Be written in a manner designed to be understood by an average individual and, where required by law, in a culturally and linguistically appropriate manner.
- Include information sufficient to identify the Claim involved (including the date of service, the health care Provider, and the Claim amount [if applicable]); you can also request from the reviewer the diagnosis and treatment codes and their explanation.
- Include the specific reasons for the Adverse Benefit Determination (including the denial code and its meaning and a description of the Plan's standard, if any, that was used in denying the Claim and a discussion of the decision).
- Refer to the specific Plan provisions on which the determination was based.
- Inform you that, upon request and free of charge, you are entitled to reasonable access to, and copies of, all documents, records, and other information relevant to the Claim for Benefits.
- Notify you of your right to bring legal action under ERISA.

- Include a copy of any internal rule, protocol or criterion that was relied on in making the determination or indicate that a copy of such material is available (free of charge) upon request.
- Either explain the scientific or clinical judgment made or indicate that such an explanation is available upon request, free of charge, if the determination was based on Medical Necessity or similar exclusion or limit.
- Contain a statement about the availability of contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.
- A statement about any voluntary appeal procedures your Plan may offer.
- Notify you that you can contact the Department of Labor or State Insurance Regulatory Agency to learn about other voluntary alternative dispute resolution options.

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

*Federal External Review Program*

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

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

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

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

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

An external review request should include all of the following:

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

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

*Standard External Review*

A standard external review comprises of all of the following:

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

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

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

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

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

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

business days.

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

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

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

Upon receipt of a Final External Review Decision reversing the determination made by Surest, the Surest Plan will immediately provide coverage or payment for the Benefit Claim at issue in accordance with the terms and conditions of the Surest Plan, and any applicable law regarding Plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Surest Plan will not be obligated to provide Benefits for the health care service or procedure.

*Expedited External Review*

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

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

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

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

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

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

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

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

**Limitation of Action**

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

**Benefit Claims and Appeals--Prescription Drug Program**

*Filing a Claim*

If you use an Out-of-Network Pharmacy or are unable to prove your eligibility at a Network Retail Pharmacy, you'll need to pay the full cost for the prescription and file a claim for reimbursement.

*Filing an Appeal*

To appeal a decision under the Prescription Drug Program, call CVS Caremark at 1-800-240-9623 and ask for a CVS Caremark appeals form for Nokia employees. Your appeal will be reviewed, and you will be notified of the decision.

## Section S. Your Rights Under ERISA

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA, as described below.

**Your Right to Receive Information About the Plan and About Your Benefits under the Plan**

Under ERISA, all Plan Participants have the right:

- To examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan and a copy of the latest Annual Return/Report (the Form 5500) filed by the Plan Administrator with the U.S. Department of Labor. The Plan's Annual Return/Report (Form 5500) is also available at the Public Disclosure Room, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C.

- To obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan and copies of the latest Annual Return/Report (Form 5500) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for such copies.

**Your Right to Prudent Actions by the Plan's Fiduciaries**

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

**Enforcing Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For example, if you request a copy of Plan documents or the latest Annual Return/Report (Form 5500) from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials to you and also to pay you up to $110 a day until you receive the materials (unless the materials were not

sent because of reasons beyond the control of the Plan Administrator). If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that the Plan's fiduciaries misuse the money belonging to the Plan, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement of your ERISA rights or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by going to www.dol.gov/EBSA or calling the publications hotline of the Employee Benefits Security Administration at (866) 444-EBSA (3272).

# Section T. Other Information About the Plan

### The Official Plan Documents Are Controlling

This booklet, called an SPD, is intended to summarize the material terms of the Plan (in particular, the Surest options under the Plan). The SPD is for informational purposes only. The actual terms of the Plan are reflected in the official Plan document, a copy of which can be obtained by writing to the Plan Administrator (see Section V, "Important Contacts"). Every care has been taken to ensure that this summary is accurate. In the event of a conflict between this SPD and the terms of the official Plan document, the official Plan document will control.

Because of the many detailed provisions of the Plan, no one other than the personnel or entities identified is this summary (see "Important Contacts" at the end of this SPD) is authorized to advise you concerning the terms of the Plan. Questions regarding your benefits or the Plan should be addressed as indicated in this SPD. Neither the Company nor the Plan is bound by statements made by unauthorized persons or entities. Moreover, in the event of a conflict between any information provided to you by an authorized resource and this SPD, this SPD (or the official Plan document in the event of a conflict between this SPD and the official Plan document) will control.

### The Company Has the Right to Modify, Suspend, or Terminate the Plan

The Company expects to continue the Plan. However, the Company has expressly reserved the right to modify, suspend, change or terminate the Plan at any time and for any reason.

### The Plan is Not a Contract of Employment

Your participation in the Plan, and your right to amounts contributed to and earned under your Plan account, do not create a contract of employment, which is generally considered to be "at will."

### Plan Funding and Payment of Benefits

The Surest Enhanced and Surest Standard options, Prescription Drug Program, and Employee Assistance Program are provided as part of the Medical Plan. The claims and expenses of these self-insured Medical Plan options are paid from employer and employee contributions.

The Company pays fees to outside organizations (i.e., Surest, CVS Caremark, Magellan, and Alight Solutions) to process claims and provide recordkeeping and other third-party administrative services with respect to the Plan. The fees and all benefit payments are paid from company revenues. These self-insured Medical Plan options do not guarantee benefits under a contract

or policy of insurance. The administrator of the self-insured Medical Plan options administers the benefits under the options.

**Your Plan Benefits and Rights Are Not Assignable**

Benefits payable under the Plan are not subject to assignment or alienation, nor may any Participant assign any cause of action relating to such benefits, nor any other rights with respect to the Plan, to any other person or entity, including any medical provider. Any such purported assignment or alienation shall be null and void. Notwithstanding the foregoing:

- in accordance with Section 609(b) of ERISA, payments for benefits with respect to a Participant under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act; and

- the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan.

**Authority of Plan Administrator and Claims Administrators**

The Plan Administrator has the full discretionary authority and power to control and manage all aspects of the Medical Plan, to determine eligibility for Medical Plan benefits, to interpret and construe the terms and provisions of the Medical Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Medical Plan as the Plan Administrator may deem appropriate in accordance with the terms of the Medical Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Medical Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Medical Plan, including the discretionary authority to interpret and construe the terms of the Medical Plan, to direct disbursements, and to determine eligibility for Medical Plan benefits.

The Plan Administrator has delegated its responsibility to review claims relating to eligibility to participate in the Medical Plan to the Nokia Benefits Review Team. The Plan Administrator has delegated its responsibility to review appeals of denied claims relating to eligibility to participate in the Medical Plan to the Employee Benefits Committee. The Plan Administrator has delegated its responsibility to review all other claims and appeals relating to benefits under the Medical Plan to the Claims Administrators. Each Claims Administrator has the full discretionary authority and power to control and manage all aspects of the Medical Plan with respect to which they have been delegated responsibility, including the discretionary power and control to determine eligibility for Medical Plan benefits, to interpret and construe the terms and provisions of the Medical Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Medical Plan as they may deem appropriate in accordance with the

terms of the Medical Plan and all applicable laws. See also "Decision-Making Authority" in Section R., "Claims and Appeals."

## Section U. Administrative Information

| | |
|---|---|
| **Plan Name** | The official name of the Plan is the Nokia Medical Expense Plan for Active Employees. |
| **Plan Sponsor Name and Address** | The Plan Sponsor of the Plan is Nokia of America Corporation. The address of the Plan Sponsor is:<br><br>Nokia<br>Room 6D-401A<br>600-700 Mountain Avenue<br>Murray Hill, NJ 07974 USA |
| **Plan Administrator Name and Address** | The Plan is administered by Nokia of America Corporation. The address of the Plan Administrator is:<br><br>Nokia<br>Plan Administrator<br>Room 6D-401A<br>600-700 Mountain Avenue<br>Murray Hill, NJ 07974 USA<br><br>The Plan Administrator has retained various third-party administrators (contract administrators) responsible for certain administrative activities, including administering claims and paying benefits under the terms of the Plan. In this regard:<br><br>• For the Surest options, the Plan Administrator has retained Bind Benefits, Inc., d/b/a Surest.<br>• For the Prescription Drug Program, the Plan Administrator has retained CVS Caremark.<br>• For the Employee Assistance Program, the Plan Administrator has retained Magellan.<br><br>In addition, the Plan Administrator has retained Alight Solutions LLC (using the name the Nokia Benefits Resource Center (NBRC)) as third-party administrator responsible for eligibility and enrollment under the terms of the Plan. |

| | |
|---|---|
| | For contact information for each of these third-party administrators, see Section V., "Important Contacts." |
| **Type of Administration** | The Plan is administered by the Plan Sponsor. |
| **Type of Plan** | The Plan is considered an "employee welfare benefit plan" within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). |
| **Plan Records and Plan Year** | The Plan and all its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year. |
| **Agent for Service of Legal Process** | The Nokia Legal & Compliance organization is the agent for service of legal process. Service of legal papers, including service of subpoenas, may be served directly to:<br><br>Nokia<br>Legal & Compliance<br>Room 6D-401A<br>600-700 Mountain Avenue<br>Murray Hill, NJ 07974 USA |
| **Employer Identification Number** | The Employer Identification Number assigned by the IRS to the Plan Sponsor is 22-3408857. |
| **Plan Number** | The Plan Number assigned by the Plan Sponsor to the Plan is 502. |
| **Plan Trustee** | None. Plan benefits are paid from the general assets of the Company (for the Surest options, the Prescription Drug Program, and the EAP). |

## Section V. Important Contacts

Here is a list of important contacts for the Plan:

| Contact/Service Provided | Address |
|---|---|
| **Surest**<br>Claims Administrator for the Surest medical options | Benefits.Surest.com<br>1-866-683-6440 |
| **CVS Caremark**<br>Claims Administrator for the Prescription Drug Program | Caremark.com<br>1-800-240-9623 |
| **Magellan**<br>Administrator for the Employee Assistance Program | Member.MagellanHealthcare.com<br>1-800-327-7348 |
| **Plan Administrator**<br>Administers the Plan; adjudicates eligibility claims; oversees third-party service-providers, responsible for certain disclosure to Participants regarding the Plan. | Plan Administrator<br>Nokia<br>600-700 Mountain Avenue<br>Room 6D-401A<br>Murray Hill, NJ 07974 USA |
| **Nokia Benefits Resource Center (NBRC)**<br>Call center where you can:<br>• Enroll in coverage<br>• Make changes to your coverage<br>• Review, add or change your dependent's information on file<br>• Understand how a Life Event may affect your benefits<br>• Get answers to your questions regarding eligibility and enrollment in the Plan | 1-888-232-4111 (domestic)<br>1-212-444-0994 (if calling from outside the U.S., Puerto Rico or Canada)<br>Representatives are available between 9:00 a.m. and 5:00 p.m., Eastern Time (ET), Monday through Friday.<br>If you are hearing or speech impaired, please use a Relay Service when calling a representative. |

| **Contact/Service Provided** | **Address** |
|---|---|
| | The mailing address of the NBRC is:<br><br>Nokia Benefits Resource Center<br>Dept. 07544<br>P.O. Box 64116<br>The Woodlands, TX 77387-4116 USA<br><br>Overnight mail should be sent to:<br><br>Nokia Benefits Resource Center<br>Dept. 07544<br>8770 New Trails Drive<br>The Woodlands, TX 77381 USA |
| **Nokia BenefitAnswers Plus**<br><br>Website where you can:<br>• See benefits news and updates<br>• View plan-related documents such as Summary Plan Descriptions (SPDs), Summaries of Material Modifications (SMMs), and Summary Annual Reports<br>• View enrollment materials<br>• Find carrier contact information during the year | https://www.benefitanswersplus.com/ |
| **Nokia Benefits Review Team**<br><br>The team within the Nokia Benefits Resource Center assigned the responsibility to decide claims for eligibility to participate in the Plan | Claims and Appeals Management<br>Dept 07544<br>PO Box 299107<br>Lewisville, TX 75029-9107 |
| **Nokia Employee Benefits Committee**<br><br>Serves as final review committee for Plan eligibility appeals. | Employee Benefits Committee<br>Nokia<br>600-700 Mountain Avenue<br>Room 6C-402A<br>Murray Hill, NJ 07974 USA |
| **Nokia Legal & Compliance Organization**<br><br>Authorized agent for service of process of all legal papers for the Plan, the Severance Plan Administrator, and the Nokia Employee | Legal & Compliance Organization<br>Nokia<br>600-700 Mountain Avenue<br>Room 6D-401A<br>Murray Hill, NJ 07974 USA |

| **Contact/Service Provided** | **Address** |
|---|---|
| Benefits Committee. Also authorized agent for service of subpoenas. | |
| **Nokia QMCSO Administrator**<br><br>Handles matters relating to Qualified Medical Child Support Orders ("QMCSOs") for the Plan | Send all draft or court-certified orders to:<br><br>Nokia Qualified Order Team<br>P.O. Box 1542<br>Lincolnshire, IL 60069-1542 USA<br><br>You can also fax documents and inquiries to: 1 (847) 442-0899.<br><br>For information or if you have questions: visit the Qualified Order Center website at www.QOcenter.com, email your questions to QOcenter@alight.com, or contact the Nokia Benefits Resource Center. |
| **Your Benefits Resources (YBR)™**<br><br>Website where you can:<br>• View your current coverage<br>• Review and compare your healthcare options and contribution costs<br>• Enroll in coverage<br>• Make changes to your coverage<br>• Learn more about your Nokia benefits<br>• Review, add or change your dependent's information on file<br>• Understand how a Life Event may affect your benefits<br>(Your Benefits Resources is a trademark of Alight Solutions LLC.) | You can access YBR at https://digital.alight.com/nokia, 24 hours a day, seven days a week. |

# Appendices

## Appendix 1

Benefits at a Glance – Medical

# Medical

## Surest plan options

**Please note: For the Surest medical services shown in the table below and on the following pages, you will see a copayment (copay) assigned for the covered health service.**

- **If you use an in-network provider, you will pay lower copays and the provider will not charge you any additional fees.**
- **When medical services are received from a non-network provider, eligible expenses are an amount negotiated by UnitedHealthcare, a specific amount required by law (when required by law) or an amount UnitedHealthcare has determined is typically accepted by a healthcare provider for the same or similar service.**

| | Surest Enhanced | | Surest Standard | |
|---|---|---|---|---|
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Overall provisions** | | | | |
| **Choice of doctors** | Select from within a network of medical providers | Select any medical provider | Select from within a network of medical providers | Select any medical provider |
| **Annual medical deductible** | $0 | $0 | $0 | $0 |
| **Coinsurance** (Plan paid) | 100% | 100% | 100% | 100% |
| **Medical annual out-of-pocket limit** | **Individual:** $4,000<br>**Family:** $8,000 | **Individual:** $8,000<br>**Family:** $24,000 | **Individual:** $6,000<br>**Family:** $12,000 | **Individual:** $12,000<br>**Family:** $36,000 |
| **Lifetime maximum benefit** | Unlimited for essential benefits. Generally, the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).<br>For all other benefits: Unlimited; some exclusions apply. | | | |
| **Copays for covered services** | | | | |
| **Acupuncture**<br>Limited to 30 visits/person/plan year | You pay<br>$50 copay/visit | You pay<br>$150 copay/visit | You pay<br>$70 copay/visit | You pay<br>$175 copay/visit |
| **Ambulance services (air and ground) — emergency** | You pay<br>$210 copay/transport | You pay<br>$210 copay/transport | You pay<br>$330 copay/transport | You pay<br>$330 copay/transport |
| **Ambulance services (air and ground) — nonemergency** | You pay<br>$210 copay/transport | You pay<br>$210 copay/transport | You pay<br>$330 copay/transport | You pay<br>$330 copay/transport |
| **Anesthesia** | You pay $0 copay | You pay $0 copay | You pay $0 copay | You pay $0 copay |

| | Surest Enhanced | | Surest Standard | |
|---|---|---|---|---|
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Autism spectrum disorder services** | **Virtual:** You pay $20 copay/visit<br>**Outpatient (home/office):** You pay $20 copay/visit<br>**Outpatient (facility):** You pay $110 copay/visit<br>**Inpatient:** You pay $1,600 copay/stay | **Virtual visit:** Not covered<br>**Outpatient (home/office):** You pay $160 copay/visit<br>**Outpatient (facility):** You pay $330 copay/visit<br>**Inpatient:** You pay $4,800 copay/stay | **Virtual:** You pay $40 copay/visit<br>**Outpatient (home/office):** You pay $40 copay/visit<br>**Outpatient (facility):** You pay $180 copay/visit<br>**Inpatient:** You pay $2,700 copay/stay | **Virtual visit:** Not covered<br>**Outpatient (home/office):** You pay $80 copay/visit<br>**Outpatient (facility):** You pay $540 copay/visit<br>**Inpatient:** You pay $8,100 copay/stay |
| **Birth control** (prescription birth control or medication only) | See “Coverage through the CVS Caremark prescription drug program” on page 14. | | | |
| **Birthing center** | You pay $750 – $1,500 copay/stay | You pay $4,500 copay/stay | You pay $1,500 – $3,000 copay/stay | You pay $9,000 copay/stay |
| **Blood and blood derivatives** | **Outpatient and inpatient:** You pay $175 – $875 copay/visit | **Outpatient and inpatient:** You pay $2,625 copay/visit | **Outpatient and inpatient:** You pay $400 – $1,600 copay/visit | **Outpatient and inpatient:** You pay $4,800 copay/visit |
| **Cardiac rehabilitation** (phase three maintenance not covered) | You pay $60 copay/visit | You pay $180 copay/visit | You pay $100 copay/visit | You pay $300 copay/visit |
| **Chemotherapy** | You pay $25 – $650 copay/visit | You pay up to $1,950 copay/visit | You pay $70 – $700 copay/visit | You pay up to $2,100 copay/visit |
| **Chiropractic**<br>Limited to 30 visits/person/plan year | You pay $25 copay/visit | You pay $75 copay/visit | You pay $35 copay/visit | You pay $80 copay/visit |
| **Colonoscopy — preventive and diagnostic** | **Preventive and diagnostic:** You pay $0 copay/visit | **Preventive:** You pay $160 copay/visit<br>**Diagnostic:** You pay $2,950 copay/visit | **Preventive and diagnostic:** You pay $0 copay/visit | **Preventive:** You pay $220 copay/visit<br>**Diagnostic:** You pay $2,950 copay/visit |
| **Dental services — accident only** | **Office:** You pay $20 – $105 copay/visit<br>**Outpatient:** You pay $35 – $3,000 copay/visit<br>**Inpatient:** You pay $200 – $3,000 copay/visit | **Office:** You pay $220 copay/visit<br>**Outpatient:** You pay up to $7,000 copay/visit<br>**Inpatient:** You pay up to $7,000 copay/visit | **Office:** You pay $40 – $150 copay/visit<br>**Outpatient:** You pay $70 – $4,500 copay/visit<br>**Inpatient:** You pay $600 – $4,500 copay/visit | **Office:** You pay $220 copay/visit<br>**Outpatient:** You pay up to $11,000 copay/visit<br>**Inpatient:** You pay up to $11,000 copay/visit |
| **Diabetes self-management items** | You pay $0 – $1,000 copay for diabetic supplies | You pay up to $2,000 copay for diabetic supplies | You pay $0 – $1,000 copay for diabetic supplies | You pay up to $2,000 copay for diabetic supplies |
| **Durable medical equipment** | You pay $0 – $1,000 copay | You pay up to $2,000 copay | You pay $0 – $1,000 copay | You pay up to $2,000 copay |

| | Surest Enhanced | | Surest Standard | |
|---|---|---|---|---|
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Emergency room — emergency use** | You pay $350 copay/visit (waived if admitted within 24 hours) | You pay $350 copay/visit (waived if admitted within 24 hours) | You pay $550 copay/visit (waived if admitted within 24 hours) | You pay $550 copay/visit (waived if admitted within 24 hours) |
| **Emergency room — nonemergency use** | You pay $350 copay/visit | You pay $350 copay/visit | You pay $550 copay/visit | You pay $550 copay/visit |
| **Fertility services** | Plan pays $100 – $1,500 copay/service; for a list of covered services and copays, see the Summary Plan Description at www.benefitanswersplus.com/active_m/spd.html | Not covered | Plan pays $100 – $1,500 copay/service; for a list of covered services and copays, see the Summary Plan Description at www.benefitanswersplus.com/active_m/spd.html | Not covered |
| **Habilitative and rehabilitation services**<br><br>Each type of therapy is limited to 100 visits/ person/plan year; not combined with other therapies; in- and out-of-network combined | You pay $10 – $140 copay/visit | You pay up to $240 copay/visit | You pay $20 – $200 copay/visit | You pay up to $330 copay/visit |
| **Hearing aids** | You pay $0 copay; plan pays a maximum of $5,000 every 36 months for in- and out-of-network providers combined | | | |
| **Home healthcare**<br>100-visit limit/person/plan year; in- and out-of-network combined | You pay $60 copay/visit | You pay $180 copay/visit | You pay $80 copay/visit | You pay $240 copay/visit |
| **Hospice care** | **Home:** You pay $60 copay/visit<br>**Inpatient:** You pay $2,000 copay/stay | **Home:** You pay $180 copay/visit<br>**Inpatient:** You pay $6,000 copay/stay | **Home:** You pay $80 copay/visit<br>**Inpatient:** You pay $3,500 copay/stay | **Home:** You pay $240 copay/visit<br>**Inpatient:** You pay $10,500 copay/stay |
| **Inpatient hospitalization** | You pay $200 – $3,000 copay/stay | You pay $4,800 – $7,000 copay/stay | You pay $600 – $4,500 copay/stay | You pay $7,450 – $11,000 copay/stay |
| **Maternity**<br>(office visits [pre/postnatal], in-hospital delivery services) | **Office visits (pre/postnatal):** You pay $0 copay/visit<br>**In-hospital delivery services:** You pay $750 – $1,500 copay/stay | **Office visits (pre/postnatal):** You pay $160 copay/visit<br>**In-hospital delivery services:** You pay $4,500 copay/stay | **Office visits (pre/postnatal):** You pay $0 copay/visit<br>**In-hospital delivery services:** You pay $1,500 – $3,000 copay/stay | **Office visits (pre/postnatal):** You pay $220 copay/visit<br>**In-hospital delivery services:** You pay $9,000 copay/stay |
| **Medical infusions** | You pay $40 – $2,600 copay/visit | You pay up to $7,000 | You pay $75 – $3,900 copay/visit | You pay up to $11,000 |

| | Surest Enhanced | | Surest Standard | |
|---|---|---|---|---|
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Mental health and chemical dependency** | **Virtual:** You pay $20 – $60 copay/visit<br>**Outpatient (home/office):** You pay $20 copay/visit<br>**Outpatient (facility):** You pay $110 copay/visit<br>**Inpatient:** You pay $1,600 copay/stay | **Virtual visit:** Not covered<br>**Outpatient (home/office):** You pay $40 copay/visit<br>**Outpatient (facility):** You pay $330 copay/visit<br>**Inpatient:** You pay $4,800 copay/stay | **Virtual visit:** You pay $40 – $100 copay/visit<br>**Outpatient (home/office):** You pay $40 copay/visit<br>**Outpatient (facility):** You pay $180 copay/visit<br>**Inpatient:** You pay $2,700 copay/stay | **Virtual visit:** Not covered<br>**Outpatient (home/office):** You pay $80 copay/visit<br>**Outpatient (facility):** You pay $540 copay/visit<br>**Inpatient:** You pay $8,100 copay/stay |
| **Outpatient lab/X-ray/ ultrasound/complex imaging** | **Routine diagnostic test:** You pay $0 copay<br>**Non-routine diagnostic test:** You pay $20 – $1,300 copay/visit<br>**Complex imaging:** You pay $100 – $1,400 copay/visit | **Routine diagnostic test:** You pay $0 copay<br>**Non-routine diagnostic test:** You pay up to $3,150 copay/visit<br>**Complex imaging:** You pay up to $4,200 copay/visit | **Routine diagnostic test:** You pay $0 copay<br>**Non-routine diagnostic test:** You pay $35 – $1,850 copay/visit<br>**Complex imaging:** You pay $150 – $2,400 copay/visit | **Routine diagnostic test:** You pay $0 copay<br>**Non-routine diagnostic test:** You pay up to $3,150 copay/visit<br>**Complex imaging:** You pay up to $5,850 copay/visit |
| **Physician hospital visits and consultations** | You pay $0 copay | You pay $0 copay | You pay $0 copay | You pay $0 copay |
| **Physician visits** (primary care physician [PCP] office visits, specialist office visits, urgent care center visits and virtual visits) (non-preventive) | **PCP and specialist:** You pay $20 – $105 copay/visit<br>**Urgent care center:** You pay $75 copay/visit<br>**Virtual visit (urgent and acute care and primary care):** You pay $0 copay/visit<br>**Virtual visit (specialty):** You pay $0 – $105 copay/visit | **PCP and specialist:** You pay $220 copay/visit<br>**Urgent care center:** You pay $225 copay/visit<br>**Virtual visit:** Not covered | **PCP and specialist:** You pay $40 – $150 copay/visit<br>**Urgent care center:** You pay $125 copay/visit<br>**Virtual visit (urgent and acute care and primary care):** You pay $0 copay/visit<br>**Virtual visit (specialty):** You pay $0 – $150 copay/visit | **PCP and specialist:** You pay $220 copay/visit<br>**Urgent care center:** You pay $375 copay/visit<br>**Virtual visit:** Not covered |
| **Podiatrist** | **Office:** You pay $20 – $105 copay/visit | **Office:** You pay $220 copay/visit | **Office:** You pay $40 – $150 copay/visit | **Office:** You pay $220 copay/visit |
| **Private duty nursing** | You pay $60 copay/visit | You pay $180 copay/visit | You pay $80 copay/visit | You pay $240 copay/visit |
| **Prosthetic devices** | You pay $0 – $1,000 copay | You pay up to $2,000 copay | You pay $0 – $1,000 copay | You pay up to $2,000 copay |
| **Radiation therapy** | You pay $15 – $2,100 copay | You pay up to $6,300 copay | You pay $20 – $3,700 copay | You pay up to $11,000 copay |
| **Second surgical opinion** | You pay $0 through 2nd.MD | Not covered | You pay $0 through 2nd.MD | Not covered |
| **Skilled nursing facility** 100-day limit/person/plan year; in- and out-of-network combined | You pay $1,600 copay/stay | You pay $4,800 copay/stay | You pay $2,700 copay/stay | You pay $8,100 copay/stay |

| | Surest Enhanced | | Surest Standard | |
|---|---|---|---|---|
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Smoking deterrents** (prescription only) | See “Coverage through the CVS Caremark prescription drug program” on page 14. | | | |
| **Surgery — in-office or outpatient** | You pay $35 – $3,000 copay | You pay up to $7,000 copay | You pay $70 – $4,500 copay | You pay up to $11,000 copay |
| **Surgery — inpatient** | You pay $200 – $3,000 copay | You pay up to $7,000 copay | You pay $600 – $4,500 copay | You pay up to $11,000 copay |
| **Wigs** Limited to one wig per plan year | You pay $0 – $1,000 copay | You pay up to $2,000 copay | You pay $0 – $1,000 copay | You pay up to $2,000 copay |
| **Preventive care** | | | | |
| **Routine physical exams** | You pay $0 copay/visit | You pay $160 copay/visit | You pay $0 copay/visit | You pay $220 copay/visit |
| **Well-child care** (including immunizations) | You pay $0 copay/visit | You pay $160 copay/visit | You pay $0 copay/visit | You pay $220 copay/visit |
| **Well-woman care** (ob-gyn exam) | You pay $0 copay/visit | You pay $160 copay/visit | You pay $0 copay/visit | You pay $220 copay/visit |
| **Mammogram screening** | You pay $0 copay/visit | You pay $160 copay/visit | You pay $0 copay/visit | You pay $220 copay/visit |
| **Pap smear** (in doctor’s office) | You pay $0 copay/visit | You pay $160 copay/visit | You pay $0 copay/visit | You pay $220 copay/visit |
| **Digital rectal exam and blood test for PSA** (in doctor’s office — prostate cancer screening for men age 50 and older) | You pay $0 copay/visit | You pay $160 copay/visit | You pay $0 copay/visit | You pay $220 copay/visit |
| **Newborn in-hospital care** | You pay $0 copay/visit | You pay $160 copay/visit | You pay $0 copay/visit | You pay $220 copay/visit |
| **Other important information about your medical coverage** | | | | |
| **Are you responsible for charges in excess of the allowable amount?** | Not applicable | Not applicable | Not applicable | Not applicable |
| **Who is responsible for prior authorization?** | Your provider | You | Your provider | You |
| **What is the penalty for failure to obtain prior authorization?** | Your provider will be responsible for 100% of the billed amount | You will be responsible for 100% of the billed amount | Your provider will be responsible for 100% of the billed amount | You will be responsible for 100% of the billed amount |
| **Do you have to file claim forms?** | No | Yes | No | Yes |
| **Are Centers of Excellence available?** | Transplant Resource Services | Not covered | Transplant Resource Services | Not covered |

## Appendix 2

Benefits at a Glance – Prescription Drug Program

# Prescription drug coverage

| | Surest Enhanced and UHC Enhanced | | Surest Standard and UHC Standard | |
|---|---|---|---|---|
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Coverage through the CVS Caremark prescription drug program[1,2]** | | | | |
| **Prescription drug annual out-of-pocket limit** | **Individual:** $4,000<br>**Family:** $8,000 | Not applicable | **Individual:** $4,150<br>**Family:** $8,300 | Not applicable |
| **Retail[3]**<br>(up to a 30-day supply) | **Generic:** You pay $20 copay<br>**Preferred brand:** You pay $90 copay<br>**Nonpreferred brand:** You pay $150 copay | Plan pays 60% coinsurance after you pay separate deductible<br>**Individual:** $175<br>**Two-person:** $350<br>**Family**: $525 | You pay $20 copay for generic drugs and 50% coinsurance for brand-name drugs, with an out-of-pocket minimum of $30 and maximum of $150/prescription | Plan pays 50% coinsurance after you pay separate deductible:<br>**Individual:** $225<br>**Two-person:** $450<br>**Family:** $675 |
| **Mail order**<br>(up to a 90-day supply) | **Generic:** You pay $50 copay<br>**Preferred brand:** You pay $225 copay<br>**Nonpreferred brand:** You pay $375 copay | Not applicable | You pay $50 copay for generic drugs and 50% coinsurance for brand-name drugs, with an out-of-pocket minimum of $75 and maximum of $375/prescription | Not applicable |
| **Member pays the difference** | You will pay the generic copay, plus the difference in cost between the brand-name and generic drug, if you purchase a brand-name drug when a generic equivalent is available. | | | |
| **Other important information about your medical and prescription drug coverage** | | | | |
| **$0 out-of-pocket cost for certain preventive medications** | Certain preventive medications, including some over-the-counter (OTC) medications, are covered 100% without imposing a copay, coinsurance or deductible as long as they are presented with a prescription from a licensed healthcare provider. The list of eligible medications is subject to change as Affordable Care Act guidelines are updated or modified. | | | |

1 The deductibles and out-of-pocket maximums for the prescription drug program are separate from the deductibles and/or out-of-pocket maximums for Surest and UHC medical coverage. “Member pays the difference” program charges do not count toward prescription drug annual out-of-pocket maximums.

2 Where prescription drug coverage is expressed as a percentage, it is a percentage of the plan’s cost for the drug.

3 Prescription drug copays will double after the third time you receive a 30-day supply of a maintenance medication at a retail pharmacy; for cost savings, fill up to a 90-day supply through mail order or pick up at a CVS retail pharmacy or at any Costco Pharmacy. Note the following state exceptions to the doubling of copays: **FLORIDA:** Participants residing in Florida can also obtain 90-day supplies of medications taken on an ongoing basis at any in-network retail pharmacy that fills 90-day supplies. **MINNESOTA:** Participants residing in Minnesota also have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find an in-network participating pharmacy. **OKLAHOMA:** Participants residing in or filling their prescriptions in Oklahoma can also obtain 90-day supplies of medications taken on an ongoing basis at any in-network retail pharmacy that fills 90-day supplies. **TENNESSEE:** Participants residing in Tennessee also have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find an in-network participating pharmacy. **WEST VIRGINIA:** Participants residing in West Virginia will have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find a participating pharmacy.

**Note:** Your CVS Caremark prescription drug coverage includes the PrudentRx Copay Program, a cost-saving program for certain specialty medications. For information about PrudentRx, see the *Nokia Medical Expense Plan for Active Employees Summary Plan Description (SPD) — Surest Enhanced and Standard Options* and the *Nokia Medical Expense Plan for Active Employees SPD — UHC Enhanced and Standard Options* at www.benefitanswersplus.com/active_m/spd.html.

**Remember: You may not be eligible for all of the coverage options shown in the tables above. For information about the Kaiser HMO, contact Kaiser. Carrier contact information is on page 23.**

**About Nokia**

Nokia is a global leader in connectivity for the AI era. With expertise across fixed, mobile, and transport networks, powered by the innovation of Nokia Bell Labs, we're advancing connectivity to secure a brighter world.