Assurant Health and Welfare Benefit Plan
Summary Plan Description

Rev. October 2026

Important information

Your compensation is much more than your paycheck – it also includes the value of the benefits Assurant provides. These company-provided benefits are often referred to as a "hidden paycheck," and Assurant designs the benefits to provide protection and flexibility for you and your family. The company provides certain core benefits at no cost to you, as well as optional benefits that may be offered at a shared cost or at your expense. By making informed choices, you can select the benefits that best meet your needs.

This summary plan description (SPD) describes the benefit programs available under the Assurant Health & Welfare Benefit Plan (the Plan), as amended and restated effective January 1, 2023 (the Plan Document).

Defined terms appear in italics and are found and explained in the Glossary. "Assurant" refers to Assurant, Inc. and each of its affiliates authorized to participate in the Plan.

While Assurant intends to continue these benefits, it reserves the right to amend or terminate the Plan, in whole or in part, at any time and in its sole discretion. In the event of any inconsistency between this SPD and the Plan Document (including applicable insurance contracts and policies), the Plan Document will govern. If this SPD addresses a topic not covered in the Plan Document, the SPD will control.

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How to Enroll

You'll enroll online through Workday/MyHR, using information about the Plan and the benefits programs available at myassurantbenefits.com. If you have questions, contact the People Experience Center at 1-866-324-6513 or ask ERIN. ERIN can be accessed across multiple channels, including your desktop, MS Teams, the web, MyHR and via mobile app.

Do I Need to Enroll?

Some coverage is automatically provided to you. Other benefits may require you to take action. Eligible employees are automatically enrolled in the default benefits listed in the table below, and Assurant pays 100% of the cost of the default benefits. In contrast, eligible employees must make timely, affirmative elections to enroll in the optional benefits listed in the table below. All the optional benefits require eligible employees to pay for all or part of the cost. This SPD has sections that explain each of these default benefits and optional benefits in greater detail.

Company-Paid Default Benefits (Employee is Auto-Enrolled)	
Benefit	**Cost**
Basic Life Insurance – 1x *plan pay*	Company-Paid (Assurant pays 100% of the cost)
Basic Accidental Death and Dismemberment Insurance – 1x *plan pay*	
Short-Term Disability	
Long-Term Disability (Core)	
Business Travel Accident Insurance - 5x *plan pay*	
Employee Assistance Program (EAP)	
Back-Up Care	
LiveWell Wellbeing Program	

Optional (Employee-Elected) Benefits	
Benefit	**Cost**
Medical Plan	Coverage is available for you and your eligible *dependents* under the Purple, Blue, Green, and Orange medical plans. You and Assurant share in the cost of your medical plan benefits. You pay your portion through pre-tax payroll deductions.
Prescription Drug	Prescription drug coverage is included with enrollment in a medical plan. Coverage is available for you and your eligible *dependents*. There is no separate *premium* for prescription drug coverage; costs are

	included as part of your medical plan contribution, which is shared between you and the company.
Health Savings Account (HSA)	Assurant contributes to your HSA if you enroll in the Green or Orange medical plan. You can also make pre-tax contributions.
Health Care Flexible Spending Account (FSA)	You can pay for eligible health care expenses with pre-tax money when you contribute to your FSA.
Dependent Day Care Flexible Spending Account (FSA)	You can pay for eligible *dependent* day care expenses with pre-tax money when you contribute to your FSA.
Dental Plan	Coverage is available for you and your eligible *dependent*s under the dental plan low and dental plan high. You and Assurant share in the cost of dental coverage. You pay your portion through pre-tax payroll deductions
Vision Plan	Coverage is available for you and your eligible *dependents*. You pay the *premium* through a pre-tax deduction from your paycheck.
Long-Term Disability (Buy-up Option)	You pay the *premium*
Supplemental Life (1 - 8 x *plan pay*)	You pay the *premium*
Dependent Life Supplemental AD&D (1 – 8 x *plan pay*)	You pay the *premium* You pay the *premium*
Accident Insurance	You pay the *premium*
Critical Illness Insurance	You pay the *premium*
Hospital Indemnity Insurance	You pay the *premium*
Legal Assistance Plan	You pay the *premium*
Commuter Benefits Program Tuition Reimbursement Program Adoption Assistance Surrogacy Assistance	These benefits are not subject to ERISA. They are described in the SPD as a convenience, and because there may be other applicable laws (e.g., the Internal Revenue Code) that require a written document). Coverage is available as described in the SPD.

Who is Eligible?

As an employee, you may participate in all the health and welfare programs offered under the Plan, provided you are eligible. Your *dependents* are also eligible for certain programs.

Eligible Employees

As an employee, you may be eligible to participate in the health and welfare programs described in this SPD, subject to the eligibility requirements outlined below. Certain programs also extend coverage to eligible *dependents* as described in **Eligible *Dependents***. Additional eligibility requirements may apply with respect to a specific benefit, as may be set forth in the applicable section in this SPD for that benefit.

You're not eligible to participate in the Plan if you're a:

- Employee of a leasing agency;
- Independent contractor;
- Self-employed individual;
- Seasonal employee working annually in a position of limited duration not to exceed five months; or
- Employee who is not on the U.S. payroll

Assurant's classification of a person as an employee or non-employee is conclusive and binding for purposes of benefit eligibility. If, for any reason, a person is reclassified from a non-employee to an employee, that person will not be retroactively eligible for benefits. Instead, benefit eligibility will begin prospectively from the date the reclassification is made.

Once initially eligible, you may be able to continue your participation in one or more of the benefit options if you take an approved leave of absence, even though you temporarily won't continue to satisfy the Plan's active minimum hours requirements. See **Coverage Continuation During Leaves of Absence** for more information.

Eligible Dependents

Provided you make timely elections, you may enroll your eligible *dependents* in the benefit plans you elect. You cannot enroll a *dependent* unless you are also enrolled in the same plan. A person cannot be covered under the plan as both an employee and a *dependent*. If you and your spouse/*domestic partner* are both employees, only one of you may cover any eligible children. All *dependent* enrollments are subject to *dependent* verification (see Proof of Eligibility for required documentation and deadlines).

Eligible *dependents* include (see separate definition for Dependent Life Insurance below):

- Your legal spouse or *domestic partner*;
- Your children through the end of the month in which they turn age 26, including:
    - Biological children
    - Adopted children or children placed for adoption
    - Stepchildren or *domestic partner*'s children
    - Children born through a surrogacy arrangement
    - Foster children or children under your legal guardianship (court-appointed)
    - Your children over age 26 who are mentally or physically disabled and totally *dependent* on your support provided:
        - They were covered under the plan prior to turning age 26
        - They are unmarried, and
        - You timely provide a certification of disability (see below);
    - Any child who must be covered under a Qualified Medical Support Order (QMSCO); and
    - Other children through the end of the month in which they turn age 26, if they:
        - Receive more than half of their support from you and/or your spouse or *domestic partner*;
        - Have your home as their principal residence; and

- You are the court-appointed guardian (e.g., a grandchild, you have legal custody of and claim as a *dependent* for tax purposes)

For Dependent Life Insurance, eligible *dependents* include your lawful spouse or domestic partner and your spouse's/domestic partner's unmarried children from live birth to age 19, or less than age 26 if a full-time student. These include any biological or adopted children, stepchildren and foster children. A child will be considered adopted on the date of placement in your home. Children also include any children for whom you or your domestic partner are the legal guardian, who reside with you on a permanent basis and depend on you or your spouse/domestic partner for support and maintenance.

Certification of Disability

Certification of disability must be submitted to the Plan Administrator within 31 days after the child reaches age 26. Periodic recertification may be required. Certification forms are available from the People Experience Center at 1-866-324-6513.

Domestic Partner

If you are adding a *domestic partner* or child of a *domestic partner* to your health and welfare coverage, you may need to submit evidence that you meet these requirements.

Please note that IRS regulations require employee *premiums* for *domestic partner* coverage to be paid on an after-tax basis. For administrative convenience, *premiums* are paid on a pre-tax basis and then are imputed into income. This amount will be added to your per-pay period gross income shown on your pay statement. See **Non-tax-qualified *Dependents*** and ***Imputed Income*** for more information.

Social Security Number Requirement

To comply with the Medicare Secondary Payer Act and employer reporting of health coverage, Assurant requires that you provide the Social Security number of any *dependent* you enroll under the Health Plan within 60 days of enrollment. If you enroll a newborn, you'll have six months from the date of enrollment to provide the baby's Social Security Number to the People Experience Center.

Proof of *Dependent* Eligibility

If you elect coverage for your *dependents* under the medical or dental plan, you'll be required to verify your *dependents'* eligibility. After your enrollment, you'll receive both a mailing at your home address and an email to your Assurant email from Aptia, Assurant's *dependent* verification vendor. Please read the materials you receive carefully and provide all requested documents by the deadline indicated in the correspondence.

If you elect coverage for your disabled child older than age 26, you must obtain a certification of disability form from the People Experience Center at 1-866-324-6513 or by asking ERIN and submit the completed form to Anthem by no later than 31 days after your child reaches age 26. This may be required periodically.

If you don't provide the required documentation by the deadline, your *dependents* will be removed from all applicable Plan coverage. Moreover, if we determine that you have enrolled someone who does not meet the eligibility criteria or if you fail to notify us of a change in your *dependent's* eligibility status, you may be:

- Responsible for any claims, expenses, reimbursements, or other costs paid during the period of ineligibility and
- Subject to disciplinary action up to and including termination of employment.

When to Enroll?

It is very important for you to timely enroll in the Plan during the applicable enrollment periods. There are two general enrollment periods – the initial eligibility period and open enrollment.

Initial Eligibility Period

You have 15 calendar days from your hire date or the date you become a benefits-eligible employee to enroll in your Plan benefits. Assurant will allow an additional 15 calendar day grace period to make changes to your enrollment if for some reason you are unable to enroll within the designated 15 calendar day enrollment period. All eligible employees are automatically enrolled in the default benefits listed in the **Do I Need to Enroll?** section. If you do not affirmatively elect to enroll in any of the optional benefits listed in the **Do I Need to Enroll?** section by the end of the grace period, you'll be automatically enrolled into the default benefits, and you will be deemed not to have elected to enroll in any optional benefits.

You'll not be able to change your medical, dental, vision and Flexible Spending Account elections during the calendar year unless you experience a qualified life event or have a HIPAA special enrollment right and report it through MyHR within 30 days. Assurant will allow an additional 30 calendar day grace period to make changes to your elections if for some reason you are unable to make changes within the initial designated 30 calendar day enrollment period.

If you have medical coverage from another source (e.g., spouse's employer), you can waive medical plan coverage through Assurant.

Employees of a leasing agency and independent contractors are not our employees, so they are not eligible for benefits unless and until they are hired as employees of Assurant. Their prior service as an employee of a leasing agency or as an independent contractor will not count toward satisfying the eligibility period, nor will prior employment periods for employees rehired after a 30-day break in service.

When Coverage Begins

Generally, your coverage begins on the later of your hire date or the date you become benefits-eligible. You must be actively at work for benefits to begin.

Coverage for your eligible *dependents* is effective on the date you become eligible – or the date your *dependent* becomes eligible (whichever is later).

Open Enrollment

Each fall, you'll have the opportunity to make changes to your benefit elections during Open Enrollment. For example, you can change your medical plan option (e.g., switch from the Blue plan to the Green plan) or change your coverage tier to add or remove *dependents* (e.g., move from Employee + Spouse coverage to Family coverage). You will be notified in advance of the annual Open Enrollment period each year and the enrollment materials will describe how to enroll.

If you fail to make your benefit plan elections by the Open Enrollment deadline, you'll be defaulted into your current coverage, except for any contribution elections to a *Health Savings Account* or Flexible Spending Account. You will be unable to change your elections until the next Open Enrollment period unless you experience a qualified life event or have a HIPAA special enrollment right and report it through MyHR within 60 days (which includes both the designated 30 calendar day enrollment period plus the additional 30 calendar day grace period).

You must make an active election to participate in the Health Care and *Dependent* Day Care Flexible Spending Accounts and to make your own pre-tax contributions to the *Health Savings Account (HSA)*. If you fail to elect to participate during Open Enrollment, your contributions will end at the end of the current *plan year*.

While your current Dental, Vision, Disability, Life, and AD&D Insurance elections will continue into the next year unless you make a change, Open Enrollment is the time to re-evaluate all your coverage needs. It's also a great time to review your *beneficiary* designations to make sure they reflect any changes that occurred during the year.

Any elections you make during Open Enrollment are effective January 1 of the following year, except if you elect to increase Life or *Dependent* Life Insurance during the Open Enrollment period, your coverage is effective on the later of:

- January 1 of the following calendar year; and
- The date MetLife approves your or your *dependent's* Statement of Health (SOH).

Request for Additional Enrollment Information

Assurant, the Plan Administrator and/or the Claims Administrators reserve the right to request information regarding you and your *dependents* as a condition of enrollment in the Plan (including continuing participation and enrollment). This information is necessary for proper and effective administration of the Plan and, in some cases, required by federal law. The Plan Administrator also authorizes the Claims Administrators and/or the Carrier to request such information as necessary to process claims and/or to administer that particular benefit option.

Failure to timely provide the requested information or fraudulently providing information will result in the termination of your coverage and may result in the retroactive termination of your coverage (subject to applicable notice and appeal rights) for failing to satisfy the Plan's terms of enrollment (and no continuation of coverage will be offered) and may subject you to disciplinary action, up to and including termination of employment. If coverage is terminated retroactively, you may be required to pay the Plan back for any benefits paid. See Rescission of Coverage for additional information.

Mid-year Coverage Changes

Generally, once you enroll in (or decline) coverage, your elections stay in effect for the entire *plan year*. However, there are certain limited situations in which you may change some of your elections during the year. For benefits you pay for with pre-tax contributions, you are permitted to change elections if you have a Qualified Life Event and you make an election change consistent with that Qualified Life Event. For elections under the health plan benefit options, you or one of your eligible *dependents* may be entitled to a HIPAA special enrollment right if health coverage is lost under another plan.

Qualified Life Events

If you experience a change in status, referred to here as a qualified life event, you may revoke your old election under the Plan and make a new election for the remainder of the year, provided that both the revocation and new election are on account of and correspond with the qualified life event. Changes in status that are qualified life events include the following, as well as any other events that the Plan Administrator determines are permitted under IRS regulations:

- Change in Marital Status (e.g., marriage, legal separation, annulment, or divorce)
- Change in *dependent* status, such as:
    - Birth, adoption or placement for adoption, or birth of a child from a surrogacy arrangement
    - Becoming a foster parent/legal guardian
    - Death of a spouse/*domestic partner* or *dependent*
    - Loss of *dependent* eligibility due to the attainment of age 26 or a divorce/termination of a *domestic partner*ship
    - Spouse/*domestic partner* or *dependent* becomes eligible for coverage under the Assurant Plan in his/her own right
- Significant change in your or your spouse's/*domestic partner*'s/*dependent's* employment status that affects your or his or her eligibility for coverage, such as:
    - Termination of employment
    - Change in work schedule (e.g., a strike, a start or end of an unpaid leave absence, change in worksite or change in employment) that leads to a loss or gain of eligibility for coverage
- Significant change in coverage under another plan, such as:
    - Eligibility for Medicare or Medicaid
    - Loss of eligibility for Medicare or Medicaid
    - Exhaustion of COBRA coverage from another employer (does not include termination of COBRA coverage for the failure to pay required *premiums*)
    - Certain judgments or orders regarding coverage for a *dependent* child (e.g., a QMCSO)

Generally, you will be allowed to make coverage changes only if the qualified life event results in you, your spouse/*domestic partner*, or your *dependents* gaining or losing coverage eligibility under an employer-sponsored plan. Your change in coverage must be consistent with this gain or loss of coverage. Special rules apply to mid-year changes to flexible spending accounts. See **Electing Coverage in an FSA** for more information.

Limitations

- You must submit a request to change your benefits in MyHR within 30 calendar days of the qualified life event (the designated enrollment period). **See How to Enroll** for more information. Assurant will allow an additional 30 calendar day grace period to make changes to your elections if for some reason you are unable to do so within the designated 30 calendar day enrollment period. Following the end of the grace period, you must wait until the next Open Enrollment or until you experience a separate qualified life event.
- You cannot reduce your Health Care FSA contributions to an amount that is less than the amount you've already received in reimbursements.
- You can submit for reimbursements only those expenses incurred while you and/or your *dependents* are participating in the Plan. For example, if you get married on June 1 and enroll in an FSA on June 15, only the expenses you or your spouse incur on or after June 15 are eligible for reimbursement.
- If you lose benefit eligibility and then regain it in less than 31 days and within the same calendar year (e.g., if you're rehired), you'll step back into your previous elections.
- If you lose benefit eligibility for 31 days or more or regain eligibility in the following calendar year, you must make new coverage elections.
- If you and/or your *dependents* are covered under another employer's medical plan, you cannot make changes to your Health Care FSA because of changes to the cost or coverage under the other employer's plan.

The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

Effective Date

In general, the effective date of coverage added due to a qualified life event is the later of:

- The date of the life event;
- The date MetLife accepts your Statement of Health, if required; or
- The date Lincoln Financial accepts your *evidence of insurability,* if required.

If you terminate coverage under the Plan due to a qualified life event, medical, dental and vision coverage will cease at the end of the month in which the qualified life event occurs. Participation in the Health Care and *Dependent* Day Care Flexible Spending Accounts will terminate at the end of the last pay period for which the last deduction is withheld.

HIPAA Special Enrollments Rights

If you decline enrollment for yourself or your *dependents* (including your spouse/*domestic partner*) because you have other health coverage, you may in the future be able to enroll yourself or your dependents in Assurant's health plan if you or your *dependents* lose eligibility for that other coverage (or if the employer stops contributing towards your or your d*ependent's* other coverage). However, you must request enrollment in Assurant's health plan by submitting a completed Life Event Form through MyHR 30 days after you or your *dependent's* other coverage ends (or after the employer stops its contribution toward the other coverage). Assurant will allow an additional 30 calendar day grace period to make

changes to your elections if, for some reason, you are unable to do so within the designated 30 calendar day enrollment period.

Generally, election changes are effective on the date that you submit a completed Life Event Form. In the case of a *dependent's* birth or adoption, election changes are effective on the date of birth or adoption (or placement for adoption), so long as you request enrollment within the 30 day special enrollment period or the additional 30 calendar day grace period.

- You and your *dependents* also may enroll under two additional circumstances: You or your *dependent's* state Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your *dependent* becomes eligible for a *premium* assistance subsidy provided by your state under the Children's Health Insurance Program Reauthorization Act (CHIPRA).

You or your *dependent* must request mid-year changes under these CHIPRA special enrollment rights by submitting a completed Life Event Form through MyHR within 60 days of the qualifying loss of coverage or eligibility for a subsidy. Limitations apply to the type of coverage available if you or your *dependent* becomes eligible for a *premium* assistance subsidy.

See **How to Enroll** for more information.

Changes in Cost or Coverage During the *Plan Year*

Change in Cost. If the cost of a benefit option significantly increases during the plan year, you may choose to make an increase in contributions, revoke the election and receive coverage under another benefit that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost of a benefit option significantly decreases and you already elected to participate in another benefit option providing similar coverage, you may revoke the election and elect to receive coverage provided under the benefit that decreased in cost. In addition, otherwise eligible employees who elected not to participate in the Plan may elect to participate in the benefit option that decreased in cost. For insignificant increases or decreases in the cost of a benefit option, contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

Change in Coverage. If coverage under a benefit option is significantly curtailed, you may elect to revoke your election and elect coverage under another benefit option that provides similar coverage. If the significant curtailment results in a complete loss of coverage, you may also drop coverage if no other comparable coverage is available. Further, if the Plan adds or significantly improves a benefit option during the *plan year*, you may revoke your election and elect to receive, on a prospective basis, coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Company or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations: or (b) the *plan year* for this Plan is different from the *plan year* of the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your spouse or eligible *dependents* if such individual(s)

loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

Exchange (Marketplace) Enrollment

If you are eligible to enroll for coverage in a government-sponsored Exchange during a special or annual open enrollment period, you may prospectively revoke your election for the major medical benefit option only, provided that you certify that you and any related enrollee whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of coverage under the major medical benefit option.

If one or more covered *dependents* are eligible to enroll for coverage in a government-sponsored Exchange during a special or annual open enrollment period, you may prospectively revoke an election for major medical benefit option coverage for those *dependents* (and switch to a different *coverage level*, for example, employee-only coverage, provided that you certify that the *dependents* whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of coverage under the Plan.

Tax Information

The medical, dental and vision plans, Flexible Spending Accounts and the *Health Savings Accounts* are pre-tax benefits. This means that the *premiums* or contributions are deducted from your pay before your federal income and FICA (Social Security and Medicare) taxes are calculated. Pre-tax benefit deductions reduce the amount you pay in taxes.

Non-tax-qualified *Dependents*

Unless your *domestic partner* qualifies as your tax *dependent*, you will be unable to pay for benefit coverage for your *domestic partner* and any of their children on a pre-tax basis. Therefore, medical, dental and vision plan *premiums* for non-tax-qualified *dependents* will be withheld from your pay on an after-tax basis. The portion of the *premium* that represents coverage for you and any tax-qualified *dependents* will be withheld on a pre-tax basis.

In addition, Assurant's contribution toward the cost of medical and dental plan coverage for non-tax-qualified *dependents* must be included in your taxable income. This amount, also known as *imputed income*, will be included in your annual gross income for federal tax purposes and shown on your Form W-2.

Imputed Income

The IRS requires that the cost of your Basic Life Insurance in excess of $50,000 be included in your annual gross income. Basic Life Insurance can be reduced from one times *plan pay* to $50,000 at any time. Federal income tax and FICA tax will be deducted. It also is reported on your Form W-2. See **Life Insurance** for more information.

Assurant also provides Short and Long-Term Disability (Core Option) coverage at no cost to you. The *premiums* Assurant pays for Short-Term Disability are not added to your taxable income and you'll only be taxed on the benefit when you use it. The *premiums* Assurant pays for Long-Term Disability are added to your taxable income. While there might be a slight

reduction in your net pay to cover the applicable taxes on these *premiums*, any Long-Term Disability benefits you receive will be exempt from federal income and FICA taxes.

When Coverage Ends

The following outlines when coverage under the Plan generally ends for you and your *dependents*. After your coverage ends, you may be able to continue medical, dental and vision coverage (and your participation in a Health Care Flexible Spending Account) through COBRA.

Please refer to **When Coverage Ends** under each section to learn when other benefits end.

When Your Coverage Ends

For medical, dental and vision benefits and generally unless otherwise set forth in a section of this SPD applicable to a particular benefit or in the insurance policy for an insured benefit, your coverage under a benefit in this Plan ends on the first of the following events to occur:

- Your employment terminates (whether voluntarily, including retirement, or involuntarily);
- You die;
- You're no longer in an eligible class (for example, your work schedule changes to less than 20 hours a week);
- You terminate coverage due to a qualified life event;
- You fail to make required contributions or *premium* payments on time;
- A benefit option is discontinued or is changed to end coverage for a class of employees;
- If you are on an approved leave of absence, your coverage will end as described in the **Coverage During Approved Leaves of Absence** section of this SPD; or
- The Plan is terminated.

If you elect to terminate coverage during the Open Enrollment period, your coverage will end on Dec. 31 of that same year. In the case of a divestiture of a business or a part of a business, coverage will end on the date the transaction closes.

When *Dependent* Coverage Ends

In general, unless otherwise set forth in a section of this SPD applicable to a particular benefit or in the insurance policy for an insured benefit, coverage under a benefit in the Plan for your *dependents* ends on the earliest of the following:

- The date your coverage ends;
- The date on which your spouse/*domestic partner* no longer meets the definition of an eligible *dependent*. For medical, dental and vision benefits, coverage ends on the last day of the month;
- The date on which your *dependent* child no longer meets the definition of an eligible *dependent*. For medical, dental and vision benefits, coverage ends on the last day of the month;
- The date determined by the Plan Administrator if you do not verify that a *dependent* is eligible in accordance with a *dependent* audit;

- The date a *dependent* becomes covered as a *dependent* under another employee's coverage; or
- The date a *dependent* becomes eligible for coverage as an employee.

Coverage for your *dependents* will end on Dec. 31 of the calendar year in which you elect to terminate their coverage during the Open Enrollment period. In the case of a divestiture of a business or a part of a business, coverage will end on the date the transaction closes.

Until *dependent* coverage ends, medical, dental, vision and *Dependent* Life Insurance will continue for your *dependents* each year unless you actively elect to terminate their coverage during Open Enrollment.

Rescission of Coverage

The Plan may request documentation at any time and cancel your or your *dependent's* coverage retroactively if it is determined that you or your *dependents* are involved in fraud or made an intentional misrepresentation of a material fact in seeking coverage for benefits under the Plan. If coverage is canceled retroactively under these circumstances, you'll receive a 31-day advance notice of the cancellation and an opportunity to appeal the decision under the Plan's claims and appeal procedures.

The Plan also reserves the right to cancel coverage retroactively in other situations that arise in the normal course of plan operations such as discovery of an error, failure to pay required *premiums*, failure to notify the Plan of a divorce or failure to provide required eligibility documentation. In these situations, 31-day advance notice and opportunity to appeal are not required.

Subrogation and Reimbursement

These Subrogation and Reimbursement provisions apply when the Plan pays any type of benefits under the Plan as a result of Injuries or illnesses you sustained, and you have a right to a Recovery or have received a Recovery from any source.

Definitions

As used in these Subrogation and Reimbursement provisions, "you" or "your" includes anyone on whose behalf the plan pays benefits. These Subrogation and Reimbursement provisions apply to all current or former Plan participants and Plan beneficiaries. The provisions also apply to the parents, guardian, or other representative of a *dependent* child who incurs claims and is or has been covered by the Plan. The Plan's rights under these provisions shall also apply to the personal representative or administrator of your estate, your heirs or beneficiaries, minors, and legally impaired persons. If the Member is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to these Subrogation and Reimbursement provisions. Likewise, if the Member's relatives, heirs, and/or assignees make any Recovery because of Injuries sustained by the Member, or because of the death of the Member, that Recovery shall be subject to this provision, regardless of how any Recovery is allocated or characterized.

As used in these Subrogation and Reimbursement provisions, "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella

coverage, workers' compensation insurance or fund, premises medical payments coverage, restitution, or "no-fault" or personal Injury protection insurance and/or automobile medical payments coverage, or any other first or third party insurance coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements allocate or characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to, or stand in the place of, all of your rights of Recovery with respect to any claim or potential claim against any party, due to an Injury, illness, or condition to the full extent of benefits provided or to be provided by the Plan. The Plan has the right to recover payments it makes on your behalf from any party or insurer responsible for compensating you for your illnesses or Injuries. The Plan has the right to take whatever legal action it sees fit against any person, party, or entity to recover the benefits paid under the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any Recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an Injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that Injury, illness or condition, up to and including the full amount of your Recovery. If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf. You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or Injuries.

Secondary to Other Coverage

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal Injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any Coordination of Benefits term to the contrary.

Anti-Assignment and Assignment Provisions

No benefit, right, or interest of any eligible employee or eligible *dependent* under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities, or other obligations of such person, except as otherwise required by law. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute, or levy upon, or otherwise dispose of any right to benefits payable hereunder shall be void. Notwithstanding the foregoing, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by the participant, but only as a convenience to participants. Health care providers are not, and shall not be construed as, either "participants" or beneficiaries" under

this Plan and have no right to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) participants under any circumstances.

Moreover, notwithstanding the foregoing, in order to secure the Plan's rights under these Subrogation and Reimbursement provisions, you agree to assign to the Plan any benefits or claims or rights of Recovery you have under any automobile policy or other coverage, to the full extent of the Plan's Subrogation and Reimbursement claims. This assignment allows the Plan to pursue any claim you may have regardless of whether you choose to pursue the claim.

Applicability to All Settlements and Judgments

Notwithstanding any allocation or designation of your Recovery made in any settlement agreement, judgment, verdict, release, or court order, the Plan shall have a right of full Recovery, in first priority, against any Recovery you make. Furthermore, the Plan's rights under these Subrogation and Reimbursement provisions will not be reduced due to your own negligence. The terms of these Subrogation and Reimbursement provisions shall apply and the Plan is entitled to full Recovery regardless of whether any liability for payment is admitted and regardless of whether the terms of any settlement, judgment, or verdict pertaining to your Recovery identify the medical benefits the Plan provided or purport to allocate any portion of such Recovery to payment of expenses other than medical expenses. The Plan is entitled to recover from any Recovery, even those designated as being for pain and suffering, non-economic damages, and/or general damages only.

Constructive Trust

By accepting benefits from the Plan, you agree that if you receive any payment as a result of an Injury, illness or condition, you will serve as a constructive trustee over those funds. You and your legal representative must hold in trust for the Plan the full amount of the Recovery to be paid to the Plan immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. Any Recovery you obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these Subrogation and Reimbursement provisions.

Lien Rights

The Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of your illness, Injury or condition upon any Recovery related to treatment for any illness, Injury, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds from your Recovery including, but not limited to, you, your representative or agent, and/or any other source possessing funds from your Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset. The Plan shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and/or to obtain (or preclude the transfer, dissipation or disbursement of) such portion of any Recovery in which the Plan may have a right or interest.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge the Plan's rights under these Subrogation and Reimbursement provisions are a first priority claim and are to be repaid to the Plan before you receive any Recovery for your damages. The Plan shall be entitled to full

reimbursement on a first-dollar basis from any Recovery, even if such payment to the Plan will result in a Recovery which is insufficient to make you whole or to compensate you in part or in whole for the losses, Injuries, or illnesses you sustained. The "made-whole" rule does not apply. To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs. The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund'' doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. The duty to cooperate includes, but is not limited, to the following:

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal Injury or illness to you occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your Injury, illness or condition.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You and your agents shall provide all information requested by the Plan, the claims administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal Injury litigation.
- You recognize that to the extent that the Plan paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the reasonable value of those payments or the actual paid amount, whichever is higher.
- You must not do anything to prejudice the Plan's rights under these Subrogation and Reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or Recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its rights under these Subrogation and Reimbursement provisions, the

Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery, whichever is less, from any future benefit under the Plan if:

1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
2. You fail to cooperate.

In the event you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan. The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and the Plan will not have any obligation to pay the provider or reimburse you.

You acknowledge the Plan has the right to conduct an investigation regarding the Injury, illness or condition to identify potential sources of Recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising these Subrogation and Reimbursement provisions.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing its rights under these Subrogation and Reimbursement provisions.

Discretion

The Plan Administrator has sole discretion to interpret the terms of the Subrogation and Reimbursement provisions of this Plan in its entirety and reserves the right to make changes as it deems necessary.

Assurant Health Plan

Assurant offers you the choice of four medical plan options - Purple, Blue, Green, and Orange administered by Anthem Blue Cross and Blue Shield (Anthem). If you have medical coverage elsewhere (e.g., through a spouse's employer), you can waive health plan coverage through Assurant. Health plans provide coverage for a wide range of medical expenses with different *deductibles, coinsurance* and *out-of-pocket maximums*. Health plans also provide you and your family with free *in-network preventive care* and free generic preventive prescription drugs.

Coverage for outpatient prescription drugs is administered by CVS Caremark. CVS Caremark is one of the largest providers of pharmacy benefits with more than 68,000 participating retail pharmacies nationwide. Most major drug chains and many small, independent pharmacies

are part of the CVS Caremark network. They also provide mail order service for maintenance medications.

Health Plan At-a-Glance

Health Plan Options Comparison Chart

	2027 Health Plans			
	PURPLE	**BLUE**	**GREEN**	**ORANGE**
	What the Plan Pays			
In-network Preventive Care	100%			
Lifetime maximum[1]	Unlimited			
What you pay: Annual *Deductible* (individual/family)[2,3,4]				
In-network services	$250 / $500	$450 / $900	$1,750 / $3,500	$2,500 / $5,000
Out-of-Network services	N/A	$1,450 / $2,900	$2,750 / $5,500	$4,600 / $9,200
What you Pay: *In-Network/Out-of-Network Coinsurance* or *Copay*				
Primary Care Physician	$25 copay	20%/40%		10%/30%
Specialist	$45 *copay* (includes urgent care)	20%/40%		10%/30%
Emergency Room	$300 *copay*	20%/40%		10%/30%
Hospital Inpatient and Outpatient	15%	20%/40%		10%/30%
Annual *Out-of-Pocket Maximum* (individual/family)[2,4,5]				
In-network services	$3,000/$6,000	$3,450 / $6,900	$4,200 / $8,400	$5,000 / $10,000
Out-of-network services	N/A	$6,450 / $12,900	$7,200 / $14,400	$9,200 / $18,400

[1]There's a combined $30,000 medical and prescription drug lifetime maximum benefit for infertility treatment. Precertification is required to receive this benefit.

[2] "Family" includes Employee & Spouse/Domestic Partner, Employee & Child(ren) and Employee & Family.

[3] Under an aggregate deductible, the full family deductible must be met before the plan begins sharing the cost of non-preventive covered services.

[4] Deductibles and out-of-pocket maximums for in- and out-of-network services must be met separately — they don't cross-accumulate.

[5] An embedded out-of-pocket maximum means that the Family out-of-pocket maximum includes an Individual out-of-pocket maximum. If an individual in the family reaches the Individual out-of-pocket maximum before the Family out-of-pocket maximum is reached, covered benefits for that family member will be paid at 100%.

2027 Prescription Drug Coverage

Type of Medication	Retail Pharmacy, Up to 30-Day Supply	Mail-Order or Eligible Maintenance Pharmacy, up to 90-Day Supply
Tier 1: Generic[1]	20% coinsurance, up to a $50 maximum per prescription	20% coinsurance, up to a $125 maximum per prescription
Tier 2: Preferred Brand[2]	30% coinsurance, $15 minimum / $100 maximum per prescription	30% coinsurance, $30 minimum / $200 maximum per prescription
Tier 3: Non-Preferred Brand[3]	50% coinsurance, $40 minimum / $150 maximum per prescription	50% coinsurance, $80 minimum / $300 maximum per prescription
Tier 4: Specialty[4]	30% coinsurance, $75 minimum / $200 maximum per prescription for non-PrudentRx-eligible specialty medications	Not applicable. Specialty medications are limited to a 30-day supply.
Fill Limit for Long-Term Maintenance Medications[5]	Two 30-day fills of a long-term maintenance medication at a participating network pharmacy	After two 30-day fills, obtain a 90-day supply through CVS Caremark Mail Service or an eligible CVS Retail Pharmacy

[1] Under all Health Plans, generic preventive prescriptions are covered at 100%, and brand name preventive prescriptions are not subject to the plan's deductible. Under the Blue, Green, and Orange plans, all non-preventive prescriptions are subject to the plan's deductible. Under the Purple plan, prescriptions are not subject to the deductible. Caremark periodically reviews their formulary. Certain formulary medications may be excluded from coverage from time to time and impacted members will be notified.

[2] Preferred Brand medications are medications included on the CVS Caremark Formulary Drug List.

[3] Non-Preferred Brand medications are medications not included as preferred medications on the CVS Caremark Formulary Drug List.

[4] The $75 minimum and $200 maximum apply only to non-PrudentRx-eligible specialty medications. Members prescribed a PrudentRx-eligible specialty medication who do not participate in PrudentRx are responsible for 30% coinsurance on the discounted cost of the medication after satisfying any applicable deductible. The minimum and maximum do not apply to PrudentRx-eligible specialty medications when the member does not participate in the program. Specialty medications are limited to a 30-day supply. For more information concerning PrudentRx, see the ***PrudentRx Specialty Medication Program*** *section of this SPD.*

[5] For long-term maintenance medications, the plan allows for two 30-day fills of maintenance medications at any pharmacy in the CVS Caremark network. After that, the plan will cover maintenance medications only if you have 90-day supplies filled through mail-order or at a CVS Caremark Retail Pharmacy.

Deductible treatment: Under the Blue, Green, and Orange Plans, non-preventive prescription medications are subject to the applicable deductible. After the deductible is satisfied, the applicable coinsurance, minimum, and maximum shown above apply. Under the Purple Plan, prescription medications are not subject to a deductible.

Tobacco-Free Health Credit

As an additional benefit to complement the Plan's health and group benefits program, Assurant offers a Tobacco-Free Health Credit (Credit) to active employees if they are eligible for, and enrolled in, one of the medical plan options (Purple, Blue, Green, or Orange) and certify tobacco-free status or complete the tobacco cessation alternative program.

Personify Health administers the tobacco cessation program (Program). If you certify tobacco-free status in MyHR during Open Enrollment, you will receive the Credit and will not receive any additional credits, even if you complete the tobacco cessation program.

If you are a tobacco user, you can opt to complete the tobacco cessation alternative program by participating in three confidential virtual coaching sessions. If you complete the specified tobacco cessation alternative program during the plan year, your credit will be applied retroactively to January 1 or your hire date, if hired after January 1. Upon completion of the program, you will receive a lump sum for the retroactive Credit amount and will also receive the Credit on a prospective basis paid to you each pay period to offset the cost of your medical plan's *premium*, if you are not already receiving the Credit, lowering your total cost.

Note: The Credit is only applied based on employee participation. You do not need to certify the tobacco use status of any *dependent* for whom you elect coverage under the medical plan. You must certify your tobacco user status during your initial enrollment period, otherwise you will not be eligible for the Credit for the upcoming plan year. If you incorrectly answer the tobacco use question on your certification, or if you quit smoking during the year, you may be eligible to receive the Credit on a prospective basis. You must call the People Experience Center at 1-866-324-6513 to report a change and inquire regarding the availability of the Credit. For any subsequent Open Enrollment periods, you will have the opportunity to change your tobacco status certification. If you do not change your current certification, your Tobacco-Free Health Credit status from the previous enrollment period shall apply. If you think you might be unable to participate in the tobacco cessation program, you may qualify for the opportunity to earn the same credit by a different means right for you in light of your health status. You may request this reasonable accommodation by contacting the People Experience Center at 1-866-324-6513.

Surprise Billing Claims

When you get emergency care or get treated by an *out-of-network* provider at an *in-network* hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. For additional information, see the Surprise Billing Notice under Legal Notices on myassurantbenefits.com.

Anthem is required to confirm the list of network providers in its provider directory every 90 days. If you can show that you received inaccurate information from Anthem that a provider was *in-network* on a particular claim, then you will only be liable for Network cost shares (i.e., *copayments, deductibles, and/or coinsurance*) for that claim. Your network cost-shares will be calculated based upon the maximum allowed amount.

Your cost shares for emergency services or for covered services received by an *out-of-network* provider at a network facility, will be calculated using the median plan network contract rate that we pay network providers for the geographic area where the covered service is provided. Any out-of-pocket cost shares you pay to an *out-of-network* provider for either emergency

services or for covered services provided by an *out-of-network* provider at a network facility will be applied to your network out-of-pocket limit.

Appeals of Surprise Billing Claims

If you receive emergency services from an *out-of-network* provider or covered services from an *out-of-network* provider at a Network Facility and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in **Your Right to Appeal**.

Transparency Requirements

Anthem provides the following information on anthem.com:

- Protections with respect to surprise billing claims by providers;
- Estimates on what *out-of-network* providers may charge for a particular service;
- Information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements.

Anthem, either through its price comparison tool on anthem.com or through Member Services at the phone number on the back of your Identification Card, will allow you to get:

- Cost sharing information that you would be responsible for, for a service from a specific network provider;
- A list of all network providers;
- Network negotiated rates;
- Cost sharing information on an *out-of-network* provider's services based on Anthem's reasonable estimate based on what Anthem would pay an *out-of-network* provider for the service;
- Historical *out-of-network* rates; and
- Drug pricing information.

How Anthem Administers the Medical Plans

Network-based Benefits

The Assurant Medical Plan uses a network of health care providers and facilities managed by Anthem. These network providers have agreed to provide health care services and supplies at reduced fees. As shown on the chart, **Health Plan At-a-Glance**, the Plan pays higher benefits for covered medical expenses when you use Anthem network providers under the Blue, Green, and Orange medical plans, and there are no benefits for *out-of-network* care under the Purple medical plan, except for urgent and emergency care.

Some services and supplies such as bariatric surgery (weight loss surgery) may only be covered when you use a Blue Distinction center of medical excellence. Except under the Purple medical plan, you also can use licensed providers, hospitals and medical facilities outside Anthem's network. However, your out-of-pocket expenses will generally be higher when you use *out-of-network* providers. If you use an *out-of-network* provider, eligible health care expenses will be reimbursed based on the maximum allowed amount.

All covered services must be medically necessary, and coverage or certification of services that are not medically necessary may be denied.

Anthem has also been designated by Assurant to provide administrative services for the Medical Plan, such as claims processing, care management, and other services, and to arrange for a network of health care providers whose services are covered by the Plan.

Under the Blue, Green, and Orange medical plan options, the Preferred provider Organization (PPO) Plan is for all members except residents of Florida, Georgia, Missouri, and Wisconsin. Members residing in those states are part of a specific local provider network and must use a provider from that network to receive network benefits in the area in which they live. If you are a member from Florida, Georgia, Missouri, or Wisconsin and you need care when outside your home state, please log in to anthem.com or use the Sydney Health app to access Anthem's Find Care and Cost Tool. You may also call the Member Services number on your ID card to locate participating providers.

Under the Purple medical plan, the Exclusive Provider Organization (EPO) Plan is for all members, and members must use the appropriate network of Providers based on the employee's home zip code. The network of providers available under the Purple plan may be different from the network available under the Blue, Green, and Orange plans, and *out-of-network* care is not covered except for urgent care, emergency care, or items or services protected by the Surprise Billing rules. You can log in to anthem.com to access Anthem's Find Care and Cost Tool. You may also call the Member Services number on your ID card to locate participating providers.

You may also use the tools available on the Health Plan Networks page on Assurant benefits.com to find network providers available to you under each plan, based on your zip code.

Network Services

When you use a network provider or get care as part of an authorized service, covered services will be covered at the Network level. Regardless of medical necessity, benefits will be denied for care that is not a covered service. The Plan has the final authority to decide the medical necessity of the service. If you receive covered services from an *out-of-network* provider after Anthem failed to provide you with accurate information in Anthem's provider Directory at anthem.com, or after they failed to respond to your telephone or web-based inquiry within the time required by federal law, covered services will be covered at the network level.

Maximum Allowed Amount

This section describes how Anthem determines the amount of reimbursement for covered services. Reimbursement for services rendered by network providers and *out-of-network* providers is based on this maximum allowed amount for the covered service that you receive. See **Inter-Plan Arrangements** for additional information.

The maximum allowed amount is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet the Plan's definition of covered services, to the extent such services and supplies are covered under the Plan and are not excluded;

- that are medically necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

You will be required to pay a portion of the maximum allowed amount to the extent you have not met your *deductible* or *out-of-pocket maximum*. Except for surprise billing claims, when you receive covered services from an *out-of-network* provider, you may be responsible for paying any difference between the maximum allowed amount and the provider's actual charges. This amount can be significant. No *out-of-network* benefits are available under the Purple medical plan, with the exception of urgent care, and emergency care, and items or services protected by the Surprise Billing rules.

When you receive covered services from a provider, Anthem will, to the extent applicable, apply claim processing rules to the claim submitted for those services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Anthem's determination of the maximum allowed amount. Anthem's application of these rules does not mean that the covered services you received were not medically necessary. It means Anthem has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the maximum allowed amount will be based on the single procedure code rather than a separate maximum allowed amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the maximum allowed amount for those secondary and subsequent procedures because reimbursement at 100% of the maximum allowed amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The maximum allowed amount may vary depending upon whether the provider is a network provider or an *out-of-network* provider.

For covered services performed by a network provider, the maximum allowed amount for this Plan is the rate the provider has agreed with Anthem to accept as reimbursement for the covered services. Because network providers have agreed to accept the maximum allowed amount as payment in full for those covered services, they should not send you a bill or collect for amounts above the maximum allowed amount. However, you may receive a bill or be asked to pay all or a portion of the maximum allowed amount to the extent you have not met your *deductible* or *out-of-pocket maximum*. Please call Member Services for help in finding a network provider or visit anthem.com.

Providers who have not signed any contract with Anthem and are not in any of the claims administrator's networks are *out-of-network* providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. For covered services you receive from an *out-of-network* provider, the maximum allowed amount for this Plan will be one of the following as determined by Anthem:

1. An amount based on the claims administrator's *out-of-network* provider fee schedule/rate, which Anthem has established at its' discretion, and which Anthem reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the maximum allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable provider's fees and costs to deliver care; or
4. An amount negotiated by Anthem or a third-party vendor which has been agreed to by the provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the *out-of-network* provider; or
6. An amount based on the Qualifying Payment Amount, which is generally the median contracted rate for the same or similar Provider for the same or similar service in the geographic service area; or
7. An amount as required by applicable state law.

Providers who are not network providers under the Assurant Health Plan but contracted for other products with Anthem are also considered *out-of-network* providers. The maximum allowed amount for services from these providers will be one of the five methods shown above.

For covered services rendered outside Anthem's Service Area by *out-of-network* providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule/rate or the pricing arrangements required by applicable state or federal law. In certain situations, the maximum allowed amount for out-of-area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within Anthem's Service Area, or a special negotiated price.

Unlike network providers, *out-of-network* providers may send you a bill and collect for the amount of the provider's charge that exceeds the Plan's maximum allowed amount. Except for surprise billing claims, you may be responsible for paying the difference between the maximum allowed amount and the amount the provider charges. This amount can be significant. Choosing a network provider will likely result in lower out-of-pocket costs to you. Please call Member Services for help in finding a network provider or visit Anthem's website at anthem.com.

Member Services is also available to assist you in determining this Plan's maximum allowed amount for a particular service from an *out-of-network* provider. In order for Anthem to assist you, you will need to obtain from your provider the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider's

charges to calculate your out-of-pocket responsibility. Although Member Services can assist you with this pre-service information, the final maximum allowed amount for your claim will be based on the actual claim submitted by the provider.

Member Cost Share

For certain covered services and depending on your plan design, you may be required to pay a part of the maximum allowed amount as your cost share amount (for example, *deductible*, and/or *coinsurance*).

Your cost share amount and out-of-pocket limits may vary depending on whether you received services from a network provider or *out-of-network* provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using *out-of-network* providers. See **Health Plan At-a-Glance** for your cost share responsibilities and limitations, or call Member Services to learn how this Plan's benefits or cost share amounts may vary by the type of provider you use.

The Plan will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your provider for non-covered services, regardless of whether such services are performed by a network provider or *out-of-network* provider. Non-covered services include services specifically excluded from coverage by the terms of this SPD and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

Authorized Services

In some circumstances, such as where there is no network provider available for the covered service, the Plan may authorize the Network cost share amounts *(deductible*, *copayment and/or coinsurance*) to apply to claim for a covered service you receive from an *out-of-network* provider. In such circumstance, you must contact the claims administrator in advance of obtaining the covered service. The Plan also must authorize the network cost share amounts to apply to a claim for covered services if you receive emergency services from an *out-of-network* provider and are not able to contact the claims administrator until after the covered service is rendered. If the Plan authorizes a Network cost share amount to apply to a covered service received from an *out-of-network* provider, you also may still be liable for the difference between the maximum allowed amount and the *out-of-network* provider's charge unless your claim involves a surprise billing claim. Please contact Member Services for Authorized Services information or to request authorization.

Family Coverage

Family coverage includes Employee & Spouse/*Domestic Partner*, Employee & Child(ren) and Employee & Family. Your annual *deductible* and *out-of-pocket maximum*, and the Assurant contribution to your HSA will depend on whether you elect Individual (Employee-only) coverage or Family coverage.

Annual Deductible

Under the Blue, Green, and Orange medical plan options, the *deductible* is the amount of eligible medical and prescription expenses you must pay on an annual basis before the Plan begins to pay its share of your covered expenses. The annual *deductible* does not apply to *Preventive Care* and Preventive Medications.

Under the Purple medical plan option, the annual *deductible* does not apply to doctor visits, specialist visits (including urgent care visits), Emergency Room visits, *Preventive Care*, or prescription drugs. There is no coverage for *out-of-network* services, except for urgent care, emergency care, and items or services protected by the Surprise Billing rules.

Under the Blue, Green and Orange medical plan options, there are separate in- and *out-of-network deductibles* for all three health plans. If you're using *out-of-network* providers, you'll pay more for coverage and be subject to a higher *deductible*. Any amount accumulated toward your *in-network deductible* also will not count toward your *out-of-network deductible* (and vice versa).

If you elect family coverage under the Purple, Blue, Green, or Orange medical plan, there is no individual deductible. This means that the entire family deductible must be met before benefits that are subject to the deductible begin for any covered family member. Any combination of enrolled family members may incur expenses to satisfy the family deductible. Preventive care benefits and preventive prescription drugs are not subject to the deductible.

Deductibles are not pro-rated for mid-year enrollments into the Plan. If your *deductible* is not satisfied by the end of the calendar year, the amount credited at year-end does not carry over to the next calendar year

Coinsurance

You pay a certain percentage of the cost of covered services through coinsurance. After your *deductible*, generally, the Plan pays 80% (for the Purple, Blue, or Green plans) or 90% (for the Orange plan) of the cost of most covered services, and you pay 20% (for the Purple, Blue, or Green plan) or 10% (for the Orange plan) up until a limit called the *out-of-pocket maximum*. Your coinsurance will be higher if you use *out-of-network* providers under the Blue, Green, or Orange plans.

Annual Out-of-Pocket Maximum

The *out-of-pocket maximum* is the most you'll pay toward covered expenses each calendar year. Once you meet your individual or family *out-of-pocket maximum*, the Plan pays 100% of covered expenses for the remainder of the year. The *out-of-pocket maximum* varies by medical plan option (Purple, Blue, Green, and Orange), coverage tier (e.g., Employee only, Employee and Family) and whether you use *in-network* providers or *out-of-network* providers. Any amount accumulated toward your *in-network out-of-pocket maximum* will not count toward your *out-of-network out-of-pocket maximum* (and vice versa). (There is no *out-of-network* coverage available under the Purple plan except for urgent care and emergency care services).

If you elect Family coverage under the Blue plan, there is no individual *out-of-pocket maximum*. This means that the entire family *out-of-pocket maximum* must be met before the Plan begins to pay 100% for any covered family member (except for *preventive care* benefits and generic preventive prescription drugs). Any combination of you and /or one or more *dependents* can incur expenses to meet the Family *out-of-pocket maximum*.

If you elect Family coverage under the Purple, Green, or Orange plan, each family member has an individual *out-of-pocket maximum* amount equal to the *out-of-pocket maximum* for

Employee-only coverage. Once a family member satisfies the individual *out-of-pocket maximum*, the Plan will begin to pay 100% for that family member's eligible medical expenses. The family member does not need to wait for the family *out-of-pocket maximum* to be satisfied. Once the family's combined expenses reach the family *out-of-pocket maximum*, the Plan will begin to pay 100% for all covered family members' eligible expenses for the remainder of the calendar year.

The following expenses are excluded from your *out-of-pocket maximum*:

- Charges in excess of the maximum allowed amount.
- Penalties for not obtaining pre-certification.
- Charges in excess of Plan limits.
- Expenses incurred for non-covered services.
- Expenses incurred for non-emergency use of the emergency room.
- Charges related to the dispense-as-written penalty under the prescription drug benefit; and
- Difference between the network pharmacy charge and the *out-of-network* charge

Mental Health and Substance Abuse

If you are enrolled in the Blue, Green or Orange plans and use an *out-of-network* provider for mental health professional visit services, those claims will process toward your *in-network* office professional visit coverage. Unlike *in-network* providers, when you receive covered services from an *out-of-network* provider, that provider may charge you the difference between their billed amount and the Plan's maximum allowed amount, plus any *in-network deductible* and/or coinsurance that is applied to the claim. You are responsible for paying the difference.

Choosing a Network Provider will likely result in lower Out-of-Pocket costs to you. If you need help understanding the costs associated with using an *out-of-network* provider or help finding an *in-network* provider, please call Member Services or visit the at www.anthem.com.

Health Savings Account

A *Health Savings Account* (HSA) is an account that you can open when you enroll in the Green and Orange medical plans. An HSA allows you to save money on a tax-free basis to help pay for out-of-pocket health care expenses. If you don't use the money in your account by the end of the year, the balance rolls over to the next year. You own your account balance, and you can take it with you when you leave Assurant, meaning you can choose to save it to spend on your health care expenses in retirement. See **Portability** for more information.

You may elect an amount to contribute to your HSA that will be deducted from your paycheck before taxes. As a convenience to our employees, Assurant has arranged to have the annual company and wellbeing contributions and your pre-tax HSA payroll deductions, if any, deposited into an HSA maintained by Anthem. Assurant's role is limited to passing the contributions to the account. Assurant has no authority or control over the funds deposited in your HSA or any investment options associated with it. WealthCare Saver is the HSA custodian.

Accessing HSA Funds

If you enroll in the Green or Orange medical plan and are eligible for an HSA, you'll receive a debit card from Anthem in the mail. If you have more than one type of savings and/or spending account(s), the single debit card will work for all of them and has "smart" processing logic to know which transactions to pull from which account. To access your HSA funds:

- You can use your debit card to pay for eligible expenses such as prescriptions, *deductibles* and *coinsurance* as long as you have funds available in your account.
- You can use the Anthem member portal to pay for your eligible out-of-pocket expenses directly from your online account to your provider or to reimburse yourself.

Contributions

In January (or upon your initial enrollment in the Green or Orange medical plan, Assurant will deposit $250 (Individual) or $500 (Family) to your HSA account, and thereafter, deposit up to an additional $250 (Individual) or $500 (Family) in equal bi-weekly increments each pay period. The bi-weekly Company contribution will be prorated based on your hire date and you must be actively employed on the date the contributions are made in order to receive them

To be eligible for the company contributions, you must be actively employed on the date the contributions are made.

If you elect to contribute to your HSA, your contributions are withheld from payroll on a pre-tax basis. A small number of states currently do not permit tax-deferred contributions to HSAs, and employees living in these states will be taxed appropriately.

Eligibility for an HSA

HSA eligibility is determined under IRS rules and the terms and conditions of the agreement with the HSA custodian. Contributions can be made to your HSA during any month that you meet the following criteria on the first day of that month:

- Enrolled in one of the qualified high *deductible* medical plan options (such as the Green or Orange plan).
- Have no other health coverage except what is permitted as other health coverage by the IRS.
- Not be enrolled in Medicare.
- Not be claimed as a *dependent* on someone else's tax return.
- Not have access to dollars in a general purpose Flexible Spending Account (FSA) that can pay for any medical expenses before the HSA's required *deductible* is met, including a spouse's health care FSA. (Limited Purpose FSAs are acceptable other coverage).

A *dependent's* coverage under a non-qualifying plan, such as Medicare, does not disqualify you from having an HSA.

If you enroll in the Green or Orange medical plan with an HSA, but are ineligible for an HSA, you must call the People Experience Center at 1-866-324-6513 within four business days of your coverage effective date to opt out of the HSA and avoid any adverse tax consequences.

Maximum Annual Contribution

The maximum contribution you can make to an HSA is determined each year by the IRS and will be provided at open enrollment. The maximum HSA contributions for the 2027 calendar year is $4,500 for self-only coverage and $9,000 for family coverage. This limit includes the company contribution. There is also an additional $1,000 annual "catch up" contribution if you're age 55 or older and if you cover a spouse who is age 55 or older on your medical plan, they may also be eligible to make their own catch-up contribution.

Generally, the maximum annual contribution is prorated if you're not eligible to contribute to the HSA for the full calendar year. However, if you're HSA-eligible on Dec. 1, you can make the full annual contribution provided you remain HSA-eligible and contribute to it in the following calendar year. If you don't meet both conditions, any contributions above the pro-rated amount will be taxable and subject to an excise tax.

Contributions to your HSA will be invested in the interest-earning HSA cash account. When your account balance reaches $1,000, additional investment options are available. A full list of available investments can be found on your Anthem member portal. Interest rates on the account are variable.

Timing of Contributions

Your HSA is effective once your account has been setup and funded. Your pre-tax contributions will begin the first pay period of the month following your hire date but only if you have timely completed your account setup.

Note: You can start, stop or change your HSA contributions in MyHR at any time. Your changes will be implemented the next tax period as soon as administratively feasible after your request.

In January (or upon your initial enrollment), Assurant will deposit $250 (Individual) or $500 (Family) to your HSA account and an additional $250 (Individual)/$500 (Family) will be distributed evenly throughout the year to your health plan account on a bi-weekly basis. The bi-weekly Company contribution will be prorated based on your hire date and you must be actively employed on the date the contributions are made in order to receive them. Any wellbeing contributions are deposited as they are earned throughout the year.

Qualified Medical Expenses

Medical expenses must be incurred while you're participating in the HSA to be considered "qualified." While IRS Publication 502 provides more detailed information on qualified medical expenses, the following are some examples:

- *Deductibles* and *coinsurance* under medical, dental and vision plans.
- Prescription drugs and over-the-counter medications.
- Prescription eyeglasses, contact lenses and contact lens solution.
- Hearing aids and wheelchairs.
- Qualified long-term care expenses and insurance *premium*s for a qualified Long-Term Care insurance policy.
- COBRA *premium*s; and
- *Premiums* for health care coverage while you or your eligible *dependent* is receiving unemployment compensation.

Generally, health insurance *premiums* are not qualified medical expenses except as noted above. In addition, otherwise qualified medical expenses that were paid by insurance companies or other sources are not qualified medical expenses. This is true whether the payments were made directly to you, to the patient, or to the provider of the medical services.

For individuals age 65 or older, the following *premiums* are also qualified expenses:

- Medicare Parts A, B and D.
- Medicare HMO (Part C).
- Your share of *premiums* for employer-sponsored health insurance; and

Note: *Premiums* for Medigap policies are not qualified medical expenses.

You may make tax-free withdrawals to pay for your eligible *dependent's* qualified medical expenses, even if they are not covered under a high-*deductible* health plan. For this purpose, children between the ages of 19 through 24 must be full-time students when the expense is incurred.

If you cover a *dependent* under the health plan who does not qualify as a tax *dependent*, you cannot use your HSA to pay for his or her expenses. These non-tax qualified *dependents* may set up their own HSA and may contribute up to the maximum amount for family coverage. To set up an account, your non-tax qualified *dependent* can call Anthem at 1-855-285-4212.

Taxes

Amounts withdrawn from an HSA to pay for qualified medical expenses are not taxable. Withdrawals for non-qualified expenses are taxable and, if you're under age 65, are subject to an additional 20% excise tax.

After the end of the year, Anthem makes available IRS forms to account holders showing total contributions to and distributions (withdrawals) from their HSAs reported in the calendar year. This information also is provided to the Internal Revenue Service. Account holders must file IRS Form 1040 and complete IRS Form 8889 to report HSA contributions and distributions. All contributions to your HSA are reported to the Internal Revenue Service via your IRS Form W-2.

While you should speak with your tax advisor, it is important to keep itemized receipts as back-up for your HSA withdrawals.

Portability

Your HSA belongs to you. If you leave Assurant or retire, you can maintain the account at WealthCare Saver (at your own cost) or roll over the balance to your own financial institution. For more information on rollovers and transfers, please contact Anthem at 1-855-285-4212.

You can continue to use your HSA funds to pay for qualified medical expenses after you leave Assurant. If you're eligible for and enrolled in a qualified high-*deductible* health plan, you also can continue to make new contributions to your HSA.

Maximum Benefits

Generally, the Assurant health plan provides an unlimited lifetime maximum benefit. However, certain benefits are limited either on an annual or lifetime basis as outlined below:

- The annual maximum for chiropractic treatment involving chiropractic care (spinal manipulation) is 20 visits per calendar year.
- The annual maximum for outpatient physical, occupational and speech therapy is a combined 90 visits per calendar year. A visit consists of no more than one hour of therapy. The calendar year limit of 90 visits applies to *in-network* and *out-of-network* benefits, if applicable, for all professional therapy services combined; however, no more than 30 of these combined visits will be covered through an *out-of-network* provider.
- Private duty nursing services are covered when medically necessary. These visits count toward the applicable Home Health Care visit maximum.
- The annual maximum for skilled nursing is 120 visits per calendar year.
- The annual maximum for home health care is 200 visits per calendar year.
- Covered hospice services are provided in accordance with the terms of the Plan and are not subject to an annual visit maximum.
- The combined lifetime maximum benefit for comprehensive medical and prescription drug fertility expenses (see **Special Programs – Fertility Benefits**) is $30,000.

Note: The limits identified above and throughout this section are a combined amount that is the total of all benefits paid under the medical plan, including *in-network* and *out-of-network* benefits and benefits provided under all health plans offered under the Plan.

Pre-certification

Pre-certification – the authorization of a specific medical procedure - helps you determine whether the services being recommended are covered under the medical plan. Pre-certification promotes the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service in which they are performed. It also allows Anthem to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning) and to register you for specialized programs or case management when appropriate.

Anthem utilizes its clinical coverage guidelines, such as medical policy and *preventive care* clinical coverage guidelines, to assist in making medical necessity decisions. Anthem reserves the right to review and update these clinical coverage guidelines periodically.

Pre-certification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date you receive service:

- You must be eligible for benefits.
- The service or surgery must be a covered benefit under the Plan.
- The service cannot be subject to an exclusion under the Plan; and
- You must not have exceeded any applicable Plan limits.

Inpatient admissions and certain outpatient procedures and services must be pre-certified by Anthem. While a member of your family, a hospital staff member, or the attending physician can contact Anthem on your behalf, you're responsible for ensuring that the admission or medical services have been pre-certified. If you're admitted to a hospital as an emergency admission, the admission must be certified no later than two business days after the admission. Services that are not pre-certified may be denied.

Pre-certification (or pre-determination) confirms whether a service is covered or not by the Assurant Health Plan and includes a review of medical necessity based on each individual situation. Pre-certification is based on several pieces of information including: eligibility, procedure code, provider documentation, and diagnosis code. Pre-certification does not guarantee coverage for reasons such as: Plan rules may change between Pre-certification and service or the billed service isn't coded as expected. You'll be notified by letter once a determination has been made.

The following medical services require pre-certification for you to receive benefits. To pre-certify, contact Anthem at 1-855-285-4212. To avoid denial of services, be sure to call before receiving services or no later than two business days after an emergency admission. Remember that Pre-certification is always *your responsibility,* whether or not the admitting doctor is in the Anthem Blue Cross and Blue Shield network. For services that do not require pre-certification, you can call for a pre-determination for coverage verification.

Services not requiring pre-certification for coverage but recommended for pre-determination of medical necessity due to the existence of post service claim edits and/or the potential cost of services to the member if denied by Anthem for lack of medical necessity include procedures, equipment, and/or specialty infusion drugs which have medically necessary criteria determined by Corporate Medical Policy or Adopted Clinical Guidelines. A complete list of Medical Policies and Clinical Guidelines is available by visiting Anthem.com and using the Provider tab for accessing information. You may also call the Customer Service number on the member ID card to see if the specific requested code is subject to medical policy or clinical guideline criteria.

How to Pre-certify

You're responsible for obtaining required pre-certifications. While a member of your family, a hospital staff member or the attending physician can contact Anthem to request pre-certification on your behalf, you're ultimately responsible for ensuring that the admission or medical services and expenses have been pre-certified. You're financially responsible for services and/or settings that are not covered under the Plan based on an adverse determination of medical necessity or experimental/investigative. You can pre-certify by calling Anthem at 1-855-285-4212.

When you pre-certify an inpatient admission to a facility, Anthem will notify you, your physician and the facility about your pre-certified length of stay. If your physician recommends that your stay be extended, additional days also need to be certified. You, your physician, or the facility will need to call Anthem at 1-855-285-4212 as soon as reasonably possible, but no later than the final authorized day. Anthem will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If additional information is needed to make a decision, Anthem will notify the requesting provider. They will send you written notification of the specific information necessary to complete the review. If Anthem does not receive the information requested or if the information is provided after the deadline specified in the written notification, a decision will be made based upon the information in Anthem's possession.

Notification of the pre-certification or extended stay decision may be given by Anthem by the following methods:

- Verbal: oral notification given to the requesting provider via telephone or via electronic means if agreed to by the provider.
- Written: mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and you or your authorized representative.

If pre-certification determines that the admission or services and supplies are not covered expenses, the notification will explain why and how Anthem's decision can be appealed. You or your provider may request a review of the pre-certification decision.

The claims administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make medical necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The claims administrator reserves the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the pre-certification phone number on the back of your Identification Card.

If you are not satisfied with the Plan's decision under this section of your benefits, please refer to **Your Right to Appeal** to see what rights may be available to you.

Medical Services Requiring Pre-certification

This section lists various types of medical services, all of which require pre-certification.

A complete list of Medical Policies and Clinical Guidelines is available by visiting www.Anthem.com and using the Provider tab for accessing information. You may also call the Customer Service number on the member ID card to see if the specific requested code is subject to medical policy or clinical guideline criteria.

Inpatient Admission:

- Acute Inpatient.
- Acute Rehabilitation.
- LTACH (Long Term Acute Care Hospital).
- Skilled Nursing Facility
- OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay).
- Emergency Care Admissions - *Precertification* is not required; however, Plan notification should be provided as soon as possible.

Diagnostic Testing:

- BRCA Genetic Testing.
- Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability and Congenital Anomalies.
- Gene Expression Profiling for Managing Breast Cancer Treatment.
- Gene Mutation Testing for Cancer Susceptibility and Management.

- Genetic Testing for Inherited Diseases.
- Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP) Attenuated FAP and MYH-Associated Polyposis.
- Preimplantation Genetic Diagnosis Testing.
- Prostate Saturation Biopsy.
- Testing for Biochemical Markers for Alzheimer's Disease.
- Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling.
- Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders.

Durable Medical Equipment (DME)/Prosthetics:

- Augmentative and Alternative Communication (AAC) Devices with Digitized or Synthesized Speech Output.
- Compression Devices for Lymphedema.
- Electric Tumor Treatment Field (TTF).
- External Upper Limb Stimulation for the Treatment of Tremors.
- Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES).
- High Frequency Chest Compression Devices for Airway Clearance.
- Implantable Infusion Pumps.
- Intrapulmonary Percussive Ventilation Device.
- Microprocessor Controlled Knee-Ankle-Foot Orthosis.
- Microprocessor Controlled Lower Limb Prosthesis.
- Myoelectric Upper Extremity Prosthetic Devices.
- Neuromuscular Electrical Training for the Treatment of Obstructive Sleep Apnea or Snoring.
- Noninvasive Electrical Bone Growth Stimulation of the Appendicular Skeleton.
- Robotic Arm Assistive Devices.
- Standing Frames.
- Ultrasonic Diathermy Devices.
- Ultrasound Bone Growth Stimulation.
- Powered Wheeled Mobility Devices.

Gender Affirming Surgery:

- This Plan provides benefits for many of the charges for gender affirming surgery for members diagnosed with Gender Dysphoria. Gender affirming surgery must be approved by us for the type of surgery requested and must be authorized prior to being performed. Charges for services that are not authorized for the gender affirming surgery requested will not be considered covered services. Some conditions apply, and all services must be authorized by Anthem as outlined in **Health Care Management – Pre-certification**.

Cellular and Gene Therapy Services:

- Your Plan includes benefits for cellular and gene therapy services when Anthem approves the benefits in advance through *Precertification*. Please refer to **Health Care**

Management – Pre-certification for details on the *Precertification* process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is a Network Provider for other services it may not be an approved Provider for certain cellular and gene therapy services. Please call Anthem to find out which Providers are approved Providers.

Human Organ and Bone Marrow/Stem Cell Transplants:

- Inpatient admissions for ALL solid organ and bone marrow/stem cell transplants (including Kidney only transplants).
- Outpatient: All procedures considered to be transplant or transplant related including but not limited to:
    - Donor Leukocyte Infusion.
    - Intrathecal treatment of Spinal Muscular Atrophy (SMA) Spinraza (nusinersen).
    - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy).
    - (CAR) T-cell immunotherapy treatment including but not limited to:
- Amtagvi (lifileucel)
- Axicabtagene ciloleucel (Yescarta™).
- Brexucabtagene Autoleucel (Tecartus).
- Carvykti(ciltacabtagene autoleucel) (CAR-T).
- Idecabtagene vicleucel (Abecma).
- Lisocabtagene maraleucel (Breyanzi).
- Tisagenlecleucel (Kymriah™)
- Gene Replacement Therapy (Clear confirmation that the group has excluded the benefit is required. If the benefit is covered, pre-certification is required). Including but not limited to:
    - Gene Therapy for Duchenne Muscular Dystrophy
    - Gene Therapy for Ocular Conditions/ Voretigene neparvovec-rzyl (Luxturna™).
    - Gene Therapy for Sickle Cell Disease
    - Gene Therapy for Spinal Muscular Atrophy/ onasemnogene abeparvovec-xioi (Zolgensma®).
    - Gene Therapy for Hemophilia
    - Gene Therapy for Metachromatic Leukodystrophy
    - Gene Therapy for Beta Thalassemia Betibeglogene autotemcel (ZYNTEGLO).
    - Gene Therapy for Cerebral Adrenoleukodystrophy (CALD).

Mental Health/Substance Abuse (MHSA)

- Acute Inpatient Admissions.
- Transcranial Magnetic Stimulation (TMS).
- Residential Care.
- Behavioral Health In-home Programs.
- Applied Behavioral Analysis (ABA)*.
- Intensive Outpatient Therapy (IOP).
- Partial Hospitalization (PHP).

*Services not requiring pre-certification for coverage but recommended for pre-determination of medical necessity due to the existence of post service claim edits and/or the potential cost of services to the member if denied by Anthem for lack of medical necessity.

Other Outpatient and Surgical Services:

- Aduhelm (aducanumab).
- Ambulance Services: Air and Water (excludes 911 initiated emergency transport).
- Ablative Techniques as a Treatment for Barrett's Esophagus.
- Allogeneic, Xenographic, Synthetic, Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting.
    - Insertion/injection of prosthetic material collagen implants.
- Axial Lumbar Interbody Fusion.
- Balloon Sinus Ostial Dilation.
- Bariatric Surgery and Other Treatments for Clinically Severe Obesity- *If the benefit is covered, pre-certification is required.
- Blepharoplasty, Blepharoptosis Repair, and Brow Lift.
- Bone-Anchored and Bone Conduction Hearing Aids.
- Breast Procedures; including Reconstructive Surgery, Implants and other Breast Procedures.
- Bronchial Thermoplasty.
- Cardiac Contractility Modulation Therapy.
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure.
- Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty.
- Cardioverter Defibrillators.
- Cervical and Thoracic Discography.
- Cochlear Implants and Auditory Brainstem Implants.
- Corneal Collagen Cross-Linking.
- Cosmetic and Reconstructive Services: Skin Related, including but not limited to:
    - Brachioplasty
    - Chin Implant, Mentoplasty, Osteoplasty Mandible
    - Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
- Cosmetic and Reconstructive Services of the Head and Neck, including but not limited to:
    - Facial Plastic Surgery Otoplasty
    - Rhinophyma.
    - Rhinoplasty or Rhinoseptoplasty (procedure which combines both rhinoplasty and septoplasty).
    - Rhytidectomy (Face lift).
    - Cranial Nerve Procedures.
    - Ear or Body Piercing.
    - Frown Lines.
    - Neck Tuck (Submental Lipectomy.
- Cosmetic and Reconstructive Services of the Trunk and Groin, including but not limited to:

    - Brachioplasty.
    - Buttock/Thigh Lift.
    - Congenital Abnormalities.
    - Lipectomy/Liposuction.
    - Repair of Pectus Excavatum/Carinatum.
    - Procedures on the Genitalia.
- Cryosurgical Ablation of Solid Tumors Outside the Liver.
- Deep Brain, Cortical, and Cerebellar Stimulation.
- Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing Systems.
- Doppler-Guided Transanal Hemorrhoidal Dearterialization.
- Electrophysiology-Guided Noninvasive Stereotactic Cardiac Radioablation.
- Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities).
- Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis.
- Focal Laser Ablation for the Treatment of Prostate Cancer.
- Functional Endoscopic Sinus Surgery (FESS).
- Home Parenteral Nutrition.
- Hyperbaric Oxygen Therapy (Systemic/Topical).
- Immunoprophylaxis for respiratory syncytial virus (RSV)/ Synagis (palivizumab).
- Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry.
- Implanted Devices for Spinal Stenosis.
- Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS).
- Implanted Artificial Iris Devices.
- Implanted Port Delivery Systems to Treat Ocular Disease.
- Implantable Infusion Pumps.
- Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain.
- Intracardiac Ischemia Monitoring.
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir).
- Keratoprosthesis.
- Leadless Pacemaker.
- Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies. Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD).
- Lysis of Epidural Adhesions.
- Mandibular/Maxillary (Orthognathic) Surgery.
- Manipulation Under Anesthesia.
- Mastectomy for Gynecomastia.
- Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts).
- Meniscal Allograft Transplantation of the Knee.
- Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis.
- Nasal Surgery for the Treatment of Obstructive Sleep Apnea and Snoring.
- Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring.

- Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management.
- Panniculectomy and Abdominoplasty.
- Partial Left Ventriculectomy. Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention.
- Penile Prosthesis Implantation.
- Percutaneous and Endoscopic Spinal Surgery.
- Percutaneous Neurolysis for Chronic Neck and Back Pain.
- Percutaneous Vertebral Disc and Vertebral Endplate Procedures.
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty.
- Perirectal Spacers for Use During Prostate Radiotherapy.
- Photocoagulation of Macular Drusen.
- Presbyopia and Astigmatism-Correcting Intraocular Lenses.
- Private Duty Nursing in the Home Setting.
- Reduction Mammaplasty.
- Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence and Urinary Retention.
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury.
- Sacroiliac Joint Fusion, Open.
- Self-Expanding Absorptive Sinus Ostial Dilation.
- Sipuleucel-T (Provenge®) Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer.
- Surgical and Ablative Treatments for Chronic Headaches.
- Therapeutic Apheresis.
- Total Ankle Replacement.
- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins.
- Transcatheter Heart Valve Procedures.
- Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia and Gastroparesis.
- Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects.
- Treatment of Osteochondral Defects.
- Treatment of Temporomandibular Disorders.
- Treatments for Urinary Incontinence.
- Treatment of Varicose Veins (Lower Extremities).
- Vagus Nerve Stimulation.
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome and Varicocele.
- Venous Angioplasty with or without Stent Placement/ Venous Stenting.
- Viscocanalostomy and Canaloplasty.
- Wireless Cardiac Resynchronization Therapy for Left Ventricular Pacing.
- Wearable Cardioverter-Defibrillator.

Out of Network Referrals:

Out of Network Services consideration of payment at *in-network* benefit level may be authorized, based on network availability and/or medical necessity.

Radiation Therapy/Radiology Services:

- Catheter-based Embolization Procedures for Malignant Lesions Outside the Liver.
- Cryosurgical or Radiofrequency Ablation to Treat Solid Tumors Outside the Liver.
- Intensity Modulated Radiation Therapy (IMRT).
- MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications.
- Proton Beam Therapy.
- Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy (Azedra, Lutathera, Pluvicto, Zevalin).
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT).
- Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule.
- Xofigo (Radium Ra 223 Dichloride)

Carelon Medical Benefits Management

Members may have benefit plans with specialty services medically managed as part of a purchased program called Carelon Medical Benefits Management, which helps to ensure delivery of healthcare services that are more clinically appropriate, safer, and more affordable.

For more information, or to determine if preapproval is needed contact the phone number on the back of the member ID card, or via the provider portal at https://www.providerportal.com You may also call Carelon toll-free at 888-953-6703.

Note: For procedures managed by Carelon, those designated pre-certification requirements apply to Carelon Program eligible members only.

Carelon Medical Benefit Management provides benefits management for the programs listed below:

- Cardiovascular Services.
- Diagnostic Imaging Management.
- Genetic Testing.
- Musculoskeletal (MSK) Program and Site of Care.
- Oncology Drugs.
- Outpatient Sleep Testing and Therapy Services.

Medical Special Drugs Administered in Your Home or by a Home Infusion Provider

Your plan covers specialty drugs that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient facility when they are covered services. This may include specialty drugs for infusion therapy, chemotherapy, blood products, certain injectable, and any drug that must be administered by a provider. This section applies when a provider orders the drug and a medical provider administers it to you in a medical setting or in your home by a home infusion provider. Specialty drugs which you can administer to yourself (or a caregiver

may administer to you), or specialty drugs you get from a Retail or Mail Order Pharmacy are not covered under your medical benefit and may be covered under the pharmacy benefit.

Pre-certification is required for certain Medically Administered Specialty Drugs to help make sure proper use and guidelines for these drugs are followed. Your provider will submit clinical information which will be reviewed for decision. We will give the results of our decision to both you and your Provider by letter.

For a list of Medically Administered Specialty Drugs that need pre-certification, please call the phone number on the back of your ID card. The pre-certification list is reviewed and updated from time to time. Including a Specialty Drug on the list does not guarantee coverage under your plan. Your provider may check with us to verify Specialty Drug coverage, to find out which drugs are covered under this section and if pre-certification is required.

High Tech Radiology

Assurant has selected an innovative imaging cost and quality program for Anthem Blue Cross and Blue Shield members. This program provides you with access to important information about imaging services you might need. Before receiving services, you must confirm that Carelon has pre-certified your test and is sending you to an approved network facility. Your tests could be delayed if your doctor skips this step.

If you need an MRI or CT scan, it's important to know that costs can vary quite a bit depending on where you receive the service. Sometimes the differences are significant – anywhere from $300 to $3,000 – but a higher price doesn't guarantee higher quality. The Health Plan requires you to pay a portion of this cost (as your *deductible* and *coinsurance*) so where you go can make a very big difference to your wallet.

High tech radiology services requiring pre-certification include:

- Computed Tomography (CT/CTA).
- Magnetic Resonance Imaging (MRA/MRA).
- Nuclear Cardiology.
- Positron Emission Tomography (PET).
- Stress Echocardiography.
- Resting Transthoracic Echocardiography.
- Transesophageal Echocardiography.

That's where the AIM Imaging Cost & Quality Program comes in – AIM does the research for you and makes it available to help you find the right location for your service. Here's how the program works:

- Your doctor refers you to a radiology provider for an MRI or CT scan.
- You pre-certify the service by contacting AIM at 1-888-953-6703 and providing them with the name of the procedure, the referring physician's contact information, name of the facility the referring physician recommends.
    - Carelon works with your doctor to help make sure that you're receiving the right test using evidence-based guidelines.
    - Carelon also reviews the referral to see if there are other high-quality providers in your area that have a lower price than the one you were referred to.

- If Carelon finds another provider that meets the quality and price criteria, AIM will call to let you know.

You have the choice – you can see the radiology provider your doctor suggested OR you can choose to see a provider that Carelon tells you about. They will even help you schedule an appointment with the new provider.

Musculoskeletal and Pain Management Program

The Musculoskeletal and Pain Management program, can help you and your doctor make the best decisions so you can get the right care in the right place. As part of this new program, Prior Authorization will be required to help you understand the treatment options and requirements for plan coverage before you have joint surgery or spinal pain treatment.

If you have a musculoskeletal condition and you and your doctor are considering any of the treatments below, your doctor must contact Anthem before scheduling them:

- Spine, hip, knee or shoulder joint surgery.
- Spinal pain treatment, such as spinal pain injections, epidurals, nerve blocks, ablations, thermal destruction of the intervertebral disc or use of spinal stimulators.

Your doctor can contact Anthem through the provider portal or by calling the number for Image/Cardio/Sleep/Genetic/Ortho on your Identification card. If you do not contact Carelon (1-888-953-6703) before receiving services, a claim may not be paid. Here's what happens next:

1. Your treatment will be reviewed by orthopedic, neurosurgical and pain specialists using state-of-the-art clinical criteria and considering your benefits.
2. The review may also include a phone call between one of our specialists and your doctor to help determine the right test, the right treatment and the right place for your care.
3. After the review, your doctor will talk to you about your treatment options.

Sleep Management Program

Your Plan includes a sleep management program that helps your Physician make better informed decisions about your treatment. The Sleep Management program includes outpatient and home sleep testing and therapy. If you require sleep testing, depending on your medical condition, you may be asked to complete the sleep study in your home. Home sleep studies provide the added benefit of reflecting your normal sleep pattern while sleeping in the comfort of your own bed versus going to an outpatient facility for the test.

As part of this program, you're required to get pre-certification for:

- Home sleep tests (HST).
- In-lab sleep studies (polysomnography or PSG, a recording of behavior during sleep).
- Titration studies (to determine the exact pressure needed for treatment); and
- Treatment orders for equipment, including positive airway pressure devices (APAP, CPAP, BPAP, ASV), oral devices and related supplies.

If you need ongoing treatment, we will review your care quarterly to assure that medical criteria are met for coverage. Your equipment supplier or your doctor will be required to

provide periodic updates to ensure clinical appropriateness. Ongoing claim approval will depend partly on how you comply with the treatment your doctor has ordered.

Please talk to your Physician about getting approval for any sleep testing and therapy equipment and supplies. If you have questions about your care, please talk with your Physician. For questions about your Plan or benefits, please call Member Services.

Decision Support and Notice Requirements

Beginning in 2027, every covered member will have access to a dedicated Family Advocate through Anthem's Total Health Connections program. Whether you need help finding care, understanding your benefits, coordinating appointments, or managing a health condition, you'll have personalized support every step of the way, all accessible through the Sydney® Health app.

Family Advocates work with members to connect them to available clinical, behavioral health, wellness, and care-management resources based on individual needs and circumstances.

These services are available at no additional cost to eligible members.

Decision and Notice Requirements

The claims administrator will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on Federal laws. You may call the phone number on the back of your Identification Card for more details.

If more information is needed to make a decision, the claims administrator will tell the requesting provider of the specific information needed to finish the review. If the claims administrator does not get the specific information needed by the required timeframe, the claims administrator will make a decision based upon the information it has. The claims administrator will notify you and your provider of its decision as required by Federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request

Post-Service Review	30 calendar days from the receipt of the request

Important Information

From time-to-time certain medical management processes (including utilization management, case management, and disease management) may be waived, enhanced, changed or ended. An alternate benefit may be offered if, in the Plan's sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

Certain qualifying providers may be selected to take part in a program or a provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. Your claim may also be exempted from medical review if certain conditions apply.

Just because a process, provider or claim is exempted from the standards which otherwise would apply, it does not mean that this will occur in the future or will do so in the future for any other provider, claim or Member. The Plan may stop or change any such exemption with or without advance notice.

You may find out whether a provider is taking part in certain programs or a provider arrangement by contacting the Member Services number on the back of your Identification Card.

The claims administrator also may identify certain providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a provider is selected under this program, then the claims administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this provider, even if those guidelines are not used for all providers delivering services to this Plan's members.

Health Plan Individual Case Management

The *claims administrator's* individual health plan case management programs (Case Management) helps coordinate services for members with health care needs due to serious, complex, and/or chronic health conditions. The *claims administrator's* programs coordinate benefits and educate members who agree to take part in the Case Management program to help meet their health-related needs.

The *claims administrator's* Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of your health plan Case Management staff. These Case Management programs are separate from any covered services you are receiving.

If you meet program criteria and agree to take part, the *claims administrator* will help you meet your identified health care needs, this is reached through contact team work with you and/or your authorized representative, treating Physician(s), and other *providers*.

In addition, the *claims administrator* may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or Injury, the Plan may provide benefits for alternate care that is not listed as a covered service. The Plan may also extend covered services beyond the Benefit Maximums of this Plan. The claims administrator will make any recommendation of alternate or extended benefits to the Plan on a case-by-case basis, if at the claims administrator's discretion, the alternate or extended benefit is in the best interest of you and the Plan and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the claims administrator will notify you or your authorized representative in writing.

Series of Services

When a single charge is made for a series of services, each service will bear a pro-rata share of the expense. Anthem (for health, behavioral health and substance abuse claims) will determine the pro-rata share. Only that pro-rata share of the expense will be considered to have been an expense incurred on the date of such service.

Covered Expenses

For a service, medical supply or prescription drug to be covered under the Assurant Health Plan, it must:

- Be medically necessary as determined by Anthem.
- Be obtained while coverage is in effect.
- Not exceed the maximums and limitations; and
- Be obtained in accordance with all the terms, policies and procedures outlined in this summary.

Preventive Care

This section describes the covered expenses for services and supplies provided when you're well. Early detection of disease can often be the difference between life and death, between being well and being disabled. The Assurant Health Plan encourages you and your family to get the preventive services that are appropriate for your age, gender and other risk factors such as family medical history, by covering the following routine preventive services. If you use a network provider or if you don't live within the Anthem network area, these services will be reimbursed at 100% and are not subject to the *deductible*. If you use an *out-of-network* provider, these services will be subject to the *deductible* and *coinsurance*.

Following is a list of preventive services that are generally covered at 100%. The complete list can also be found on myassurantbenefits.com.

- Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer.
    - Cervical cancer.
    - Colorectal cancer.

    - High blood pressure.
    - Type 2 Diabetes Mellitus.
    - Cholesterol.
    - Child and Adult Obesity.
- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- *Preventive care* and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- Prostate Cancer Screening - PSA (routine); Includes digital rectal exam and Prostate specific antigen (PSA) test.
    - Routine eye exams, including refractions (does not include fittings for glasses or contact lenses). Anthem offers discounts on glasses and contacts. Visit eyewearspecialoffers.com for the details.
- Routine hearing exams performed by an otolaryngologist, otologist or an audiologist.
- Additional *preventive care* and screenings for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    - Women's contraceptives (Refer to Prescription Drug Coverage for details), sterilization procedures and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs) and implants.
    - Breastfeeding support, supplies and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
    - Gestational diabetes *screening*.
    - **Additional Breast Cancer Imaging Services**
      In certain circumstances, additional imaging or follow-up services (such as magnetic resonance imaging (MRI), ultrasound, or biopsy) may be recommended following an initial screening mammogram. These services are generally considered diagnostic in nature and are covered based on medical necessity and Anthem's clinical guidelines. Coverage for these services may be subject to applicable deductibles, coinsurance, or copayments, depending on the terms of the applicable medical plan option.
    - **Preventive Maternity Care:** Certain prenatal, postpartum, and other maternity-related preventive services may be covered without member cost-sharing when provided by an in-network provider and in accordance with applicable preventive care guidelines. Maternity-related services that do not qualify as preventive care remain subject to the Plan's applicable deductible, copayment, coinsurance, and other coverage provisions.

If a disease or condition is suspected or identified as a result of a routine preventative service, any further exams and tests for that disease or condition will be considered diagnostic and may be subject to the *deductible, coinsurance, or copay*, depending on which health plan option you're enrolled in, and whether or not you have met your *deductible* or *out-of-pocket maximum*.

If you're receiving services for an existing condition, then the service is not considered preventive.

Covered Services

The following services are subject to the *deductible* and *coinsurance* unless otherwise specified in this booklet:

Inpatient Services (pre-certification required)

- Hospital inpatient services.
- Birthing Center.
- Delivery room and newborn nursery services for well-baby care.
- Inpatient services for behavioral health and substance abuse treatment.
- Inpatient Room Charges. Covered charges include semiprivate room and board, general nursing care and intensive or cardiac care. If you stay in a private room, the maximum allowed amount is based on the hospital's prevalent semiprivate rate. If you're admitted to a hospital that has only private rooms, the maximum allowed amount is based on the hospital's prevalent room rate.
- Intensive Care Unit, Cardiac Care Unit, Neonatal intensive Care Unit.
- Services and Supplies provided and billed by the hospital while you're an inpatient, including the use of the operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examination and radiation and speech therapy are also covered. Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.
- Medical care. General medical care, consultations, second opinions, intensive care, monitoring and newborn care.
- Surgeon.
- Assistant surgeon – covered only if surgery is covered.
- Acupuncture – covered only if performed as anesthesia in connection with a covered surgical procedure.
- Anesthesiologist.
- Pathologist.
- Professional therapy services include chemotherapy, radiation therapy, dialysis, hemodialysis, infusion therapy, physical therapy, occupational therapy, speech therapy and respiratory therapy. The annual maximum for outpatient physical, occupational and speech therapy is a combined 90 visits per calendar year and a visit consists of no more than one hour of therapy. The calendar year limit of 90 visits apply to *in-network* and *out-of-network* benefits for all professional therapy services combined; however, no more than 30 of these combined visits will be covered through an *out-of-network* provider.
- Radiologist.
- Bariatric Surgery (weight loss surgery); (pre-certification required) see Special Programs – Bariatric Surgery for additional details.
- Behavioral Health and Substance Abuse. Detoxification and Residential Treatment (pre-certification required).

- Organ Transplant (pre-certification required) see Special Programs – Organ Transplants for additional details.

Hospice Care

Covered hospice services are provided in accordance with the terms of the Plan and are not subject to an annual visit maximum.

Bereavement Counseling

Bereavement counseling services provided as part of a covered hospice program are covered in accordance with the terms of the Plan.

- Skilled Nursing Facility - limited to 120 visits per calendar year, combined In and out-of-Network (pre-certification required).
- Gender Affirming Surgery: Assurant covers precertified gender affirming surgery and transition-related care services in accordance with Anthem Medical Policies. The Plan provides benefits for many of the charges for gender affirming surgery for members diagnosed with Gender Dysphoria. Gender affirming surgery must be approved by Anthem for the type of surgery requested and must be authorized prior to being performed. Charges for services that are not authorized for the gender affirming surgery requested will not be considered covered services. Some conditions apply, and all services must be authorized by Anthem as outlined in the Health Care Management – Pre-certification section. Below is an overview of covered services:
    - Surgical procedures (including chest, breast, and genital surgeries).
    - Reconstructive surgical procedures (including any associated medically necessary repairs and revisions).
    - Mental health counseling.
    - Provider and laboratory visits.
    - Hair removal, through electrolysis, laser treatment, or waxing (not as part of reconstructive surgery).
    - Hair removal required for genital reconstruction surgery (eg: electrolysis of free flap or other donor
    - skin sites).
    - Tracheal shave or reduction thyroid chondroplasty.
    - Facial feminization surgeries, including rhinoplasty, facial bone reduction, face-lift, blepharoplasty.
    - Voice modification surgery.
    - Voice modification therapy.
    - Lipoplasty or lipofilling for body masculinization or femininization.
    - Travel and lodging.
    - Hormone therapy – Covered under the Prescription Drug plan administered by CVS Caremark (pre-certification for certain prescription drugs may be required).

Outpatient Hospital Services

- Institutional/Outpatient Hospital Facility Charges.
- Outpatient/Ambulatory Surgery.
- Intensive Outpatient Therapy (IOP) and Partial Hospitalization (PHP) for behavioral health and substance abuse conditions.
- Methadone Treatment Centers (for the treatment of addiction).
- Surgeon.
- Anesthesiologist.
- Radiologist.
- Pathologist.
- Professional Consultation / Second Opinion and
- Pre-surgical/Pre-admission Testing.

Emergency Services

Emergency room and ambulance services are covered for an emergency medical condition. Covered services include ancillary services routinely available to the emergency department of a hospital.

Network and *out-of-network* services are reimbursed at the network level of benefits. However, the allowable charge for *out-of-network* services will be the greatest of:

- The amount negotiated with network providers for the emergency services furnished.
- The *out-of-network* pricing used by the claims administrator or
- The amount that would be paid under Medicare for the emergency service.

You'll be taken to the nearest facility that can give care for your condition.

Benefits also include medically necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you're not taken to a facility.

Any *out-of-network* follow up treatment will not be reimbursed at network levels.

Life-threatening Medical Emergency or Serious Accidental Injury

Coverage is provided for hospital emergency room care including a medical or behavioral health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition, and within the capabilities of the staff and facilities available at the hospital, such further medical or behavioral health examination and treatment as are required to stabilize the patient. Emergency service care does not require any prior authorization from the Plan. Services provided for conditions that do not meet the definition of emergency will not be covered.

Stabilize means, with respect to an emergency medical condition: to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Medically necessary services will be covered whether you get care from a network or *out-of-network* provider. Emergency care you get from an *out-of-network* provider will be covered as a network service and will not require pre-certification. The *out-of-network* provider can only charge you any applicable *deductible, coinsurance, and/or copayment* and cannot bill you for the difference between the maximum allowed amount and their billed charges until your condition is stable, the *out-of-network* provider has provided you with proper notice, and you have provided consent to additional treatment, as described in the Surprise Billing Notice posted with the legal notices on myassurantbenefits.com.

Your cost shares will be based on the maximum allowed amount and will be applied to your network *deductible* and network out-of-pocket limit.

Treatment you get after your condition has stabilized is not emergency care. Please refer to the Surprise Billing Notice posted with the legal notices on myassurantbenefits.com for more details on how this will impact your benefits.

The maximum allowed amount for emergency care from an *out-of-network* provider will be determined using the median plan network contract rate we pay network providers for the geographic area where the service is provided. Charges for the use of an emergency room for a non-emergency medical condition will be reimbursed at 50% and the unpaid amount will not apply towards the *deductible* or *out-of-pocket maximum*.

Ambulance Service

Medically necessary ambulance services are covered when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, you are taken:
    - From your home, the scene of an accident or medical emergency to a hospital.
    - Between hospitals, including when Anthem requires you to move from an *out-of-network* hospital to a network hospital.
    - Between a hospital and a Skilled Nursing Facility or other approved facility.
- For air or water ambulance, you are taken:
    - From the scene of an accident or medical emergency to a hospital.
    - Between hospitals, including when Anthem requires you to move from an *out-of-network* hospital to a network hospital.
    - Between a hospital and an approved facility.

Ambulance services are subject to medical necessity reviews by Anthem. Emergency ground ambulance services do not require *precertification* and are allowed regardless of whether the provider is a network provider or *out-of-network* provider.

Non-emergency ambulance services are subject to medical necessity reviews by Anthem. Emergency ground ambulance services do not require *precertification* and are allowed regardless of whether the provider is a network provider or *out-of-network* provider.

You must be taken to the nearest facility that can give care for your condition. In certain cases, Anthem may approve benefits for transportation to a facility that is not the nearest facility.

Benefits also include medically necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or physician are not a covered service.

Other non-covered ambulance services include, but are not limited to:

- a physician's office or clinic; or
- a morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a hospital that is not an acute care hospital (such as a skilled nursing facility or a rehabilitation facility), or if you are taken to a physician's office or your home.

Hospital to Hospital Transport

If you are moving from one hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the hospital that first treats you cannot give you the medical services you need. Certain specialized services are not available at all hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain hospitals. To be covered, you must be taken to the closest hospital that can treat you. Coverage is not available for air ambulance transfers simply because you, your family, or your provider prefers a specific hospital or physician.

Hearing Aid Benefits

The Assurant Health Plan covers a hearing aid benefit of $3,000 per ear every three years with a prescription. Additionally, if you're experiencing mild to moderate hearing loss, Assurant will now offer over-the-counter (OTC) hearing aids with a prescription for a convenient, cost-effective, and user-friendly solution for improving and managing your hearing health. You'll have a wide range of options, including brands, styles, and features like Bluetooth, rechargeable batteries, and tinnitus reduction for phantom noises in your ears, like ringing. You can buy these devices online and in stores. In some cases, your audiologist may offer these devices as well.

Inclusive Care

Part of living a healthy life is finding a doctor you trust. To make this easier for Members who are lesbian, gay, bisexual, transgender, and queer (LGBTQ+), Inclusive Care helps You find

doctors who will treat You with dignity and respect and who are experienced in providing compassionate, high-quality LGBTQ+ healthcare. When using an Inclusive Care Center of Excellence, and the treatment has been pre-approved by Anthem, you may be eligible for the travel and lodging benefit. *Deductible* and other cost-shares may apply for travel and lodging benefits. Call the Member Services number on the back of Your Identification Card for information.

The program is available to Members looking for:

- Access to the Plan's large Network of medical and mental health professionals, including primary and specialty care from a Provider with LGBTQ+ experience.
- Expert, whole-healthcare regardless of gender identity.
- World Professional Association for Transgender Health (WPATH) Standards of Care for gender-affirmation services, based upon your benefit coverage.
- Counseling for mental health and emotional well-being.
- Support for coming out at work.
- HIV/AIDS treatment and PrEP medication.
- Information on gender-affirming surgery and services, benefits, and options.

Gender Affirming Surgery and Services

Equal health coverage for transgender individuals is available as this Plan provides benefits for many of the charges for gender-affirming surgery and services for members diagnosed with gender identity disorder, also known as Gender Dysphoria. Gender-affirming surgery and services must be approved by Anthem for the type of procedure requested and must be authorized prior to being performed. Transgender care does require the use of medications as part of your care plan. These medications are accessed through your CVS Caremark.

While these products may require a prior authorization to confirm clinical appropriateness, the Plan does include transgender care in coverage determinations.

Outpatient Services

- **Acupuncture** - medically necessary acupuncture services received in an outpatient or office setting are covered, subject to applicable deductibles, copayments, and coinsurance. Allergy Testing and Treatment. Serum and allergy shot is not subject to the annual *deductible*.
- Behavioral Health and Substance Abuse Care provided by a psychiatrist, psychologist, licensed clinical social worker (L.C.S.W.), mental health clinical nurse specialist, licensed marriage and family therapist (L.M.F.T.), Licensed Professional Counselor (L.P.C.) or any agency licensed by the state to give these services, when required to be covered by law.
- Blood Therapy (processing and storage).
- Cardiac and Pulmonary Rehabilitation.
- Chemotherapy
- Chiropractic Care (Spinal Manipulation) subject to applicable plan cost sharing and limited to 20 visits per calendar year. Other covered services, including x-rays, do not count toward the annual visit maximum if the visit does not include spinal

manipulation. The 20-visit annual maximum applies to all covered chiropractic services regardless of diagnosis, condition or treatment purpose.

- Clinical Trial Benefits - include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are covered services under the Plan.
- Contraceptive services and supplies including:
    - Contraceptive devices prescribed by a physician provided they have been approved by the U.S. Food and Drug Administration.
    - Related outpatient services such as:
    - Consultations.
    - Exams.
    - Procedures.
    - Other medical services and supplies.

  Refer to the Covered Expenses under the Prescription Drug Coverage for information on coverage of oral contraceptives.

Dental and Oral Surgery

- Covered oral surgery services include the surgical removal of impacted teeth when medically necessary.
- Services required for the initial repair of an injury to the jaw, sound natural teeth, mouth or face required as a result of an accident and are not excessive in scope, duration or intensity to provide safe, adequate and appropriate treatment without adversely affecting your condition. Injury as a result of chewing or biting is not considered an accidental injury except where the chewing or biting results from an act of domestic violence or directly from a medical condition. Treatment must be completed within 24 months of the accident.
- The Plan also includes benefits for hospital charges and anesthetics provided for dental care if the member meets any of the following conditions:
    - The member is under age five.
    - The member has a severe impairment that requires hospitalization or general anesthesia for dental care; or
    - The member has a medical condition that requires hospitalization or general anesthesia for dental care.
- Diagnostic X-rays and labs.
- Diagnostic services by a physician or specialist physician.
- Dialysis, Hemodialysis.
- Emergency Care and ambulance services - care received for an emergency medical condition will be covered at the network level of benefits. Except for surprise billing claims, if an *out-of-network* provider is used, you may be responsible to pay the difference between the maximum allowed amount and the amount the *out-of-network* provider charges.
- Eye Care – medical eye care exams and treatment of disease or injury to the eye.
- Gender-Affirming Surgery and Services
    - Covered Services include, but are not limited to, mental health benefits; medical visits or laboratory services; reconstructive surgical procedures related to

gender reassignment (including reconstructive chest, breast, and genital procedures); hair removal, such as electrolysis, laser treatment, etc. (not as a part of reconstructive surgery); tracheal shave/reduction; facial feminization surgeries; voice modification surgery; voice modification therapy; and lipoplasty/filling for body masculinization or feminization. Depending on your benefit plan, travel and lodging, and short-term disability benefits may be available. Please confirm with your Pharmacy Provider if pharmaceutical coverage for hormone replacement therapies, including puberty blockers for youth is covered.

- Gender Identity Disorder/Gender Dysphoria - The distress a person feels due to a mismatch between their gender identity: their personal sense of their own gender and their gender assigned at birth.

Services Not Eligible for Coverage Your Plan does not include benefits for the following:

a. Services determined to be Experimental/Investigational.
b. Services provided by a non-approved provider or at a non-approved facility; or
c. Services not approved in advance through pre-certification.

- Home Health Services – see Home Health Services for details.
- Hospice Care Services - limited to 210 visits per calendar year, combined In and *out-of-network*.
- Fertility Benefits – The Plan includes benefits for the diagnosis and treatment of infertility as well as Fertility. Benefits available to members without a need to demonstrate infertility. No Fertility Benefits are available to a spouse or *domestic partner* if that spouse or *domestic partner* is not also covered under the Plan. Covered services include diagnostic and exploratory procedures to determine whether a member suffers from infertility. This includes surgical procedures to correct any diagnosed disease or condition affecting the reproductive organs such as endometriosis, collapsed/clogged fallopian tubes or testicular failure. The combined lifetime maximum benefit for comprehensive medical and prescription drug fertility expenses is $30,000 fertility. Refer to Special Programs - Fertility Benefits for additional information and benefits.
- Infusion Therapy.
- Maternity Care - physician's initial office visit and global care (pre- and post-natal care and delivery); abortion. Not covered for employees, spouses and *domestic partner*s acting as a surrogate.
- Medical and Surgical Equipment – charges by a supplier for medical supplies, durable medical equipment (DME), orthotics (foot and shoe) and external prosthetic appliances. The rental of equipment or, In lieu of rental, the initial purchase of DME if Long-Term care is planned and the equipment cannot be rented or is likely to cost less to purchase than to rent. The decision to buy or rent is at Anthem's discretion. Diabetic supplies- lancets, syringes, insulin, etc. - are covered under the Prescription Drug Coverage. DME in excess of $5,000 (combined limit for rental or purchase) requires Pre-certification. Note that orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet are not covered unless the e orthopedic shoe is an integral part of a covered leg brace or to prevent complications of diabetes.

Durable Medical Equipment (DME), Medical Devices, and Supplies

The Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use.
- It is manufactured solely to serve a medical purpose.
- It is not merely for comfort or convenience.
- It is normally not useful to a person not ill or injured.
- It is ordered by a Physician.
- The Physician certifies in writing the Medical Necessity for the equipment. The proof at any time of the continuing Medical Necessity of any item.

Equipment, devices, supplies, and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation will not be covered. The Plan's reimbursement for durable medical equipment, orthotics, prosthetics, devices, and supplies, hearing aids and wigs will be based on the Maximum Allowed Amount for a standard item that is Medically Necessary to meet Your needs. If You choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the Maximum Allowed Amount for the standard item, and You will be required to pay any costs that exceed the Maximum Allowed Amount. Please check with Your Provider or contact us if You have questions about the Maximum Allowed Amount.

- Nutritional Counseling - only for members with diabetes or those diagnosed with an eating disorder.
- Obesity Services - Non-surgical services. Also see Bariatric Surgery.
- Physician Services - home and office visits; office surgery.
- Prescription Injectables/Prescription Drugs Dispensed in a physician's Office - See the Prescription Drug section of this booklet for information on all other covered prescription drug expenses.
- *Preventive Care* - see *Preventive Care* for details.
- Private Duty Nursing - services provided in the home must be pre-certified. The member's condition must require nursing care that requires the education, training and technical skills of a R.N. or L.P.N. and visiting nursing care is not adequate. Benefits are limited to 70 eight-hour shifts per calendar year. Services provided in a hospital or health care facility are not covered if care can be provided adequately by the facility's general nursing staff, if it were fully staffed.
- Prosthetic Appliances -Prosthetic devices to improve or correct conditions resulting from accidental injury or illness are covered if medically necessary and ordered by a physician. Prosthetic devices include: artificial limbs and accessories, artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); and external breast prostheses used after breast removal.
- Radiation Therapy.

- Reconstructive Surgery – only to the extent medically necessary if surgery is needed to:
  - Improve a significant functional impairment of a body part.
  - Correct the result of an accidental injury provided that surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
  - Correct the result of an injury that occurred during a covered surgical procedure provided the reconstructive surgery occurs no more than 24 months after the original injury.
  - Reconstructive Surgery benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance as well as surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a covered service under this plan.
- Reconstructive Breast Surgery –following a mastectomy for reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also covered is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy including lymphedema.
- Respiratory Therapy.
- Sterilization Services - vasectomy services are covered. Sterilization and contraceptives for women are covered under *Preventive Care*.
- Therapy Services - physical, speech and occupational therapy are limited to 90 visits (combined) per calendar year. This includes services needed due to developmental delay. A visit consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.
- Transplants – any medically necessary human organ and stem cell/bone marrow transplants and transfusion performed as determined by the claims administrator including necessary acquisition procedures, collection and storage including medically necessary myeloablative therapy. Procedures must be performed in a center of excellence to be considered a covered expense. See Transplants and Limitations and Exclusions for important information.
- Urgent Care - Services received for a sudden, serious, or unexpected illness, injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong or treat a health problem that is not life-threatening.
- Vision Therapy.

Special Programs

Bariatric Surgery (weight loss surgery)

The Assurant Health Plan covers bariatric surgery if it is pre-certified and performed at a Blue Distinction center of excellence facility. If you need to travel to the center of excellence for the surgery, the Plan will cover certain travel expenses for you and a companion when the facility is more than 75 miles away from your home. Call Anthem at 1-855-285-4212 to pre-certify.

Refer to Travel and Lodging Benefit and Limitations and Exclusions for important information.

Home Health Care

All home health care services must be pre-certified. Limited to 200 visits per calendar year, combined In and *out-of-network*). Covered services include:

- Visits by a R.N. or L.P.N.
- Visits by a qualified physiotherapist, speech therapist and inhalation therapist certified by the National Board of Respiratory Therapy.
- Services provided by a licensed Medical Social Services Worker when medically necessary to enable you to understand the emotional, social and environmental factors resulting from or affecting your illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance.
- Administration or infusion of prescribed drugs; and
- Oxygen and its administration.

Covered services do not include:

- Services that are not medically necessary or of a non-skilled level of care.
- Convalescent or custodial care where you have spent a period of time for recovery of an illness or surgery and skilled care is not required or the services being rendered are only for aid in daily living (e.g., feeding, dressing, toileting).
- Dietician services.
- Hemodialysis treatment.
- Food, housing, homemaker services, sitters, home –delivered meals.
- Services and supplies that are not included in the home health care plan.
- Services of a person who ordinarily resides in your home or is a member of your or your spouse's/*domestic partner*'s family.
- Any services for any period during which you're not under the continuing care of a physician; and
- Any services or supplies not specifically listed as covered.

Fertility Benefits

For health plan enrollees, the Plan covers certain fertility services including ovulation induction, intrauterine insemination (IUI), and in-vitro fertilization (IVF) with one year of embryo storage when services are performed by an *in-network* provider. Coverage also includes medically necessary fertility preservation of eggs and sperm with one year of storage. These services must be pre-certified and are subject to a $30,000 combined lifetime maximum benefit for fertility medical services, treatments, and prescriptions. The fertility benefit is available to all eligible members with or without a diagnosis of infertility. Fertility and pregnancy benefits are not covered under the Assurant health plan for employees, spouses or *domestic partner*s acting as a surrogate.

In order to access and maximize this benefit, prior authorization by WINFertility is required prior to initiation of medical treatment. By applying the most medically appropriate treatments, access to care is intended to reduce risks and costs. Failure to initiate preauthorization of services for each service will result in a denial of benefits. Coverage is

subject to available benefit at time of claim submission. Out-of-pocket responsibilities may be applicable and should be verified prior to initiating services.

Covered Benefits:

1. Artificial Insemination (AI), Intrauterine Insemination (IUI), and Time Intercourse (TI) cycles
    a. with or without stimulation with oral agents (e.g., clomiphene citrate, letrozole)
2. Assisted Reproductive Technologies (ART):
    a. Monitoring of ovarian stimulation by ultrasound and related hormone assays.
    b. In Vitro Fertilization (IVF) Oocyte retrieval.
    c. Embryology services to include: oocyte identification, sperm identification, in vitro fertilization (IVF), Intracytoplasmic Sperm Injection (ICSI), embryo culture, embryo thaw, embryo preparation for transfer, embryo cryopreservation.
3. ART related services:
    a. Oocyte Thaw cycles and Frozen Embryo Transfer (FET) cycles (including use of donor eggs and donor embryos).
    b. Oocyte cryopreservation cycles including one year of storage when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes).
    c. Sperm cryopreservation including one year of storage when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes).
    d. Embryo Biopsy for Preimplantation Genetic Testing (PGT), Preimplantation Genetic Testing (PGD) and Preimplantation Genetic Screening (PGS) subject to Anthem medical guidelines.
    e. Storage of cryopreserved Embryos for up to 1 year beginning from the initial date of cryopreservation.

Benefit Specifics:

All frozen embryos (or all euploid frozen embryos, if PGT was performed) stored after a completed cycle with ovarian stimulation should be utilized prior to coverage availability for another ovarian stimulation cycle for IVF (unless the coverage is for a fertility preservation cycle) when clinically appropriate. Embryo transfer guidelines per the American Society of Reproductive Medicine (ASRM) should be followed for all embryo transfers (fresh and frozen cycles) and elective single embryo transfer should be utilized when clinically appropriate.

Exclusions: The following services are not covered:

1. Gonadotropin or menotropin stimulated ovulation induction cycles including monitoring of Timed Intercourse and IUI cycles unless member has a diagnosis of hypogonadotropic anovulatory disorders or hypopituitarism, or after member has not ovulated or conceived after a prior trial of 3 cycles or clomiphene citrate or letrozole.
2. If a member has undergone an elective sterilization procedure, they are not eligible for benefits unless they undergo a successful reversal; or WIN's consulting medical director determines that the reversal of the elective sterilization procedure is not medically indicated or will not improve the likelihood of conception due to

multifactorial causes of infertility. Reversal of a sterilization procedure is not covered. However, the partner that did not elect voluntary sterilization could be eligible for benefits based on plan design.

3. Reversal of a voluntary sterilization is not covered.
4. Experimental or investigational medical and surgical procedures.
5. Services which are not medically appropriate.
6. Expenses for procuring Donated Oocytes or Sperm, including all medical expenses, travel expenses, agency, laboratory and donor fees, psychological screening, FDA testing for the donor and partner, genetics screening and all medications for the donor (e.g. suppression medications, stimulation medications.
7. Services which are not listed as covered in this benefit.

Refer to Limitations and Exclusions for important information. For more information about your Fertility benefits, contact WINFertility at 1-866-227-2690.

Transplants

The following organ (solid organ, stem cell, bone marrow and tissue) transplants are covered by the Plan at the *In-network* level of benefits only if pre-certified and performed at a facility designated by Anthem Blue Cross and Blue Shield as a Blue Distinction center of excellence for the type of transplant being performed. All other facilities are subject to out of network *deductible* and *coinsurance*. Call Anthem at 1-855-285-4212 to pre-certify the procedure and to locate appropriate Centers of Medical Excellence.

- Heart.
- Lung.
- Heart/Lung.
- Simultaneous Pancreas/Kidney.
- Pancreas.
- Liver.
- Bone Marrow/Stem Cell.

Please note that there are instances where your provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search and/ or a collection and storage is NOT an approval for the subsequent requested transplant. A separate medical necessity determination will be made for the transplant procedure.

For services rendered in a Blue Distinction facility, the Plan will provide assistance with reasonable and necessary travel expenses as determined by Anthem when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your covered transplant procedure will be performed.

Refer to Travel and Lodging Benefit and Limitations and Exclusions below, for important information.

Travel and Lodging Benefit

You may be eligible for reimbursement of Travel and Lodging expenses incurred by you or your eligible family members. Eligibility would be granted when a network provider option is not available within 75 miles of the Employee's home, and the medical services are rendered by the next closest network provider (for services related to Transplant or Bariatric surgery, care must be provided at an *in-network* Blue Distinction Center of Excellence). Eligible Travel and Lodging expenses would be reimbursable after claims for the medical services are processed and approved; and the Employee has completed expense forms and submitted with the appropriate receipts. Expenses for Travel and Lodging for the recipient and a companion must be verified by the Plan and may be available as follows:

- Transportation is covered, including expenses for personal car mileage at the current Federal rate of reimbursement, of the patient and one companion who is traveling on the same day(s) to and/or from the site of the surgery for an evaluation, the procedure, or necessary post-discharge follow-up;
- Reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per-diem rate of $50 for one person or $100 a day for two people (a maximum of $50 per person — $100 for patient and companion combined — per night is paid toward lodging expenses; meals are not covered);
- Travel and lodging expenses are available only if the Member resides more than 75 miles from the Network Facility where services are received;
- If the patient is a covered *Dependent* minor child, the transportation expenses of two companions will be covered; lodging expenses will be reimbursed at the $100 per-diem rate.
- These benefits are subject to a maximum of $10,000 per occurrence, and a combined overall lifetime maximum of $20,000 per covered person, for all transportation and lodging expenses incurred by the Member receiving the service and companion (companions, if the covered *Dependent* is a minor), and reimbursed under the Plan.
- For information about the transportation and lodging benefits, please contact your Anthem Family Advocate at 1-855-285-4212.

The Employee must submit itemized receipts for Travel and Lodging expenses in a form satisfactory to Anthem when claims are filed. Anthem will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Note: In light of the U.S. Supreme Court's ruling in Dobbs v. Jackson Women's Health, any claim submitted for payment that is related to reproductive health services shall be subject to additional review to determine if payment is legally permitted under applicable state law.

Travel and Lodging Benefit Exclusions

- Meals - Restaurants and Take Out: Meals and snacks.
- Meals - Groceries: Food and beverage (excluding alcohol).
- Travel - Lodging: valet parking.
- Travel - Personal car mileage (except if the individual does not fly, and only covered to and from the facility).
- Convenience items: telephone, fax.
- Entertainment items: movies, books, and video rentals.

- Furnishing for apartments: cooking utensils, appliances, furniture.
- Groceries: Alcohol, cigarettes, paper products, toiletries; personal hygiene products.
- Laundry service or dry cleaning.
- Gratuities of any kind.
- Laundry detergent.
- Moving trucks (e.g. U-Haul).

Assurant Health Plan Limitations and Exclusions

The following services are excluded from or limited by the Assurant Health Plan:

- Expenses incurred before coverage begins or after it ends.
- Admissions for non-inpatient services - admission or continued hospital or skilled nursing facility stay for medical care or diagnostic studies not medically required on an inpatient basis.
- Administrative charges - charges for any of the following:
    - Failure to keep a scheduled visit.
    - Completion of claim forms or medical records or reports unless otherwise required by law.
    - For physician or hospital's stand-by services.
    - For holiday or overtime rates.
    - Membership, administrative, or access fees charged by physicians or other providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results and
    - Specific medical reports including those not directly related to the treatment of the member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- Allergy Services - specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity and urine autoinjections.
- Alternative Therapies - services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy at a salon, Reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology (study of the iris), biofeedback, recreational or educational sleep therapy or other forms of self-care or non-medical self-help training and any related diagnostic testing.
- Biomicroscopy - including field charting or aniseikonic investigation.
- Certain Providers - Service you get from providers that are not licensed by law to provide covered services as defined in this SPD. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
- Charges or any portion of a charge in excess of the maximum allowed amount as determined by the claims administrator except for surprise billing claims as outlined in the Surprise Billing Notice posted with the legal notices on myassurantbenefits.com.

- Christian Science Practitioner.
- Comfort and Convenience Items – personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, consumer wearable/ personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications. Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is medically necessary in your situation. Reimbursement will be based on the maximum allowable Amount for a standard item that is a covered service, serves the same purpose, and is medically necessary. Any expense that exceeds the maximum allowable Amount for the standard item which is a covered service is your responsibility.
- Complications of non-covered procedures.
- Cosmetic surgery/Cosmetic Services/Beautification Procedures - cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification or treatment relating to the consequences of, or as a result of, cosmetic surgery. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be medically necessary by the claims administrator are not covered. This exclusion does not apply to surgery to restore function if a body area has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of injuries that caused the impairment, or as a continuation of a staged reconstruction procedure for congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate. This exclusion does not apply to breast reconstructive surgery.
- Complications directly related to cosmetic services treatment or surgery, as determined by the claims administrator, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the member was covered by another carrier or self-funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including, but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
- Court-ordered Services - or those required by court order as a condition of parole or probation.
- Custodial Care and Rest Care - custodial care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a physician. Inpatient room and board charges in connection with a hospital or skilled nursing facility stay primarily for environmental change, physical therapy or treatment of chronic pain.
- Daily Room Charges - daily room charges while the Plan is paying for an intensive care, cardiac care, or other special care unit.

- Dental Care - dental care and treatment and oral surgery (by physicians or qualified dental professionals) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Summary Plan Description.
- Educational Services - Educational services for remedial education including evaluation or treatment of learning impairment, minimal brain dysfunctions, learning disorders, behavioral and cognitive rehabilitation. This includes educational services, treatment or testing and training related to behavioral (conduct) problems, including but not limited to services for conditions related to autistic disease of childhood, hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, intellectual impairment and behavioral problems. Special education, including lessons in sign language to instruct a member whose ability to speak has been lost or impaired, to function without that ability is not covered.
- Excessive Expenses - expenses in excess of the Plan's maximum allowed amount.
- Employer or Association Medical/Dental Department - received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust or similar person or group.
- Experimental/Investigative Services - treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the claims administrator's judgment, experimental/ investigative for the diagnosis for which the member is being treated. Also, services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the claims administrator. An experimental/investigative service is not made eligible for coverage by the fact that other treatment is considered by a member's physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
- Family Members - services rendered by a provider who is a close relative or member of your household. Close relative means wife or husband, parent or grandparent, child, brother or sister, by blood, marriage (including in-laws) or adoption.
- Foot Care - foot care only to improve comfort or appearance, routine care of corns, calluses, toenails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for medically necessary foot care required as part of the treatment of diabetes and for members with impaired circulation to the lower extremities.
- Free Services - services and supplies for which you have no legal obligation to pay or for which no charge has been made or would be made if you had no health insurance coverage.
- Government Programs - treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the member had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for

participation. Such programs include, but are not limited to, school speech and reading programs.

- Halfway House - services provided in a halfway house.
- Health Spa - expenses incurred at a health spa or similar facility.
- Ineligible Hospital - any services rendered or supplies provided while you're confined in an ineligible hospital.
- Ineligible Provider - any services rendered or supplies provided while you're a patient or receive services at or from an ineligible provider.
- Inpatient Rehabilitation Programs - inpatient rehabilitation in a hospital or hospital-based rehabilitation facility, when the member is medically stable and does not require skilled nursing care or the constant availability of a physician or:
    - The treatment is for maintenance therapy.
    - The treatment is for congenital learning or neurological impairment/disorder.
    - The treatment is for communication training, educational training or vocational training or
    - The member has no restorative potential.
- International Services - non-emergency treatment of chronic illnesses received outside the United States performed without pre-authorization. See the information on the Blue Cross Blue Shield Global Core® Program under Programs and Services through Anthem Blue Cross and Blue Shield.
- Maintenance Care - services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
- Marital Counseling - services and treatment related to religious counseling, marital/relationship counseling and sex therapy
- Medicare Benefits – benefits for which Medicare is the primary payor. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the member has enrolled in Medicare Part B. Services provided pursuant to a private contract between the member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act. For *domestic partner*s enrolled in the Plan who become eligible for Medicare due to age or disability while you are still actively employed, Medicare will be treated as the primary payer, whether your *domestic partner* is enrolled in Medicare or not, and the Plan will pay secondary, unless otherwise prohibited by Medicare Secondary Payer rules. Costs can be significant if the *domestic partner* is not enrolled in Medicare Part B.
- Never Events – the Plan will not pay for errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a health care facility. The provider will be expected to absorb such costs. This exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure, or operating on the wrong patient.
- Non-covered Services - any item, service, supply or care not specifically listed as a covered service in this Summary Plan Description.
- Non-licensed provider – treatment or services provided by a non-licensed provider, or that do not require a license to provide; services that consist of supervision by a

provider of a non-licensed person; services performed by a relative of a member for which, in the absence of any health benefits coverage, no charge would be made; services provided to the member by a local, state, or federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the member is not required to pay for them or they are provided to the member for free.

- Not medically necessary Services - Care, supplies, or equipment not medically necessary, as determined by the claims administrator, for the treatment of an injury or illness. This includes, but is not limited to, care which does not meet the claims administrator's medical policy, clinical coverage guidelines or benefit policy guidelines.
- Nutritional Counseling except for members with diabetes or those diagnosed with an eating disorder.
- Obesity Services - Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or prescription drugs, or dietary control (except as related to covered nutritional counseling). Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it's the sole means of nutrition. Food supplements. Services for inpatient treatment of bulimia, anorexia or other eating disorders which consist of primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care, or counseling. Weight loss programs included but are not limited to, commercial weight loss programs (Weight Watcher, Jenny Craig, and LA Weight Loss), nutritional supplements, appetite suppressants, and supplies of a similar nature. This exclusion does not apply to bariatric surgery when approved by the Plan.
- Over the Counter Drug Equivalents - Drugs, devices, products, or supplies with over-the-counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over-the-counter Drug, device, product, or supply. This exclusion does not apply to over-the-counter products that the Plan must cover as a *preventive care* benefit under federal law with a prescription.
- Prescription Drugs - Any prescription drugs purchased at a retail or Mail Service Pharmacy are not covered by Anthem Blue Cross and Blue Shield. Prescription benefits are provided through CVS Caremark. See Prescription Drug Coverage section of this Summary Plan Description.
- Private Duty Nursing – For Private Duty Nursing services except when provided through the Home Health Care benefit.
- Private Rooms - Private room, except as specified in Covered Services.
- Research Screenings – For examinations related to research screenings, unless required by law.
- Residential accommodations - Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility, or residential treatment center.
- Reversal of Sterilization - Services related to or performed in conjunction with reverse sterilization.
- Routine Examinations - Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school

athletic programs, recreational camps or retreats or any insurance program which are not called for by known symptoms, illness or injury except those which may be specifically listed as *Preventive Care*.

- Safe Surroundings. Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Sclerotherapy. The treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
- Services Not Specified as Covered. No benefits are available for services that are not specifically described as covered services in this Summary Plan Description. This exclusion applies even if your physician orders the service.
- Sexual Dysfunction. Medical/surgical services or supplies for treatment of male or female sexual or erectile dysfunctions or inadequacies. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing. Refer to Prescription Drug Coverage.
- Shoes and Orthotics. Shoe inserts, orthotics (except when prescribed by a physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed medically necessary) and orthopedic shoes (except when an orthopedic shoe is an integral part of a covered leg brace).
- Smoking Cessation. Programs and treatment of nicotine addiction including gum, patches and prescription drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products, unless otherwise required by law, are not covered through Anthem Blue Cross and Blue Shield. Certain Smoking Cessation programs and treatment may be provided through the Assurant Wellbeing Program. Refer to the Preventive Drug List and Wellbeing Program Offerings.
- Spider Veins. Treatment of telangiectatic dermal veins (spider veins) by any method.
- Supplies or Equipment (including durable medical equipment) not medically necessary.
- Supplies or equipment not medically necessary for the treatment of an injury or illness. Non-covered supplies are inclusive of but not limited to:
    - Band-aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards;
    - Household supplies, including but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs;
    - The purchase or rental of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet / tanning equipment;
    - Water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, air purifiers, humidifiers, dehumidifiers;
    - Escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances improvements made to a member's house or place of business and adjustments made to vehicles;
    - Air conditioners, humidifiers, dehumidifiers, or purifiers;
    - Rental or purchase of equipment if you're in a facility which provides such equipment;

    - Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications;
    - Other items of equipment that the claims administrator determines do not meet the listed criteria;
    - Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is medically necessary in your situation. Reimbursement will be based on the maximum allowable amount for a standard item that is a covered service, serves the same purpose, and is medically necessary. Any expense that exceeds the maximum allowable amount for the standard item which is a covered service is *your responsibility*;
- Surrogacy benefits are not covered for employees, spouses or *domestic partners* acting as a surrogate.
- Telecommunication or E-visits. Advice of consultation given by any form of telecommunication, except as outlined under LiveHealth Online and medical or mental health visits performed by *in-network* providers who have the ability to provide audio/visual visits using the internet via webcam or other mobile device. Telephonic-only and all out-of-network telehealth services are excluded.
- Temporomandibular Joint (TMJ) Treatment - covered services and supplies for the diagnosis and treatment of temporomandibular joint disorder (TMJ) are covered when medically necessary and provided in accordance with the terms of the Plan. Benefits are subject to applicable deductibles, copayments, and coinsurance.
- Thermograms and thermography.
- Therapy Services. Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Summary Plan Description. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy, and boot camp therapy, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne. Note: tattoos applied to assist in covered medical treatments, such as markers for radiation therapy are covered
- Transplant Services. The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
    - Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
    - Transportation, travel or lodging expenses for more than one non-donor travel companion;
    - Donation related services or supplies, including search, associated with organ acquisition and procurement;
    - Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
    - Any transplant not specifically listed as covered.
- Transportation provided by other than a state licensed professional ambulance service, and ambulance services other than for an emergency medical condition.

Transportation to another area for medical care is also excluded except when medically necessary for you to be moved by ambulance from one hospital to another hospital. Ambulance transportation from the hospital to the home is not covered.

- Travel Costs and Mileage except as authorized by the claims administrator, on behalf of the company.
- Trusses, corsets and other support items.
- Vision care services and supplies, including but not limited to eyeglasses, contact lenses and related examinations and services. Analysis of vision or the testing of its acuity except as otherwise indicated under *Preventive Care*. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, i.e. diabetes.
- Vein Treatment - Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- Vision Surgeries. Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
- Vitamins, minerals and food supplement, as well as vitamin injections not determined to be medically necessary in the treatment of a specific illness. Nutritional supplements; services, supplies and/ or nutritional sustenance products (food) related to enteral feeding, except when determined to be medically necessary.
- Waived Cost-Shares *out-of-network* - For any service for which you're responsible under the terms of this Plan to pay a *copayment, coinsurance or deductible* and the *copayment, coinsurance or deducible* is waived by an out-of-network provider.
- Waived Fees - Any portion of a provider's fee or charge which is ordinarily due from a member but which has been waived. If a provider routinely waives (does not require the member to pay) a *Deductible* or out-of-Pocket amount, the claims administrator will calculate the actual Provider fee or charge the fee or charge by the amount waived.
- War/Military Duty. Any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Charges for services directly related military service provided or available from the Veterans' Administration or military facilities also are excluded except as required by law.
- Worker's Compensation. Care for any condition or injury recognized or allowed as a compensable loss through any workers' compensation, occupational disease or similar law. If workers' compensation benefits are not available to you, then this exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third-party.

Coordination of Benefits

Some people have coverage under more than one group medical plan. Coordination of benefits provisions determine which plan is the primary carrier – the one that must pay benefits first. Assurant's Health Plan has a coordination of benefits provision to determine

which plan is primary and to help eliminate duplicate payments for the same services. The following guidelines apply for determining which is primary:

- The plan that covers a person as an employee pays benefits before the plan that covers the person as a *dependent*.
- The plan without a coordination of benefits provision will pay benefits before a plan that contains such a provision.
- If both parents' plans cover a *dependent*, the birthday rule applies, and the plan of the parent born earlier in the year is primary and the other is secondary. In the case of a divorce or separation, the plan of the parent (who has not remarried) with custody is the primary plan, unless a court decree names one parent responsible for providing medical coverage in which case that parent's plan is primary.
- If the parent with custody remarries, that parent's plan pays first, the stepparent's plan pays second and the plan of the parent without custody pays third, unless a court decree names one parent responsible for providing medical coverage in which case that parent's plan is primary.
- The plan that covers a person as an active employee will pay benefits before a plan that covers the person as a retiree or former employee.
- If the above guidelines do not establish a primary plan, then the plan that has covered the person longer is usually primary.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election made by anyone to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary. The Assurant Health Plan is administered under a maintenance of benefits (MOB) payment method. Under MOB, when the Assurant Health Plan is the secondary carrier, the benefit payable under the primary carrier will be deducted from the benefit normally paid by the Plan. You'll receive benefits up to but no greater than what you would have received under the Assurant Health Plan if there was no other medical plan.

Coordination with Medicare Coverage

Please notify the People Experience Center at 1-866-324-6513 if you or your spouse/*domestic partner* start Medicare benefits. The way medical coverage under the Assurant Health Plan coordinates with Medicare depends on age and whether you are an active or inactive employee. Generally, when an individual is covered under the Assurant Health Plan and Medicare, Medicare is the primary carrier. However, if you or your enrolled spouse becomes eligible for Medicare due to age or disability while you're actively employed, the Assurant Health Plan will continue to be your primary carrier. In this situation you may want to consider, taking into account the information on Medicare.gov, postponing enrolling in Medicare Parts B and C - which have monthly *premiums* - until you retire or terminate employment. For enrolled *domestic partner*s, the Assurant Health Plan will not be the primary carrier if the enrolled *domestic partner* becomes eligible for Medicare due to age or disability while you're actively employed. Medicare will be treated as the primary carrier, whether your *domestic partner* enrolls in Medicare or not. Please refer to medicare.gov for more details on when you should enroll, and when you're allowed to delay enrollment without penalties.

If you delayed enrolling in Medicare Part B because you had group health coverage as an active employee, you have an eight-month special Medicare Part B enrollment period that begins when you retire or terminate employment. If you enroll during the first month of the eight-month period, your Medicare Part B coverage will be effective on the first day of that month. If you enroll during any of the remaining seven months, your coverage will be effective the first of the month following the month in which you enroll. There are two important reasons to enroll in Medicare on a timely basis:

- Your Medicare Part B *premium* may be higher if you don't enroll during the special enrollment period.

Claims Payment

Participating providers have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore, if participating network hospitals, physicians and ancillary providers are used, claims for their services will generally not have to be filed by the member. In addition, when *out-of-network* coverage is available, many *out-of-network* hospitals and physicians will also file claims if the information on the BlueCross BlueShield Identification Card is provided to them. If the provider requests a claim form to file a claim, a claim form can be obtained at myassurantbenefits.com or by contacting the People Experience Center.

You will be required to pay a portion of the maximum allowed amount to the extent you have not met your *deductible* or *out-of-pocket maximum*. Except for *surprise billing* claims, when you receive covered services from an *out-of-network* provider, you may be responsible for paying any difference between the maximum allowed amount and the provider's actual charges. This amount can be significant. No *out-of-network* benefits are available under the Purple health plan, with the exception of urgent care, emergency care, and items or services protected by the Surprise Billing rules. See the Surprise Billing Notice posted under Legal Notices on at myassurantbenefits.com.

You will be required to pay a portion of the maximum allowed amount to the extent you have not met your *Deductible* or have a *copayment* or *coinsurance*. Except for surprise billing claims*, when you receive covered services from an *out-of-network* provider, you may be responsible for paying any difference between the maximum allowed amount and the provider's actual charges. This amount can be significant.

How to File Claims

Claims must be filed with the claims administrator within twelve (12) months after the service was provided. This section describes when to file a benefits claim and when a hospital or physician will file the claim for you.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, you must receive treatment from a network provider. When admitted to a network hospital, present your identification card. Upon discharge, you'll be billed only for your portion of the deductible or coinsurance, or for any charges not covered by the Plan.

When you receive covered services from a network physician or other network provider, ask the provider to complete a claim form. Payment for covered services will be made directly to the provider.

For health care expenses other than those billed by a network provider, use a claim form to report your expenses. You may obtain a claim form from myassurantbenefits.com or by contacting the People Experience Center. Claims should include your name, Plan and Group numbers exactly as they appear on your Identification Card. Attach all bills to the claim form and file directly with the claims administrator. Be sure to keep a photocopy of all forms and bills for your records. The address is on the claim form.

Save all bills and statements related to your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

If your claim for benefits is denied, you may file an appeal. See Claims Appeals for information.

Member Rights and Responsibilities

As a member you have rights and responsibilities when receiving health care. As your health care partner, the claims administrator wants to make sure your rights are respected while providing your health benefits. That means giving you access to the claims administrator's network health care providers and the information you need to make the best decisions for your health. As a member, you should also take an active role in your care.

You have the right to:

- Speak freely and privately with your health care providers about all health care options and treatment needed for your condition no matter what the cost or whether it is covered under your Plan.
- Work with your Doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect the claims administrator to keep your personal health information private by following the claims administrator's privacy policies, and state and Federal laws.
- Get the information you need to help make sure you get the most from your health Plan and share your feedback. This includes information on:
    - The claims administrator's company and services.
    - The claims administrator network of health care providers.
    - Your rights and responsibilities.
    - The rules of your health plan.
    - The way your Health Plan works.
- Make a complaint or file an appeal about:
    - Your health Plan and any care you receive.
    - Any covered service or benefit decision that your health plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care you may get in the future. This includes asking your doctor to tell you how that may affect your health now and in the future.

- Get the most up-to-date information from a health care provider about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.
- Get help at any time, by calling the Member Services number located on the back of your Identification Card or by visiting anthem.com.

You have the responsibility to:

- Read all information about your health benefits and ask for help if you have questions. • Follow all health plan rules and policies.
- Choose a Network Primary Care Physician, also called a PCP, if your plan requires it.
- Treat all doctors, health care providers and staff with respect.
- Keep all scheduled appointments. Call your health care provider's office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your health care providers to make a treatment plan that you all agree on. • Inform your health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the health care plan that you have agreed on with your health care providers.
- Give the claims administrator, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you're eligible for under your health plan. This may include information about other health insurance benefits you have along with your coverage with the plan.
- If you have any changes to your name or address, make the change directly in MyHR. If you experience a qualified life event and need to change the family members covered under your plan, submit the life event change in MyHR.

If you would like more information, have comments, or would like to contact the claims administrator, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your identification card.

The claims administrator wants to provide high-quality customer service to our members. Benefits and coverage for services given under the plan are governed by the Assurant's plan and not by this member Rights and Responsibilities statement.

Inter-Plan Arrangements

Out-of-Area Services

Anthem BCBS has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area the claims administrator serves (the Anthem BCBS "Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem BCBS Service Area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. Explained below is how both kinds of providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive covered services within the geographic area served by a Host Blue, the claims administrator will still fulfill its contractual obligations. But, the Host Blue is responsible for (a) contracting with its providers; and (b) handling its interactions with those providers.

When you receive covered services outside the Anthem/Empire/Anthem BCBS Service Area and the claim is processed through the BlueCard® Program, the amount you pay is calculated based on the lower of:

The billed charges for covered services; or

The negotiated price that the Host Blue makes available to the claims administrator.

Often this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the provider. Sometimes, it is an estimated price that takes into account special arrangements with that provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the Plan used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem BCBS may process your claims for covered services through Negotiated Arrangements for National Accounts. The amount you pay for covered services under this arrangement will be calculated based on the lower of either billed charges for covered services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem BCBS by the Host Blue.

C. Special Cases:

Value-Based Programs: BlueCard® Program

If you receive covered services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such arrangement, except

when a Host Blue passes these fees to Anthem BCBS through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangement

If Anthem BCBS has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Employer on your behalf, Anthem BCBS will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees** Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. **Nonparticipating Providers Outside the Claims Administrator's Service Area** The pricing method used for nonparticipating provider claims incurred outside the Anthem BCBS Service Area is described in claims payment.

F. **Blue Cross Blue Shield Global Core® Program** If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up-to-date health Identification Card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll-free number is 1-800-810-2583. Or you can call them collect at 804-673-1177.
If you need Inpatient hospital care, you or someone on your behalf, should contact the claims administrator for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the Health Care Management – Pre-certification section in this Booklet for further information. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core®

In most cases, when you arrange Inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any *copayment*, *coinsurance* or *deductible* amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and Outpatient services.

You will find the address for mailing the claim on the form.

When you need Blue Cross Blue Shield Global Core® claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at bcbsglobalcore.com
- You will find the address for mailing the claim on the form.

Unauthorized Use of Identification Card

If you permit your identification card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you'll be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the member's coverage. This includes fraudulent acts to obtain medical services and/or prescription drugs.

Questions About Coverage or Claims

If you have questions about your coverage, contact your Plan Administrator or the claims administrator's Member Services Department. Be sure to always give your member identification number.

When asking about a claim, give the following information:

- identification number;
- patient's name and address;
- date of service and type of service received; and
- Provider name and address (Hospital or Physician)

To find out if a Hospital or Physician is a network provider, call them directly or call the claims administrator.

The Plan does not supply you with a Hospital or Physician. In addition, neither the Plan nor the claims administrator is responsible for any Injuries or damages you may suffer due to actions of any Hospital, Physician or other person. In order to process your claims, the claims administrator or the Plan Administrator may request additional information about the medical treatment you received and/or other group health insurance you may have. This information will be treated confidentially.

An oral explanation of your benefits by an employee of the claims administrator, Plan Administrator or Plan Sponsor is not legally binding.

Any correspondence mailed to you will be sent to your most current address. You are responsible for notifying the Plan Administrator or the claims administrator of Your new address.

Programs and Services through Anthem BlueCross BlueShield

Anthem's Website

anthem.com is a great place to start if you have questions about using your health care coverage. It is your online resource for personalized benefits and health information. You simply log on to register. Once you register you can:

- Find providers in the Anthem network.
- Print a temporary ID card and/or request a permanent one.
- Review your covered *dependents*.
- Contact Member Services.
- Check explanation of benefits statements for your claims.
- Access general sources of health information.
- Get discounts on over 50 products and services that help promote better health and wellbeing.
- Get great discounts on vision care from 1-800 CONTACTS and Premier Lasik Network.

ComplexCare

If you're at risk for frequent and high levels of medical care, the ComplexCare program reaches out to you to offer support and assistance in managing your health care needs. ComplexCare empowers you for selfcare of your condition(s), while encouraging positive health behavior changes through ongoing interventions. ComplexCare nurses will work with you and your physician(s) to offer:

- Personalized attention, goal planning, health and lifestyle coaching.
- Strategies to promote self-management skills and medication adherence.
- Resources to answer health-related questions about specific treatments.
- Access to other essential health care management programs and
- Coordination of care between multiple providers and services.

The program helps you effectively manage your health to improve your health status and quality of life, as well as decreased use of acute medical services.

Total Health Connections

Through Anthem's Total Health Connections program, covered members have access to a dedicated Family Advocate who can assist with understanding benefits, finding in-network providers, coordinating care, resolving claims and billing questions, and accessing available health and wellbeing resources. Members may also access many health plan resources through Anthem, including the Sydney Health app.

Building Healthy Families

Building Healthy Families is an intuitive digital experience providing health plan enrollees access to pregnancy, maternity, and post-partum care as well as parenting support.

- Comprehensive digital support through the Sydney Health app.
- Tracking tools for ovulation, weight, blood pressure, due date, and prenatal milestones.

- Personalized path with app notifications, pre/post behavioral health screenings, health-risk monitoring, and partner profile sharing.
- Meditation, mindfulness tools, and educational support available 24/7 through Sydney Health convenient mobile app.
- Individual child profiles, parenting trackers for feeding, diapering, development, and vaccinations. Visit the Sydney Health app or www.anthem.com to enroll today.

Autism Spectrum Disorders (ASD) Program

The ASD Program is comprised of a specialized, dedicated team of clinicians within Anthem who have been trained on the unique challenges and needs of families with a member who has a diagnosis of ASD. The ASD Program provides specialized case management services for members with autism spectrum disorders and their families. Visit anthem.com or call 1-844-269-0538 for additional information.

Education

LiveHealth Online

LiveHealth Online provides certain professional services online 24/7 for generally less money than the average doctor visit or trip to the emergency room. LiveHealth Online connects Assurant Health Plan members to board-certified doctors via live two-way video from your personal computer, tablet or mobile device. This service is available to all active employees, regardless of whether you participate in the Assurant Health Plan. However, if you're enrolled in the Assurant Health Plan, any costs associated with your online visit will be applied toward your *deductible* and *coinsurance*.

Future Moms with Breastfeeding Support is available on LiveHealth Online. You can have secure and private video chats with a certified lactation consultant, counselor or registered dietitian at no cost when using Future Moms with Breastfeeding Support on LiveHealth Online. These professionals will be able to provide personalized support to help you with breastfeeding techniques, and consult about milk production, baby hunger cues, foods to avoid, postpartum nutrition and more. Sign up for free at livehealthonline.com or on the mobile app.

MyHealth Advantage

MyHealth Advantage is a free service that helps keep you and your bank account healthier. Here's how it works: Anthem reviews your incoming health claims to see if they can save you any money. Anthem can check to see what medications you're taking and alert your doctor if they spot a potential drug interaction. Anthem also keeps track of your routine tests and checkups, reminding you to make these appointments by mailing you MyHealth Notes. MyHealth Notes summarize your recent claims. From time to time, Anthem offers tips to save you money on prescription drugs and other health care supplies.

NurseLine

You may have emergencies or questions for nurses around-the-clock. The NurseLine provides you with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses, you can make more informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is

trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues.

The NurseLine is available 24 hours a day, seven days a week at 1-800-700-9184. Specifically, the 24/7 NurseLine features:

- A skilled clinical team – RN-licensed nurses who help members assess symptoms, understand medical conditions, ensure members receive the right care in the right setting and refer you to programs and tools appropriate to your condition.
- Bilingual RNs, language line and hearing-impaired services.
- Access to the AudioHealth Library, containing hundreds of audiotapes on a wide variety of health topics.
- Proactive callbacks within 24 to 48 hours for members referred to 911 emergency services, poison control and pediatric members with needs identified as either emergent or urgent; and
- Referrals to relevant community resources.

Virtual Care

Through Anthem's website, www.anthem.com, and Anthem's Sydney Health mobile application, Anthem members have access to convenient, affordable, on-demand and scheduled secure medical text-chat and video visits for Urgent Care and primary care spanning Urgent Care, prevention and wellness, and condition management for adults ages 18-64. Anthem's virtual care experience also provides Members with care guidance through a variety of tools such as the AI-driven symptom checker for assessing their symptoms prior to receiving virtual medical care.

Our virtual primary care service offers Members:

- comprehensive primary care, coordinated by a care team;
- 24/7, on-demand Urgent Care support;
- full *preventive care* wellness exam;
- chronic condition visits;
- personalized care plans and follow-ups; and
- unlimited access to care, including Prescription refills and referrals.

Teladoc Health

The Teladoc Health for Diabetes program helps make living with Type 1 or Type 2 diabetes easier. Once enrolled, eligible participants receive an advanced and connected blood glucose meter, unlimited strips and lancets, insights with every reading and coaches to support you along the way, all at no cost to you. The program is completely confidential and offered to employees and *dependents* living with a diabetes diagnosis and covered under the Assurant Health Plan. If you qualify, register at teladochealth.com/register/assurant or call 1-800-945-4355. Use registration code: Assurant.

Headway

Members enrolled in an Anthem medical plan may use Headway to locate and schedule appointments with participating in-network mental health providers, including therapists and

medication-management providers. Covered services remain subject to applicable Plan terms and cost-sharing requirements.

Sydney Health Mobile App

The Sydney Health Mobile App is available to members enrolled in an Assurant medical plan. Sydney provides a personalized digital experience that helps members access benefit information, view claims, find and schedule care, access digital ID cards, and connect with available health and wellbeing resources.

Identity Protection Services

Identity protection services are available with your Anthem health plans. To learn more about these services, please visit anthemcares.allclearid.com.

Find Care

Quality and price for health care can be different depending on where you go, and cost isn't necessarily related to the quality of care you can expect to receive. For example, if you need an MRI of the knee in DeKalb County, GA., the cost of an MRI from network providers ranges from $561 to $1,656. Unless you already have met your *out-of-pocket maximum* for the year, you'll be paying at least a portion of the cost. Your choice of providers has a direct impact on your wallet.

Find Care lets you compare network providers, facilities and services based on quality, cost and convenience. Find Care, on anthem.com, or with the Sydney Health mobile app, is available to employees and their eligible adult *dependents* enrolled in the Assurant Health Plan.

Health Plan Individual Case Management

The claims administrator's individual health plan case management programs (Case Management) helps coordinate services for members with health care needs due to serious, complex, and/or chronic health conditions. The claims administrator's programs coordinate benefits and educate members who agree to take part in the Case Management program to help meet their health-related needs.

The claims administrator's Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan Case Management staff. These Case Management programs are separate from any covered services you're receiving. If you meet program criteria and agree to take part, the claims administrator will help you meet your identified health care needs. This is reached through contact and teamwork with you and/or your authorized representative, treating physician(s), and other providers.

In addition, the claims administrator may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a covered service. The plan may also extend covered

services beyond the benefit maximums of this plan. The claims administrator will make any recommendation of alternate or extended benefits to the plan on a case-by-case basis, if at the claims administrator's discretion the alternate or extended benefit is in the best interest of you and the plan and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate the plan to provide the same benefits again to you or to any other member. The plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the claims administrator will notify you or your authorized representative in writing.

Wellbeing Program Offerings

Assurant strives to offer employees sufficient resources to protect what matters most to you - your physical, emotional, social and financial wellbeing. You can take advantage of most of these wellbeing programs even if you're not enrolled in the Assurant Health Plan. Visit the Live Well page on myassurantbenefits.com for more information about the wellbeing programs available.

Prescription Drug Coverage

Coverage for outpatient prescription drugs is administered by CVS Caremark, which offers both retail and mail order options.

Most prescription drugs that are approved by the U.S. Food and Drug Administration (FDA) and prescribed to manage or treat medical conditions such as an illness or injury, are covered under the Assurant Health Plan. To obtain information on medications, register on the CVS Caremark website at caremark.com. Click on Learn About Medications, then Drug Reference and Interactions.

The Assurant Health Plan pays benefits only for prescription drug expenses that are medically necessary.

How the Prescription Drug Program Works

The Prescription Drug Program is part of Assurant's Health Plan. It shares a single *deductible* with your other covered expenses as shown on the Health Plan At-a-Glance chart.

Network-based Benefits

When you get your prescriptions from an *in-network* pharmacy, your costs are lower. For maintenance medications, or medications that you fill monthly, your costs are lower when these are filled at a CVS pharmacy or through the mail-order service for a 90-day supply. Go to caremark.com to locate a network CVS Caremark pharmacy near you.

You must present your ID card to the network pharmacy every time you get a prescription filled to be eligible for network benefits. Your prescription ID card is the same ID card from Anthem that you use for medical services. The network pharmacy will calculate your claim online. You'll pay any *deductible*, if applicable and *coinsurance* directly to the pharmacy. You do not have to complete or submit claim forms. The pharmacy will take care of the claim submissions.

Using an *out-of-network* pharmacy is likely to cost you more money. You'll be responsible for your usual share of the cost (for example, 50% up to $50 per script) plus the difference between the full retail price of the drug at the non-participating pharmacy and CVS Caremark's discounted price. Not only will you probably pay more when using an *out-of-network* pharmacy, but you'll have to pay for your prescriptions up front, file the claim with CVS Caremark and wait for reimbursement. Claim forms are available at caremark.com. You'll then need to submit a claim form along with a copy of the detailed pharmacy receipt to CVS Caremark to receive reimbursement. You may not receive coverage for *out-of-network* benefits under the Purple health plan

Dispense as Written

To encourage the use of cost-effective FDA-approved generic equivalents, Assurant's Health Plan includes "Dispense as Written" guidelines. When a prescribed brand-name drug has an FDA-approved generic equivalent, you'll receive the generic equivalent unless your physician specifies "Dispense as Written" or "DAW" on the script.

If your physician does not specify DAW and you select the brand-name drug, you'll pay your share of the cost plus the difference in price between the brand-name drug and the generic drug. You'll never pay more than the actual cost of the brand-name drug, but you may pay more than the prescription maximums shown in the Health Plan At-a-Glance Section.

Prior Authorization Requirements

Certain medications require prior authorization to be covered under the Plan. These medications are generally those that may have multiple uses and equally effective alternative therapies. Criteria may need to be assessed for the safety and effectiveness of these medications. You can find the list of medications requiring prior authorization in the Tools and Resources section of myassurantbenefits.com under Medications Requiring Prior Authorization. Caremark may update this list throughout the year. The most updated list can be found on caremark.com.

If you continue using one of these drugs without prior approval for medical necessity, you may be required to pay the full cost. Please have your prescriber contact the CVS Caremark® Prior Authorization Department at 1-855-240-0536 to request a prior authorization.

If prior authorization is required, your pharmacist will notify your doctor that a prior authorization is needed. The doctor can call 1-800-626-3046 to provide information necessary for a prior authorization. Coverage for the prescribed medication will not be available until CVS Caremark has determined that the medication is eligible for coverage.

Using a CVS Caremark Participating Retail Pharmacy without Your ID Card

If you take your prescription to a CVS Caremark participating retail pharmacy and do not present your CVS Caremark ID card at the time of purchase and the pharmacy does not have your card on file, you may be required to pay 100% of the prescription price at purchase. Some retail pharmacies will rerun your card, reprocess the transaction and refund the difference between what you paid and the applicable coinsurance. However, you must request this within a specific period of time, usually seven to 14 days after your purchase. The determination of whether to reprocess your transaction is at the discretion of the pharmacy. Ask your retail pharmacy for its policy.

If the retail pharmacy does not rerun your card, you must submit a claim form along with the original prescription receipt(s) to CVS Caremark. You can request a claim form from CVS Caremark, or you can print a claim form from the CVS Caremark website.

Note: A network pharmacy may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

Important Information on Refills

A prescription drug (retail and mail order) will not be refilled until the date when at least 50% of the supply could have been used as prescribed, with the exception of erectile dysfunction prescriptions, such as Viagra, Levitra and Cialis. For example, if you have a prescription for a 90-day supply plus two refills, a refill will not be covered until 45 days from the date the previous 90-day supply was filled.

Fill Limit for Long-term Medications

Your plan allows two 30-day fills of long-term medications at any pharmacy in our network. After that, your plan will cover long-term medications only if you have 90-day supplies filled through mail service or at a CVS pharmacy. If you continue to have 30-day supplies of long-term medications filled after two times, you will be responsible for the entire cost of the medication.

Covered Expenses

Preventive Medications

Preventive medications can help keep you healthy and prevent serious complications. Regardless of which Health Plan option you elect, the deductible does not apply to covered preventive medications. Generic preventive medications are covered at 100%.

Covered brand-name preventive medications are not subject to the deductible. The amount you pay for a covered brand-name preventive medication depends on the medication's assigned tier and whether the prescription is filled through an eligible retail or mail-order pharmacy. Applicable coinsurance, minimums, and maximums are shown in the Health Plan At-a-Glance section.

Preventive medications for the following types of conditions will be covered if prescribed for a preventive purpose and must be purchased from a CVS Pharmacy or through the applicable mail-order service for a 90-day supply:

- Coronary artery disease (e.g., Simvastatin, Zocor).
- Diabetes (e.g., Metformin Hcl, Glucotrol).
- Hypertension (e.g., Lisinopril, Atenolol, Toprol XL, Hydrochlorothiazide).
- Osteoporosis (e.g., Fortical, Fosamax).
- Pre-natal vitamins.
- Respiratory disorders (e.g., Singulair).
- Smoking cessation (e.g., Zyban).
- Stroke (e.g., Warfarin, Coumadin, Lovenox).

For a complete list of covered preventive medications, please refer to the Preventive Drug List on myassurantbenefits.com

Non-preventive Medications

The cost of non-preventive medications under the Blue, Green, and Orange Plans will apply toward your health plan deductible. After you satisfy the applicable deductible, your cost share will depend on the medication's assigned tier and whether the prescription is filled through a retail pharmacy or mail-order pharmacy. Applicable coinsurance, minimums, and maximums are shown in the Health Plan At-a-Glance section.

Under the Purple Plan, prescription medications are not subject to the deductible.

Certain specialty medications are subject to the Plan's PrudentRx program. If you take an eligible specialty medication, PrudentRx may help lower your costs. Eligible participants are automatically enrolled, and most will pay $0 for covered specialty medications. Because the Green and Orange Plans are high-deductible health plans, participants must meet their deductible before the PrudentRx benefit applies. Blue and Purple Plan participants can receive the benefit without first meeting a deductible. For more information concerning PrudentRx, see the **PrudentRx Specialty Medication Program** section of this SPD.

You can find examples of how the Plan pays for non-preventive medications after your *deductible* is met on myassurantbenefits.com > Benefits > Health Plan section.

Other Covered Expenses

The following prescription drugs, medications and supplies also are covered under the Assurant Health Plan:

- Self-injectable drugs are covered at the network level of benefits only when dispensed through a network retail pharmacy or CVS Caremark's specialty pharmacy network. Go to caremark.com to review the list of self-injectable drugs. The list may be updated from time to time. Each prescription is limited to a maximum 30-day supply.
- Off-Label Use. FDA-approved prescription drugs may be covered when the off-label use of the drug has not been approved by the FDA for that indication. Coverage of off-label use of these drugs may be subject to requirements or limitations.
- Diabetic Supplies. The following diabetic supplies are covered if prescribed by a physician:
    - Diabetic needles and syringes.
    - Blood glucose strips, keystone blood test strips, urine testing strips.
    - Lancets/lancing devices.
- Contraceptives. The following generic and single-source brand contraceptives and contraceptive devices are covered at 100%:
    - Oral contraceptives.
    - Diaphragms, one per 365 consecutive-day period.
    - Injectable contraceptives.
    - Contraceptive patches
    - Contraceptive rings.
    - Implantable contraceptives and IUDs are covered when obtained from a physician. However, your health care provider will purchase it directly from the IUD distributor. The IUD distributor will bill CVS Caremark directly. Your physician will provide insertion and removal of the device. If you have any questions, please call CVS Caremark at 1-866-587-4799.

- Respiratory Prescription Devices

Note: You'll be charged the *out-of-network* benefit for prescription drugs recently approved by the FDA but not yet reviewed by CVS Caremark. An exception applies for contraceptive products that an individual and their attending provider have determined to be medically appropriate for the individual.

Exclusions and Limitations

Not all prescription drugs are covered, even if prescribed, recommended, or approved by your health care provider. Medicines, supplies, and expenses that are not covered or have limited coverage include but are not limited to:

- Medicines otherwise covered under the Assurant Health Plan.
- Medicines intended solely for cosmetic purposes, such as Latisse and Botox Cosmetic.
- Self-care medicines and products (such as hand lotion).
- Any medicine not approved by the FDA to be lawfully marketed for the proposed use.
- Any medicine that is not identified in the American Hospital *Formulary* Service Drug Information [AHFS] and Thomson MicroMedex as effective for the participant's diagnosed condition.
- Medicines determined to be experimental or still under clinical investigation by health providers. These are medications that have not been approved by the Food and Drug Administration (FDA) and are considered experimental and/or still under clinical review.
- Over-the-counter medicines, even if the medicine also is available by prescription (e.g., Tagament®, Claritin®, Zantac®, or Monistat®).
- Allergy serums, covered by Anthem.
- Nutritional and diet supplements, including any supplements for newborn infants.
- Any medicine provided and entirely consumed at the time and place it is prescribed.
- Dental implants (e.g. Arestin).
- Prescription devices such as elastic bandages and supports, GI-GU ostomy and irrigation supplies; however, respiratory prescription devices are covered.
- Vaccines and toxoids are not covered under the CVS Caremark Mail Service Program. However, eligible vaccines and toxoids are covered when the prescriptions are filled at retail pharmacies. See Preventive Services List in the Appendix for coverage details.
- Any medicine provided while the person is an inpatient or outpatient in any health care facility
- Any drug or medicine considered illegal under the Federal Food, Drug and Cosmetic Act, including, but not limited to, prescription drugs purchased in foreign countries for re-importation into the United States and prescription drugs purchased on the Internet from foreign countries. However, medicines purchased while on vacation in a foreign country due to an emergency medical condition may be covered. Call CVS Caremark if you have questions about coverage under these circumstances.
- Any supply with a National Drug Code (NDC) that is classified as a device, not a medicine except for Intrauterine Devices (IUDs).
- Fertility and infertility treatment prescription drug coverage in excess of the $30,000 lifetime maximum (the lifetime maximum is a combined maximum that includes

fertility and infertility medical services and treatment). Fertility and pregnancy benefits are not covered under the Assurant health plan for employees, spouses or *domestic partners* acting as a surrogate.

- Any medicine determined by CVS Caremark to be not medically necessary.
- Glucose monitors, tablets and other nonprescription diabetic supplies; Syringes are covered under the Plan and CVS Caremark provides glucose monitors and lancet devices free of charge. For more information and to see if you qualify, contact the CVS Caremark Diabetic Meter Team at 1-800-588-4456.
- Vitamins and supplements, except for prenatal vitamins.
- Oral hematopoietic mixtures except for folic acid for women age 55 or less.
- Oral immunotherapy agents.
- Oral over-the-counter (OTC) aspirin products except for individuals age 12 or older (with a prescription)
- Prescription and OTC (with prescription) iron supplementation products except for children ages 6 months to 12 months.
- Prescription oral fluoride supplementation products prescribed by a physician except for children ages 5 and younger.
- Prescription and OTC (with prescription) folic acid supplementation products, including prenatal vitamins containing folic acid except for women less than 55 years of age.
- Alcohol wipes.
- Expenses for administration or injection of any medicine (may be covered by the Anthem Blue Cross and Blue Shield).
- Any prescription which exceeds the day supply limit per prescription or refill.
- Any refill of a medicine exceeding the number of refills specified by the health care provider.
- Any refill of a medicine more than one year after the latest prescription for the medicine or other than as permitted by the law of the jurisdiction in which the medicine is dispensed.
- Medicines that do not meet prior authorization requirements, including but not limited to Lupron, growth hormone medications, anabolic medications, androgen medications and acne medications.
- Topical acne agents (e.g. Retin A) for participants 30 years of age and older.
- Any Erectile Dysfunction (ED) medications exceeding 6 doses in a 30-day period or 18 doses per 90-day supply.
- **GLP-1 Medication Coverage**
    - Effective January 1, 2027, GLP-1 medications prescribed solely for weight loss are excluded from coverage under the Plan, and the CVS Weight Management Program is discontinued.
    - GLP-1 medications prescribed for diabetes, or another covered clinical condition may remain eligible for coverage, subject to applicable formulary, prior authorization, medical necessity, and other Plan requirements. Other medically necessary non-GLP-1 weight-loss medications may remain covered in accordance with the Plan's terms.

Contact CVS Caremark at 1-866-587-4799 if you have questions about whether a particular medication is covered by the Plan.

Programs and Services through CVS Caremark

Clinical Programs

CVS Caremark uses evidence-based resources from FDA-approved prescribing indications, consensus clinical prescribing guidelines and peer-reviewed studies to develop its clinical programs. These programs are designed to reduce unnecessary prescription drug use and to improve the quality of care and member safety. Specifics of these clinical programs are detailed below.

Note - As the Claims Administrator of the prescription drug benefit program, CVS Caremark may contact your provider regarding your prescription. This may result in your provider prescribing a different quantity, brand name product or a generic equivalent in place of your original prescription. No substitutions will be made by CVS Caremark without either written or verbal approval from your provider

Specialty Guideline Management Program

Specialty drugs are often prescribed for various conditions including, but not limited to the following: asthma, Crohn's disease, cystic fibrosis, multiple sclerosis, oncology, rheumatoid arthritis and transplants. All specialty medications must be dispensed by CVS Caremark specialty pharmacies and will be denied through regular CVS Caremark national retail network pharmacies. CVS specialty pharmacies will work directly with you and your provider whenever a specialty drug is prescribed to ensure:

- You're on the right drug that is age-appropriate and effective for you;
- The specialty drug is used properly;
- Inappropriate utilization is avoided; and
- Unsafe or ineffective therapies are discontinued in a timely manner.

In addition to providing the specialty drugs, personalized pharmacy care management services are available to you such as:

- Access to an on-call pharmacist 24 hours a day, seven days a week.
- Coordination of care with you and your doctor.
- Convenient delivery directly to you or your doctor's office.

Advanced Control Specialty *Formulary* Assurant has incorporated a special program feature, Advanced Control Specialty *Formulary*, to help manage the cost of specialty drugs. This program designates preferred drugs within select therapeutic drug categories. When a non-preferred specialty drug is first prescribed, CVS Caremark will reach out to your prescribing physician to suggest switching to the preferred alternative. The preferred alternative offers the same therapeutic benefits at a lower cost.

PrudentRx Specialty Medication Program

Effective January 1, 2027, the Plan offers the PrudentRx program for certain specialty medications identified on the PrudentRx Program Drug List, which may change periodically.

PrudentRx assists eligible members in obtaining available manufacturer copay assistance to reduce their out-of-pocket costs for covered specialty medications.

Participation and Cost-Sharing

Eligible members are automatically enrolled in PrudentRx but must complete any required registration in an available manufacturer copay assistance program to participate. PrudentRx will contact eligible members to assist with enrollment. Participating members generally pay $0 for covered PrudentRx-eligible specialty medications, subject to satisfaction of any applicable deductible. Members enrolled in the Green or Orange Plan must satisfy their applicable deductible before receiving the $0 benefit for medications not included on the Plan's HDHP Preventive Drug List.

Members who opt out of PrudentRx or fail to complete required enrollment in an available manufacturer copay assistance program remain eligible for coverage of their medications but are responsible for 30% coinsurance, without the otherwise applicable minimum or maximum coinsurance limits, after satisfying any applicable deductible.

Manufacturer Assistance

If manufacturer copay assistance is unavailable, exhausted, or insufficient to cover the applicable coinsurance, the Plan will cover the remaining coinsurance for participating members, subject to satisfaction of any applicable deductible. For members enrolled in the Green or Orange Plan, the deductible must first be satisfied for medications not included on the Plan's HDHP Preventive Drug List.

Deductibles and Out-of-Pocket Maximums

Amounts paid on a member's behalf, including manufacturer copay assistance, do not count toward the member's deductible or out-of-pocket maximum unless required by applicable law. Amounts paid directly by members for PrudentRx-eligible medications count toward the applicable deductible and Affordable Care Act out-of-pocket maximum.

For information about eligible medications, enrollment requirements, or opting out, contact PrudentRx at 1-800-578-4403.

Online Medicine - and Disease-specific Education and Counseling

Disease-specific information is available through cvsspecialty.com. This online support includes interactive areas to submit questions to pharmacists and nurses.

Drug Savings Review Program

This program reviews claims to determine if the drugs are being prescribed appropriately for the condition, in the right dose, and to help ensure best treatment practices are being followed. CVS Caremark pharmacists will communicate with the prescribing physician if it determines that improvements can be made.

Enhanced Retrospective Review Program

This program reviews prescriptions for therapeutic duplication management, age-appropriate management and related concerns. The prescribing physician receives a patient-specific report identifying any clinical issues and suggestions for ways to improve.

Employee Assistance Program (EAP)

Chances are we all will experience a personal problem at some point in our lives. Usually we can handle it ourselves, but sometimes we need help from a professional. The EAP is there when you need it most. Employees, household members, and *dependents* up to age 26 outside the home may call 1-800-634-6433, 24 hours a day, seven days a week.

Whether you have a problem that seems impossible to resolve yourself or you just need help in finding resources such as child or elder care, the EAP can help. When you call, you'll speak with licensed professionals in psychology, clinical social work and counseling.

Services Provided by Lyra Wellbeing

EAP services are provided by Lyra Wellbeing. You can reach Lyra Wellbeing at 1-800-634-6433 or visit their website at lyrawellbeing.health and enter the company login code: ASSURANT.

The Lyra Wellbeing website provides information on your EAP benefits along with mental health topics and articles designed to assist you in coping with life's many daily stressors.

Here are just a few of the kinds of issues the EAP may be able to help you with:

- Alcohol or drug abuse.
- Child and elder care issues
- Depression.
- Domestic violence.
- Family issues.
- Financial worries.
- Legal problems.
- Marital problems.
- Stress

In addition to the counseling services, legal and financial referrals are available.

- Legal: An initial telephonic consultation with a local attorney at no cost. A discount of 25% off the hourly rate, with participating attorneys, if you decide to pursue the legal issue.
- Financial: Initial consultation by phone with a financial counselor on issues related to budgeting, taxes, debt consolidation or investing.
- Work/Life: Telephonic consultations with a specialist for child care, elder care, college planning, wedding planning, pet care and many additional items.

Accessing the EAP

You can receive a referral to an EAP counselor by contacting the EAP Call Center or by requesting a session through the website.

When you call, you'll speak with a specially trained staff member. He or she will ask you what kind of problem you're having and will then assist you in scheduling an appointment with an EAP counselor. If you're in an immediate crisis when you call, you'll be connected to a counselor right away. The EAP also offers an online tool that will open an EAP session request and allow you to search for a provider. The tool is quick, easy to use and any information

provided is kept confidential. After logging in to the EAP Member section, and entering company login code: ASSURANT, click the “Request Counseling” button.

The EAP provides up to eight counseling sessions free of charge. If your problem requires longer treatment, your EAP counselor will help you find the best available resource in the community for dealing with your particular situation. If you or your *dependent* is enrolled in the Assurant Health Plan, benefits for these services may be available under your coverage. Refer to the Health Plan section for additional information.

Confidentiality

The EAP is a confidential resource. Any contact you have with the EAP will not be revealed to anyone without your permission, except as required by law or as may be permitted by HIPAA for plan administration purposes.

Dental Plans

Assurant’s dental plans emphasize preventive and diagnostic care by covering regular checkups and preventive dentistry at 100% with no *deductible*. Dental care is administered by MetLife and provided through a dental preferred provider organization – MetLife’s Preferred Dental provider – that allows you to stay in the network or go outside of it.

The dental plans pay benefits based on the negotiated fee if you use a network provider or on the usual, customary and reasonable fee for *out-of-network* care, as determined by MetLife. To find a network provider near you, visit MetLife’s employee website, MyBenefits at metlife.com/mybenefits.

Services and treatments must be dentally or medically necessary and performed by a qualified dental professional.

MetLife determines the usual, customary and reasonable charge for a covered *out-of-network* dental service based on the following criteria:

- The usual fee: The fee the qualified dental professional charges the majority of his or her patients for the same service.
- The customary charge: The fee charged for the same service by most other equally qualified professionals in the locality.
- The reasonable fee: The appropriate fee based on the complexity of the service, degree of skill required and any other pertinent factors. The reasonable fee applies if the service or supply is so unusual that MetLife cannot determine the usual and customary charge for it.

Online Dental Resources

You can review dental and vision benefits, find a participating qualified dental professional and even check your dental claims status through MetLife’s MyBenefits website.

Note: Dental ID cards are not mailed to members and are available only from MetLife’ website. You can access and print your ID online via MetLife’s MyBenefits website at metlife.com/mybenefits. Your member ID card will list only your name, and it serves as the ID card for you and any covered *dependents*.

Dental Plans At-a-Glance

The following is an overview of the Assurant Dental Plans. Choose from a Dental High and Low plan. The High and Low Dental Plans offer a broad range of coverage to plan participants, which includes *Preventive care*, Basic services, certain Restorative services, and for the High Dental Plan, Orthodontic care.

Each time you receive care, the Dental Plans allow you to choose whether to use dentists participating in the MetLife Preferred Dentist Plus Program or non-participating dentists. If you use participating dentists, you will have a lower *deductible* and *coinsurance* on benefits paid by the Plan

Applies to High and Low Dental Plans		
IF YOU USE:		
Dental Plan Feature	**MetLife PDP Plus Dentist *In-Network***	**Any Dentist *Out-of-Network***
Deductible	$50 individual / $100 family	$75 individual / $150 family
	Deductibles for participating and non-participating dentists apply toward each other.	
Preventative care (Check-ups, cleanings, sealants**)	• 2 check-ups/*plan year* • No *deductible* • Plan pays 100% of Negotiated Fee • You pay nothing	• 2 check-ups/*plan year* • No *deductible* • Plan pays 100% of R&C Fee*
Basic services (Fillings, extractions, root canals)	• *Deductible* applies • Plan pays 80% of Negotiated Fee • You pay 20%	• *Deductible* applies • Plan pays 70% of R&C Fee* • You pay 30%
Major services (Dentures, bridges, inlays/inlays, crowns, dental implants)	• *Deductible* applies • Plan pays 50% of Negotiated Fee • You pay 50%	• *Deductible* applies • Plan pays 40% of R&C Fee* • You pay 60%
Periodontics (Treatments of gums & bones of mouth)	• *Deductible* applies • Plan pays 80% of Negotiated Fee • You pay 20%	• *Deductible* applies • Plan pays 70% of R&C Fee* • You pay 30%

Dental Plan Maximums			
Dental Plan	**Maximum Benefits**		
High Plan	$2,000 per person, per year. Some restrictions may apply. For details, call MetLife at 1-800-942-0854.		
Low Plan	$1,000 per person, per year. Some restrictions may apply. For details, call MetLife at 1-800-942-0854.		
Applies to High Dental Plan Only			
Orthodontics (available to plan participants, spouse and children under age 26 when treatment begins)	• No deductible • Plan pays 50% of negotiated fee • You pay 50%	• No deductible • Plan pays 50% of R&C fee* • You pay 50%	Separate lifetime maximum: $1,500 *(does NOT count toward plan year maximum)*

**Subject to reasonable and customary (also called usual and prevailing) fee limits. You also pay all charges over reasonable and customary fees. The Reasonable and Customary fee is based on the lowest of 1) the dentist's actual charge, 2) the dentist's usual charge for the same or similar services or 3) the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.*

***For sealants, only one application of sealant material every 36 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 16th birthday.*

If you have any questions or would like to have a provider listing sent to you, you can call one of knowledgeable customer service representatives at 1-800-942-0854, or visit us on the web at: www.metlife.com/mybenefits

Frequently Asked Questions

Who is a participating dentist?
A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30%-45% below the average fees charged in a dentist's community for the same or substantially similar services,

How do I find a participating dentist?
There are thousands of general dentists and specialists to choose from nationwide—so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

What services are covered under this plan?
All services defined under the group dental benefits plans are covered.

May I choose a non-participating dentist?
Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist, your out-of-pocket costs may be higher. He/she hasn't agreed to accept negotiated fees. So, you may be responsible for any difference in cost between the dentist's fee and your plan's benefit payment.

Can my dentist apply for participation in the network?
Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-TWK for an application. ††The website and phone number are for use by dental professionals only.

How are claims processed?
Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854.

Can I find out what my out-of-pocket expenses will be before receiving a service?
Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary

depending upon plan maximums, *deductibles*, frequency limits and other conditions at time of payment.

How does MetLife coordinate benefits with other insurance plans?
Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

Do I need an ID card?
No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

† Based on internal analysis by MetLife. Negotiated Fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
††Due to contractual requirements, MetLife is prevented from soliciting certain providers.
***Refer to your dental benefits plan summary for your out-of-network dental coverage.*

How the Plans Work

Deductible

You must meet your annual *deductible* for covered basic and major services before your dental plan begins to cover your costs. Preventive/diagnostic and orthodontic services are covered without having to meet the *deductible*.

The *deductible* for *in-network* services is $50 for Employee-only coverage and $100 for Family coverage. The *deductible* for *out-of-network* services is $75 for Employee-only coverage and $150 for Family coverage. Two enrolled family members must satisfy their individual *deductibles* before the *deductible* is satisfied for the whole family. So, if you and your spouse each satisfy the individual *deductible* of $50, your family *deductible* is met. But, if you satisfy your individual *deductible* and two of your *dependents* accumulate $25 each toward their individual *deductibles*, your family *deductible* is not yet met.

Coinsurance

Coinsurance is the percentage of covered expenses you pay once the *deductible* has been met. For example, basic services from a network provider are covered at 80%. You're responsible for the remaining 20% of expenses once your *deductible* has been met.

Maximum Benefits The Low Dental Plan pays a maximum benefit for all eligible dental expenses of $1,000 per calendar year and the High Dental Plan pays a maximum benefit of $2,000 per calendar year for each covered family member.

There is a lifetime maximum benefit of $1,500 for orthodontic services under High Dental Plan for each covered family member. There are no orthodontic services offered under Low Dental Plan.

There is a lifetime maximum benefit of $1,000 for treatment of temporomandibular joint disorder (TMJ) treatment.

Special Provisions

Missing Teeth Limitation

The dental plan will not pay benefits to replace a missing tooth/teeth that are missing on or before your or your *dependent's* coverage is effective under the plan, except for congenitally missing teeth. If the dental plan pays benefits for a natural tooth/teeth that is/are extracted while the Assurant coverage is in effect, it's possible that you may be eligible for benefits for a fixed bridge or removable denture. To determine the benefits, your dentist should submit a predetermination of benefits to MetLife for review.

Predetermination of Benefits

The dental plan's predetermination of benefits provision allows you to find out ahead of time how much the plan will pay for a proposed course of dental treatment.
Before starting a course of dental treatment that is expected to cost $300 or more, it is recommended that you submit the charges to MetLife, the claims administrator, for a predetermination of benefits. Follow the same procedure and use the same form that you would if you were filing a claim. MetLife will write to both you and your dentist, letting you know how much the plan will pay if you're covered when the services are performed.

If there is a less expensive alternative treatment to the one your dentist proposes but which produces a professionally satisfactory result, the plan's reimbursement will be based on the cost of the alternative treatment. A predetermination of benefits will let you know whether:

- The services are covered expenses; and
- The charges are within usual, customary and reasonable allowances.

If there is a significant change in the treatment plan, you should request a new estimate.

Temporary Treatments

Temporary treatments are considered an integral part of the final treatment and the fees for these treatments will be combined to determine whether the charges are usual, reasonable and customary by MetLife.

Vision Service Plan (VSP) Discounts

You and your *dependents* (whether or not you're enrolled in the dental plan) also will have access to vision discounts on eye exams and eyewear through MetLife's VisionAccess Program. The services are provided by Vision Service Plan (VSP), which includes a national network of vision providers. For more information or to find a participating provider, call 1-888-GET-MET8. Provide your program code, MET2020, when making an appointment or receiving services or materials. More details also are available on myassurantbenefits.com and the below summary conflicts with the information provided in the posted benefits booklet, the booklet controls.

Covered Expenses

The following dental treatments are covered when performed by a qualified dental professional:

Preventive and Diagnostic Services

- Oral exams – two per calendar year.
- Dental prophylaxis – two per calendar year.
- Intraoral complete series X-rays, including bitewings and either 10 to 14 periapical X-rays, or panoramic film, limited to one in any 60-month period.
- Bitewing X-rays (two or four films) – limited to two times in a calendar year (if performed with 10 to 14 periapical X-rays or panoramic film, they will be considered an intraoral complete series X-ray).
- Intraoral periapical X-rays.
- Intraoral occlusal X-rays – limited to once in any six-month period.
- Other X-rays – excluding those related to orthodontic procedures or TMJ dysfunction.
- Fluoride treatment – two times in a calendar year and limited to *dependent* children under the age of 16.
- Sealants – limited to one time per tooth in any 36-month period and to children under the age of 16 on permanent molars.
- Full mouth X-rays – limited to once in any 60-month period.
- Space maintainers (including all adjustments made within six months) – limited to children under the age of 19.

You can receive up to four cleanings in 12 months, which include periodontal cleanings. Regular cleanings are limited to two times in a calendar year.

Basic Services

- Limited oral evaluation: Problem focused – covered only if no other treatment (except X-rays) is rendered during visit.
- Examination and accession of tissue.
- Stainless steel crowns are limited to once in a 36-month period and only on teeth not restorable by an amalgam or composite filling.
- Pulpotomy.
- Root canal therapy, includes pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care (limited to once on the same tooth in any 24-month period).

- Apicoectomy / periradicular surgery (anterior, biscuspid, molar, each additional root), including all pre-operative, operative and postoperative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Retrograde filling – per root
- Root amputation – per root.
- Hemisection, including any root removal and an allowance for local anesthesia and routine postoperative care; does not include a benefit for root canal therapy.
- Periodontal scaling and root planning, limited to once per quadrant in any 24-month period.
- Periodontal maintenance is limited to four cleanings (a combination of both regular and periodontal cleanings) in any 12-month period with regular cleanings limited to two in a calendar year and periodontal cleanings limited to once every three months.
- Simple extraction.
- Oral surgery, including an allowance for local anesthesia and routine post-operative care:
    - Surgical extractions (including extraction of wisdom teeth).
    - Alveoloplasty.
    - Vestibuloplasty.
    - Removal of lateral exostosis-maxilla or mandible.
    - Frenulectomy (frenectomy or frenotomy).
    - Excision of hyperplastic tissue per arch.
- Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus.
- Extraction, erupted tooth or exposed root (elevation and/or forceps removal).
- Biopsy.
- Brush biopsy.
- Incision and drainage.
- Palliative (emergency) treatment of dental pain considered for payment as a separate benefit only if no other treatment is rendered (except X-rays) during the visit.
- General anesthesia and intravenous sedation when administered in the dentist's office or outpatient surgical center in conjunction with complex oral surgical services, which are covered only when medically necessary (as determined by MetLife; benefits will be based on the benefit allowed for the corresponding intravenous sedation.)
- Consultations, only if not performed on the same day as the operative treatment.
- Amalgam replacements limited to 24 months after the placement. Multiple restorations on one surface will be considered a single filling; mesial-lingual-buccal (MLB) and distal-lingual-buccal (DLB) restorations will be considered single surface restorations.
- Silicate and plastic restorations.
- Composite restorations on both anterior and posterior teeth replacements limited to 12 months after the placement for children under age 19 and after 36 months for anyone age 19 or over; mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations. Acid etch is not covered as a separate procedure.
- Pin retention restorations – covered only in conjunction with amalgam or composite restorations; pins limited to one time per tooth.

- Therapeutic drug injections.

Major Services

All major services include an allowance for all temporary restorations and appliances and one-year follow-up care. The following major services are covered if performed by a qualified dental professional:

- Inlays, onlays and crowns – covered when the tooth cannot be restored by an amalgam or composite filling.
- Porcelain crowns on both anterior and posterior teeth (once every seven years).
- Repairs, adjustments and replacement of inlays, onlays and crowns; repairs and adjustments are limited to once in any 12-month period; replacements are not covered unless seven years have elapsed since the last placement.
- Recementing inlays, onlays, crowns and bridges.
- Crown build-up.
- Post and core, covered only for endodontically treated teeth requiring crowns.
- Periodontal surgery, limited to once per quadrant in any 36-month period; limitation applies to gingivectomy, gingival curretage, mucogingival surgery.
- Osseous surgery.
- Osseous grafts.
- Pedicle grafts.
- Endodontic endosseous implant and endosseous implant.
- Repairs, adjustments and replacement of implants; repairs and adjustments are limited to once in any 12-month period and to more than 12 months after insertion. Replacement of implants – not covered unless seven years have elapsed since the last placement and the existing implant cannot be made serviceable treatment. The initial placement of full dentures will be considered a covered service if the placement includes the initial replacement of a functioning natural tooth extracted while the person was covered, and the extracted tooth was not an abutment to an existing prosthesis. The plan will not pay for any denture until it is accepted by the patient.
- Full dentures but does not include benefits for personalized dentures or overdentures or associated treatment. The initial placement of full dentures will be considered a covered service if the placement includes the initial replacement of a functioning natural tooth extracted while the person was covered, and the extracted tooth was not an abutment to an existing prosthesis. The plan will not pay for any denture until it is accepted by the patient.
- Partial dentures, including additional clasp and rest; does not include benefits for precision or semi-precision attachments; the initial placement of partial dentures will be considered a covered eligible expense if the placement includes the initial replacement of a functioning natural tooth extracted while the covered person was covered, and the extracted tooth was not an abutment to an existing prosthesis (once every seven years).
- Relining or rebasing dentures, limited to one time in any 36-month period and more than 12 months after the initial insertion of the denture.
- Repairs, adjustments and replacement of full dentures and partial dentures; repairs and adjustments are limited to once in any 12-month period and to more than 12 months after insertion. Replacements are not covered unless seven years have

elapsed since the last placement and the denture cannot be made serviceable. Partial dentures less than seven years old will be covered if replacement is necessary due to the extraction of an additional functioning natural tooth.
- Tissue conditioning, limited to repairs or adjustment performed more than 12 months after the initial insertion of the denture.
- Fixed bridges (including Maryland Bridges), covered for a person who is at least 17 years old; the initial placement of fixed bridges will be considered a covered service if the placement includes the initial replacement of a functioning natural tooth extracted while the person was covered, and the extracted tooth was not an abutment to an existing prosthesis.
- Repairs, adjustments and replacement of fixed bridges; repairs and adjustments are limited to once in any 12-month period and to more than 12 months after initial insertion. Replacements are not covered unless seven years have elapsed since the last placement and the bridge cannot be made serviceable. Bridges less than seven years old will be eligible for consideration if replacement is needed due to the extraction of a functioning natural tooth immediately adjacent to the existing bridge. Fixed bridges replacing an extracted portion of a hemisected tooth are not covered.
- Non-surgical temporomandibular joint (TMJ) orthodontia. Treatment for myofascial pain syndrome, muscular, neural, or skeletal disorder, dysfunction or disease of the temporomandibular joint including treatment of the chewing muscles to relieve pain or muscle spasm, TMJ X-rays, and occlusal adjustments; coverage does not include an allowance for appliances for tooth movement or guidance, electronic diagnostic modalities, occlusal analysis, or muscle testing.

Orthodontic Services

Orthodontic Services are only offered under the dental plan high and include the following:

- Initial consultation.
- Moldings and impressions, including cephalometric X-rays.
- Surgical exposure of an impacted tooth, limited to services performed for orthodontic purposes.
- Installation of braces.
- Monthly visits; and
- Fixed or removable appliances to correct harmful habits.

Note that space maintainers are covered as a preventive service, not as an orthodontic expense. No payment will be made for orthodontic treatment if the appliances or bands are inserted before coverage is effective. The dental plan considers orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment done the same day is considered to be started and completed the day the treatment is received.

Benefit payments for orthodontia are made over the full course of treatment, as follows:

- An initial examination fee.
- An installation fee.
- Monthly or quarterly installments (based on fees for three monthly visits), depending on how services are billed.

Benefits will not be paid for more than three monthly visits at a time, unless submitted after the services have been rendered.

Treatment Plan

Treatment is considered to be started when:

- For a full or partial denture, the date the first impression is taken.
- For a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared.
- For root canal therapy, on the date the pulp chamber is first opened.
- For periodontal surgery, the date the surgery is performed.
- For all other treatment, the date treatment is rendered.

Treatment is considered to be completed when:

- For a full or partial denture, the date the final completed appliance is first inserted in the mouth.
- For a fixed bridge, crown, inlay and onlay, the date an appliance is cemented in place.
- For root canal therapy, the date a canal is permanently filled.

If Coverage Ends in the Middle of Treatment

If you've begun a course of dental treatment and your coverage ends before the treatment is complete, the dental plan will pay benefits for completing preventive/diagnostic, basic and major services for 30 days from the date your coverage ends. If you're in the middle of orthodontic treatment when your coverage ends, the dental plan will pay benefits through the quarterly installment that is due as of the day your coverage ends.

Exclusions and Limitations

The following is a list of expenses that are not covered under the dental plan:

- Treatments not included in the list of covered expenses and/or services.
- Treatments that are not dentally or medically necessary, as determined by MetLife.
- Services that are experimental in nature, as determined by MetLife.
- Services that do not have uniform professional endorsement.
- Treatments for a procedure after the coverage effective date if treatment for that procedure began prior to coverage effective date.
- Appliances in which the sole or primary purpose relates to:
    - The change or maintenance of vertical dimensions.
    - The alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery or temporomandibular joint disorder (TMJ).
    - Bite registration.
    - Bite analysis.
- Replacing a lost or stolen appliance.
- Educational procedures, including oral hygiene, plaque control or dietary instructions.
- Completing claim forms or missed dental appointments.
- Personal supplies or equipment, including WaterPiks, toothbrushes, or floss holders
- Treatment for a jaw fracture.

- Services provided by an immediate family member or an employee of the company; immediate family members include your spouse, *domestic partner*, parents, children, brothers, sisters, anyone who resides in your home, your spouse's or *domestic partner's* parents, children and siblings.
- Treatment covered under any other plan sponsored by the company that provides group hospital, surgical, dental or medical benefits.
- Hospital or facility charges for a room, supplies or emergency room expenses or routine chest X-rays and medical exams before oral surgery.
- Services performed outside the United States except for emergency dental treatment, as determined by the claims administrator. The maximum benefit payable to any person during a *plan year* for covered dental expenses related to emergency dental care performed outside the United States is $100.
- Treatments covered under workers' compensation or similar laws.
- To the extent permitted by law, treatments that are reimbursable by a plan of any governmental agency, including Medicare.
- Treatments provided primarily for cosmetic purposes, such as teeth whitening or bleaching.
- Treatments which may not reasonably be expected to successfully correct the person's dental condition for a period of at least three years, as determined by MetLife.
- Bacteriological studies.
- Provisional splinting.
- Excision of pericoronal tissues.
- Claims received by MetLife more than one year after expenses were incurred.

Filing a Claim

A claim is a request for dental benefits. Most dentists file claims directly with MetLife, so a separate claim is not required in most instances. Eligibility inquiries, general benefit inquiries and requests for a pre-authorization when not required will not be treated as claims for benefits. To file a paper claim, you must complete the Assurant Inc. Dental Claim Form, available at metlife.com/mybenefits under "My Forms." Mail or fax the completed form to:

MetLife Dental Claims
P.O. Box 14588
Lexington, KY 40512
Fax: 1-859-825-6726

Expenses submitted to the claims administrator must identify the treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. MetLife reserves the right to request X-rays, narratives and other diagnostic information as it deems necessary to determine benefits.

Claims must be received by MetLife within one year of the date the services are performed. Any claims submitted beyond one year from the date of service are not eligible for reimbursement.

Overpayment

If a benefit is paid and it's later shown that a lesser amount should have been paid, the dental plan will be entitled to a refund of the excess amount from you or your provider.

Coordination of Benefits

The dental plan has a coordination of benefits (COB) provision that is designed to prevent duplication of benefits when you or an enrolled *dependent* is covered for dental benefits under more than one group plan. The following is a summary of these rules:

- A benefit plan without a COB provision will pay benefits before a plan that contains such a provision.
- The plan that covers the person as an employee pays benefits before the plan that covers the person as a *dependent*. For example, the Assurant dental plan is the primary carrier for your expenses. Your spouse's plan is primary for his/her expenses.
- The plan of the parent born earlier in the year is the primary carrier for a *dependent* child. In the case of a divorce or separation, the plan of the parent with custody is the primary plan, unless a court order designates one parent responsible for providing dental coverage.
- If the above rules do not establish a primary plan, then the plan that has covered the person longer is primary. If the Assurant dental plan pays second, it pays an adjusted benefit that, combined with the benefit payable from the primary plan, equals up to 100% of covered dental expenses.

Claim Appeals

If your claim is denied in whole or in part, you can request an appeal. Refer to **Claim Appeals** for an explanation of the procedures and time frames to file an appeal.

Vision Plan

The Anthem Blue View Vision Insight Plan is offered through Anthem's Vision Partner, EyeMed, and provides benefits for eye exams, eyeglasses (frames and lenses) and contact lenses (contact lenses are in lieu of your eyeglass lenses benefit). Employees pay 100% of *premiums* through pre-tax payroll deductions. You can elect vision coverage even if you waive coverage in the Assurant medical plan.

The vision plan offers an extensive network of optometrists and vision care specialists. You'll save money by visiting *in-network* providers, which often provide better allowances and may offer additional discounts. To find a network provider near you, visit anthem.com. You don't have to sign in. Simply select "providers," then select "Find Care." Search as a Guest by selecting the type of care (VISION), the state where you want to search, the type of plan (VISION), then select "Blue View Vision Insight" as the plan/network.

Blue View Vision Plan Benefit	***In-Network***	***Out-of-Network***	**Frequency**
Routine Eye Exam			

A comprehensive eye examination	$10 *copay*	Up to $45 reimbursement	Once every calendar year
Eyeglass Frames			
One pair of eyeglass frames	$150 allowance, then 20% off any remaining balance	Up to $80 reimbursement	Once every calendar year
Eyeglass Lenses (instead of contact lenses)			
One pair of standard plastic prescription lenses: • Single vision lenses • Bifocal lenses • Trifocal lenses • Lenticular lenses	 $10 *copay* $10 *copay* $10 *copay* $10 *copay*	 Up to $30 reimbursement Up to $50 reimbursement Up to $65 reimbursement Up to $125 reimbursement	Once every calendar year

Eyeglass Lens Enhancements When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
• Transitions Lenses (for a child under age 19) • Standard polycarbonate (for a child under age 19) • Factory scratch coating	$0 *copay* $0 *copay* $0 *copay*	No allowance when obtained *out-of-network*	Same as covered eyeglass lenses

Blue View Vision Plan Benefits	***In-Network***	***Out-of-Network***	**Frequency**
Contact Lenses (instead of eyeglass lenses) You have a declining balance on your contact lenses			
Elective conventional (non-disposable) OR	$150 allowance, then 15% off any remaining balance	Up to $105 reimbursement	Once every calendar year
Elective disposable OR	$150 allowance (no additional discount)	Up to $105 reimbursement	
Non-elective (medically necessary)	Covered in full	Up to $210 reimbursement	
Low Vision Rider			
Low Vision Benefits Maximum Allowance	$1,000 (excluding *coinsurance*)		Once every two calendar years
• Supplementary Testing Examination • Supplemental Care Aids	Covered in full 25% *coinsurance*	Up to $125 reimbursement Up to 75% of cost	

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. The Anthem Blue View Vision Insight Plan is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and member's coverage is in force. This information is intended to be a brief outline of coverage. Additional information is available at anthem.com under Vision Benefits when you sign in as a member. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. A Certificate of Coverage is available upon request to the People Experience Center at 1-866-324-6513 or by asking ERIN. ERIN can be accessed across multiple channels, including your desktop, MS Teams, the web, MyHR and via mobile app.

Optional Savings Available from Blue View Vision *In-Network* Providers Only		*In-Network* Member Cost (after any applicable *copay*)
Retinal Imaging - at member's option can be performed at time of eye exam (not more than $39)		
Eyeglass Lens Upgrades When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens *copayment* applies.	• Transitions lenses (Adults) • Standard Polycarbonate(Adults) • Tint (Solid and Gradient) • UV Coating • Progressive Lenses[1] • Standard • *Premium* Tier 1 • *Premium* Tier 2 • *Premium* Tier 3 • Anti-Reflective Coating[2] • Standard • *Premium* Tier 1 • *Premium* Tier 2 • Other Add-ons	$75 $40 $15 $0 $65 $85 $95 $110 $45 $57 $68 20% off retail price

Additional Pairs of Eyeglasses		
Anytime from any Blue View Vision network provider.	• Complete Pair • Eyeglass materials purchased separately	40% off retail price 20% off retail price

[1]*Ask your provider for available progressive brands by tier and for a recommendation.*
[2] *Ask your provider for available coating brands by tier and for a recommendation.*

Optional Savings Available from Blue View Vision *In-Network* Providers Only		*In-Network* Member Cost (after any applicable copay)
Eyewear Accessories		
	Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact Lens Fit and Follow-up		
	• Standard contact lens fitting[3] • *Premium* contact lens fitting[4]	Up to $40 10% off retail price
Conventional Contact Lenses		
	Discount applies to materials only	15% off retail price

[3]*Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.*
[4]*Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.*

Out-of-Network

If you choose to receive covered services or purchase covered eyewear from an *out-of-network* provider, any network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an *out-of-network* claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at anthem.com, or from the home page menu under Support select Forms, click Change State to choose your state,

and then scroll down to Claims and select the Blue View Vision *out-of-Network* Claim Form. You may instead call member services at 1-877-635-6403 to request a claim form.
To Fax: 1-866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision
Attn: OON Claims
P.O. Box 8504 Mason, OH 45040-7111

Flexible Spending Accounts

Before the start of each *plan year*, you may elect to contribute some of your upcoming pay to a flexible spending account ("FSA"). There are three types of FSAs offered through the Plan:

- The General Purpose Health Care FSA.
- The Limited Purpose Health Care FSA.
- The *Dependent* Day Care FSA

Your medical plan election determines your Health Care FSA eligibility. If you enroll in either the Purple or Blue medical plan, you can elect either the General Purpose Health Care FSA or the Limited Purpose Health Care FSA. If you enroll in either the Green or Orange medical plan, or you waive medical plan coverage, you can elect only the Limited Purpose Health Care FSA.

It is important to estimate your FSA contributions carefully. According to IRS regulations, any amounts that you contribute but do not use before the end of the calendar year and any applicable runout period are forfeited. If you want help estimating your eligible expenses, worksheets are available on myassurantbenefits.com.

How the Plan Works

You will have an opportunity to enroll each year in any FSA for which you are eligible. As part of Open Enrollment, you will be asked to indicate the amount of pre-tax pay you want to contribute, over the course of the *plan year*, for the following *plan year*. You also may choose not to contribute to an FSA. Your FSA contributions are held in a notional account, not a bank account. No interest accrues on your contributed amounts to an FSA.

Your FSA contributions are made on a pre-tax basis, which reduces your taxable income. You do not pay federal income or Social Security taxes on your FSA contributions. This may mean that your Social Security benefits at retirement, death or disability may be reduced. Check with your tax advisor to determine how your state and local taxes may be affected by your participation in an FSA.

The table below provides estimated tax savings, depending on the percentage of your income you pay in federal income taxes – your tax bracket. Two tax bracket examples are given: 15% and 25%. Your savings may be higher if you're in a higher tax bracket. State income tax savings, if any, are not included.

Amount you contribute to an FSA	Tax savings if you're in a 15% tax bracket	Tax savings if you're in a 25% tax bracket
$600	$136	$196
$1000	$223	$326
$1,200	$272	$392

$2,400	$544	$784
$5,000	$1,132	$1,632

-Tax savings = federal income tax plus 7.65% in Social Security taxes.
-Figures in table are rounded and assume you pay Social Security taxes on your entire income.

The Internal Revenue Service (IRS) requires Assurant to report amounts contributed to a *Dependent* Day Care FSA. These amounts will appear on your Form W-2.

Electing Coverage in any FSA

To participate in the Health Care and/or the *Dependent* Day Care Flexible Spending Accounts when you first become eligible, you must make your election during your initial 15-day eligibility period or by the end of the subsequent 15-day grace period, as described in the General and Administrative section of this SPD.

Open Enrollment (actual dates each year will be communicated on the Assurant Connect intranet) is the time each year when you elect to participate in the FSA for the following year. If you want to participate, you must make an election; elections do not carry over from year-to-year. If you fail to make new elections during the annual Open Enrollment, you will be considered to have elected not to participate in the FSAs for the upcoming *plan year*. If you elect to participate during Open Enrollment, your participation is effective January 1 of the following year.

Estimate your expenses carefully before enrolling in an FSA. Here are some important things to consider:

- If you enroll in the Green or Orange medical plan, your only Health Care FSA option is a Limited Purpose Health Care FSA and it can reimburse only eligible dental and vision expenses.
- If you enroll in the Purple and Blue medical plan, or if you waive Assurant health plan coverage, your Health Care FSA is a General-Purpose Health Care FSA. It can reimburse you for eligible medical, prescription drug, dental and vision expenses that are not paid from another source (e.g., another medical or dental plan).
- If you put more money in your FSA then you can claim in expenses by the deadline, you'll forfeit the remaining balance. Use it or lose it.
- You cannot transfer money from one account to the other (e.g., from the Health Care FSA to the *Dependent* Day Care FSA).
- You cannot carry a balance in your FSA from one *plan year* to the next. Use it or lose it.

Mid-year Changes

The IRS does not allow you to change your FSA deductions during the year unless you experience a qualified life event. Changes you make due to a life event must be consistent with that life event and be reported to the People Experience Center as set forth in the Qualified Life Events section.

If you increase your annual contribution to an FSA mid-year consistent with a change in status, your new contribution per pay period is calculated by dividing the amount of the increase by the number of pay periods remaining in that calendar year. The result is then

added to your current contribution per pay period. The amount of the increase is available to be reimbursed to you for expenses incurred after the effective date of the change.

For example, if you are paid monthly and increase your annual contribution from $1,200 to $1,500 in mid-September, the additional $300 is prorated over the three remaining monthly pay periods, so that $100 is added to your current contribution per paycheck.

Only eligible expenses incurred while a person is a spouse or eligible *dependent* under the Health Care or *Dependent* Care FSA Plan are eligible for reimbursement. For example, if you get married on June 1, you may increase your contributions to your Health Care FSA, however only the expenses your spouse incurs on or after June 1 are eligible for reimbursement.

If you decrease your annual contribution to an FSA mid-year consistent with a change in status, your new contribution per pay period is calculated by subtracting the total amount you have contributed thus far during the year from your revised annual contribution amount. The difference is then divided by the number of pay periods remaining in that calendar year, and the result is subtracted from your current per pay-period contribution.

For example, suppose you are paid monthly and decrease your annual contribution from $1,200 to $600 at the end of February. At that time, you would have contributed $100 per month for two months, for a total of $200. The $200 you've already contributed is subtracted from your revised annual contribution of $600. The difference of $400 is divided by the 10 months remaining in the year. So, your new contribution becomes $40 per monthly paycheck.

You cannot decrease your contribution to an FSA below the amount for which you have already contributed, or for which you have already been reimbursed for that year. In the example above, you could not decrease your account to less than $200, because you have already contributed $200.

See **Qualified Life Events** for more information.

Health Care Flexible Spending Accounts (FSAs)

Eligible *Dependent*s under a Health Care FSA

You can be reimbursed for your eligible *dependent's* out-of-pocket health care costs, even if you do not cover your *dependent* under the Assurant Health Plan.

Eligible *dependents* under a General Purpose or Limited Purpose Health Care FSA are:

- Your legal spouse (as determined by state law).
- Your children, including adult children up to age 26 (regardless of marital or student status or if reside with you)
- Any other individual who qualifies as your tax *dependent*. This includes a child of divorced or legally separated parents, regardless of which parent is entitled to claim the *dependent* exemption, so long as the child lives with one or both of the parents and over half of the child's support is provided by the parents.
- Your *dependent* children required to be covered under a qualified medical child support order.

By submitting a request for reimbursement for an expense incurred on behalf of an individual other than your spouse, you're certifying that the individual is your eligible *dependent*.

Expenses for your *domestic partner* and his or her children are not eligible for reimbursement under the Flexible Spending Accounts.

Your Pre-tax Contributions to a Health Care FSA

The maximum annual contribution to a Health Care Flexible Spending Account is $3,400 in 2026.

General Purpose Health Care FSA

A General-Purpose Health Care Flexible Spending Account is only available to employees who enroll in either the Purple or Blue medical plan or who waive health plan coverage.

Qualifying Medical Expenses under the General-Purpose FSA

Some expenses not covered by your health insurance plan may be covered by your flexible spending account. The IRS calls these "qualified medical expenses." These expenses generally help diagnose, treat or stop an injury, illness or physical defect. Only "eligible expenses" can be reimbursed under the FSA. These expenses are defined by IRS rules and your employer's plan as described in this SPD. Eligible health FSA expenses are those that you pay for out of your pocket when you, your spouse, or eligible *dependents* get medical care. The IRS says that this includes "items and services that are meant to diagnose, cure, mitigate, treat or prevent illness or disease". Transportation for medical care is also included. You can find a list of eligible expenses online at qme.anthem.com.

The following expenses are reimbursable under the General-Purpose Health Care FSA:

- *Deductibles* and *coinsurance* under medical, dental, or vision plans.
- Expenses that exceed annual or lifetime limits under medical, dental, or vision plans.
- Eyeglasses and contact lenses.
- Hearing aids and hearing aid batteries.
- Laser eye surgery/intraocular lens implants.
- Certain weight-loss programs relating to the diagnosis of clinical obesity (a letter of medical necessity will be required).
- Smoking-cessation programs (e.g., SmokeEnders; a letter of medical necessity will be required).
- Acupuncture.
- Breast pumps and lactation supplies; and
- Over-the-counter medications (e.g., Monistat, Advil, Prilosec, Mucinex and Benadryl) and insulin (with or without a prescription).

Dual Purpose Expenses

Certain expenses have both a medical purpose and a general health, personal or cosmetic purpose. These expenses are called "dual purpose" expenses. In order to be reimbursed under the Health Care FSA, claims for a dual-purpose expense must be accompanied by a letter of medical necessity from the physician. This letter should state that the dual-purpose expense is to treat a specific medical condition that the covered person has. For example, if

your doctor recommends you use a treadmill to treat your cardiac condition, the expense may be eligible for reimbursement.

The following is a list of items that are considered dual purpose and that will require you to provide a letter of medical necessity from your doctor:

- Nasal strips.
- Nutritionist professional expenses.
- Exercise equipment or machines such as a treadmill.
- Personal trainer fees if used to treat a specific condition.
- Propecia (not for male-pattern baldness).
- Retin A (not if purchased for cosmetic purposes even if physician recommended).
- Rubdown/Massage Therapy.
- Sunscreen.
- Transportation someone other than the person receiving medical care, in connection with a transplant situation.
- Weight-loss programs.
- Lodging that is not a hospital or similar institution in connection with an Anthem center of excellence.
- Lodging of a companion in connection with an Anthem center of excellence.

Special Rule for Orthodontic Treatment Benefits

IRS regulations prohibit Flexible Spending Accounts from reimbursing expenses before the services are actually performed. This creates a challenge when seeking reimbursement for certain types of expenses, such as orthodontia, where it is common practice for the orthodontist to require payment "up front" for his/her services. If you prepay the bill or a portion of the bill, the Plan can only reimburse you initially for the amount you prepaid up to a maximum of 25% of the total cost of treatment. Your remaining reimbursement will be paid out on a monthly basis based on your total cost, your expected insurance and the expected length of treatment.

You should file just one orthodontic claim for the entire *plan year*, and you're responsible for paying your provider when payments are due. Dates of service will be considered to be the first of the month and reimbursement payments will be generated to you each month automatically. A new claim form must be submitted for each *plan year* that you elect to participate. Unless the treatment begins in January of the *plan year*, the payments will be pro-rated for the first year

When submitting your request for reimbursement, you must submit a completed Orthodontia Form located on myassurantbenefits.com.

You also can submit your orthodontia contract from your service provider as long as it contains all the required information as requested on the Orthodontia Form. Reimbursement cannot be made without one of these completed documents.

Following are two common examples:

Example 1:
Your orthodontist charges $3,500 for the course of treatment. The dental plan has a maximum lifetime orthodontic benefit of $1,500, and you elected to contribute $2,500 to your FSA for the year. You pay the orthodontist a $500 initial payment. The treatment is expected to last about 30 months. The table below shows how the FSA reimbursement would be determined.

Orthodontist's total charge	$3,500
Less benefit available under the Dental Plan	($1,500)
Your responsibility	$2,000
Your prepayment	$500
Estimated length of treatment Initial reimbursement from FSA	30 months
Initial reimbursement from FSA	$500
FSA balance remaining after initial reimbursement	$1,500
FSA monthly reimbursement ($1,500/30)	$50.00

Reimbursement of the $500 initial payment would be reimbursed in full, as it is less than 25% of the total cost. The remaining reimbursement would be made in monthly installments of $50.00.

Example 2
Your orthodontist charges $4,000 for the course of treatment. Your dental plan has a $1,500 lifetime orthodontic benefit, and you elected to contribute $2,500 to your FSA for the year. The estimated course of treatment is 30 months. You pay the orthodontist in full, at the time of the initial treatment.

Orthodontist's total charge	$4,000
Less benefit available under the Dental Plan	$1,500
Your responsibility	$2,500
Your prepayment	$2,500
Estimated length of treatment:	30 months
Initial reimbursement from FSA	$1,000
FSA balance remaining after initial reimbursement	$1,500
FSA monthly reimbursement ($1,500/30):	$50.00

You would be reimbursed for up to 25% of the total treatment cost, or $1,000. The remaining $1,500 would bereimbursed in monthly installments of $50.00.

Stockpiling

Stockpiling, which is the purchasing of large quantities of eligible medical items which can't be utilized by the end of the year in an effort to exhaust FSA funds, is prohibited by the IRS.

Exclusions under the General-Purpose FSA

In general, you cannot use a General-Purpose Health Care FSA to pay for:

- Expenses reimbursable under other benefit or insurance plans including Medicare and Medicaid.
- Expenses incurred while a person is not covered under the Health Care FSA.

- Expenses incurred during a leave of absence in which you elect to stop contributions to the Health Care FSA or fail to make required contributions
- Dietary supplements, vitamins and health aids other than those specified in the Covered Expenses section.
- Cosmetic procedures (including teeth-whitening).
- Weight-loss programs unless prescribed by a doctor to treat a diagnosis of clinical obesity.
- Expenses incurred for long-term care services; and
- Anti-baldness drugs for balding due to age.

In addition, the following list of dual purpose items are ineligible for reimbursement under the General-Purpose Health Care FSA:

- Air conditioners.
- Air purifiers.
- Allergy treatment products; household improvements to treat allergies (e.g., air purifiers).
- Automobile modifications.
- Behavioral modification – unless covered under the Health Plan.
- Birthing classes.
- Cayenne pepper.
- Chondroitin.
- Cold/hot packs.
- Dancing lessons.
- DNA collection and storage.
- Dyslexia (language training, school fees) – unless covered by the Health Plan; must be diagnosed by a physician.
- Ear plugs.
- Eggs and embryo storage fees.
- Elevator installation expenses.
- Fiber supplements.
- Fitness programs.
- Foods.
- Glucosamine.
- Herbs.
- Holistic or natural healers, dietary substitutes, drugs and medications.
- Home improvements (e.g., ramps).
- Inclinators.
- Lactation consultant.
- Language training (disabled or dyslexic child).
- Lead-based paint removal.
- Legal fees, general (bears a direct or proximate relationship to the provision of medical care).
- Legal fees in connection with fertility treatments.
- Mastectomy-related bras.
- Medical conference, admission, transportation, meals.

- Orthopedic shoes and inserts.
- Rogaine.
- Rubbing alcohol.
- Schools and education related to a behavioral health treatment facility.
- Schools and education, special (resources are used to relieve a disability).
- Special foods.
- Sperm storage fees (only to the extent necessary for immediate conception).
- St. John's Wort.
- Stem cell harvesting and or storage.
- Student health fees.
- Swimming lessons.
- Swimming pool maintenance.
- Transportation to and from a medical conference.
- Tuition for special needs program (primarily for medical care).
- Umbilical cord freezing and storage.

Limited Purpose Health Care FSA

IRS rules allow you to contribute to a *Health Savings Account (HSA)* if you're covered under a high *deductible* health plan (HDHP) and you have no other coverage that would disqualify you from contributing to an HSA. Participating in a General-Purpose FSA, because it can provide first dollar coverage of health expenses, would disqualify you from being able to contribute to an HSA. The Green and Orange health plans are considered high *deductible* health plans. If you enroll in either the Green or Orange medical plan, you are eligible to participate in a Limited-Purpose FSA only. Participating in a Limited-Purpose FSA will not disqualify you from participating in an HSA, should you choose to open one.

That is why we offer a Limited Purpose Health Care FSA to employees who enroll in the Green and Orange medical plans. A Limited Purpose Health Care FSA allows you to fund your out-of-pocket dental, LASIK surgery and vision hardware expenses on a pre-tax basis. You cannot be reimbursed for any medical or prescription expenses from the Limited Purpose Health Care FSA.

Eligible Expenses under a Limited Purpose

FSA Eligible expenses include:

- *Deductibles*, *coinsurance*, and *copays* under a dental or vision plan.
- Amounts that exceed either the annual or lifetime maximum benefit under a dental or vision plan (e.g., orthodontia).
- Prescription glasses and contact lenses; and
- Lasik eye surgery.

Special Rules under the Limited Purpose Health Care FSA

The rules regarding reimbursement of orthodontia expenses and stockpiling outlined under the General Purpose Health Care FSA also apply to the Limited Purpose Health Care FSA.

Exclusions under the Limited Purpose Health Care FSA

Exclusions under the Limited Purpose Health Care FSA include all the exclusions outlined under the General Purpose FSA, plus the following items and services:

- Medical expenses, including *deductibles*, *coinsurance*, and *copays*.
- Insurance *premiums*.
- Prescription medicines.
- Over-the-counter medicines and items.

***Dependent* Care Flexible Spending Account (FSA)**

You can contribute pre-tax dollars to the *Dependent* Care FSA to help pay for eligible child and elder care services needed so you (and your spouse, if married) can work or look for a job. You also can contribute if your spouse is a full-time student or disabled and unable to care for your children.

You can contribute up to $7,500 per calendar year if you're:

- Single and file as head of household;
- Married and file a joint income tax return; or
- Married but your spouse maintained a separate residence for the last six months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining your eligible *dependents*.

If you and your spouse reside together, but file separate federal income tax returns, you can each contribute up to $3,750.

If you're participating as a part-time employee, you'll be asked to certify that you're only requesting reimbursement for expenses that enabled you to work.

Legal limits for highly compensated employees – If you are a highly compensated employee (HCE), as defined by the IRS, your savings opportunity may be limited, the limit for each year will not be determined until early in that year. If this impacts you, you'll be notified by the People Experience Center. For illustrative purposes, in 2026, HCEs at Assurant were limited to a maximum plan year contribution of $1,500.

Eligible Dependents

Under IRS regulations, eligible *dependents* for the *Dependent* Care FSA include the following if they reside with you for more than half the year:

- A child under age 13 who you claim as a *dependent* on your income tax return.
- Any other tax *dependent* of yours, such as an elderly parent or disabled spouse, who is physically or mentally incapable of self-care and regularly spends at least 8 hours per day in your household.

Note: This definition of a *dependent* is different from the definitions in other portions of the Plan, including the Health Care FSA.

Eligible Expenses

The *dependent* care flexible spending account can be used to pay for IRS-specified *dependent* care expenses you incur so that you may work or attend school full-time. It is

important to contribute money only for *dependent* care expenses you know you will have during the upcoming year. Do not forget to subtract the times during which your *dependent* will not receive care, such as vacation or sick time. Here are examples of the types of expenses that are considered eligible:

- Nursery school, preschool or similar programs below the kindergarten level.
- Day care centers for children or *dependent* adults that provide care for more than six non-resident individuals on a regular basis and comply with all applicable state and local laws (does not include kindergarten tuition).
- Before-school or after-school care for eligible children from kindergarten up to and including age 12.
- Summer day camp or other summer programs (but not overnight camp or tutoring programs) used in lieu of regular *dependent* day care. Day camps must be attended by your eligible *dependents* for at least five consecutive days and during your normal working hours.
- A housekeeper inside your home whose duties are necessary to run your home for the well-being and protection of your eligible *dependent*.
- Home caregiver such as a governess, au pair or nanny.

Excluded Expenses

The following expenses are not eligible:

- *Dependent* care services provided inside or outside your home by:
    - Your spouse.
    - The parent of the *dependent*.
    - Your child under age 19 or
    - Anyone who is claimed by you or your spouse as a *dependent* for federal income tax purposes.
- Food, clothing and education expenses (including expenses for kindergarten).
- Transportation between your home and the place where care is provided, except when it is provided by the day care facility provider to pick up and/or take the child to and from the day care facility.
- Overnight care expenses (unless the parents work nights) or sleep away camp.
- Medical, prescription and dental expenses.
- Expenses incurred before your coverage in the *Dependent* Care FSA began; and
- Expenses for which you claim a tax credit.
- Care provided in full-time residential institution.
- Late payment fees.
- Expenses to care for *dependents* that do not live with you at least eight hours per day.
- *Dependent* day care services that are not necessary to enable you (and your Spouse, if applicable) to be gainfully employed or to attend school full-time.
- *Dependent* day care services provided if your Spouse does not work, is not in school full-time or is not disabled.

A Word about Taxes

Before you enroll in an FSA, you also may want to consider the tax consequences. You cannot deduct on your personal income tax return any medical care expenses that are reimbursed by your health care FSA. For every dollar of reimbursement you receive through the *Dependent* Day Care FSA, your *dependent* care tax credit is reduced by a dollar. So, if you elect to participate in the *Dependent* Day Care FSA, you are making a decision not to take the federal *dependent* care tax credit for those same expenses.

In most cases, the *Dependent* Day Care FSA will offer you the greater tax savings. However, it is important to note that in some cases, your tax savings may be greater if you use the *dependent* care tax credit rather than the spending account for part or all of your *dependent* care expenses. Refer to IRS Publication 503 for a complete discussion of the tax credit.

Filing a Health Care or *Dependent* Care FSA Claim

All claims for a given Plan year must be incurred by December 31 (or earlier if coverage ends earlier) and all claims and supporting documentation must be filed by March 31 of the calendar year following the year the expense was incurred. Claims filed after this deadline for expenses incurred in the previous Plan year will be denied.

IRS regulations do not allow the Plan to issue a reimbursement before the service is actually performed. For example, if you pre-pay child care services or the orthodontist's fee, you should provide a breakdown of the provider's charges on a monthly or quarterly basis.

Claims can be processed the following ways:

Online: Log into your account at anthem.com to file your claim electronically and upload your documentation.

Via fax or mail: Reimbursement request claim forms may be filed either via fax or US Mail and sent to the following locations: FAX: (978) 856-6604; US Mail: Anthem BlueCross Blue Shield, PO Box 161606, Altamonte Springs, FL 32716

The General-Purpose Health Care FSA and Limited Purpose Health Care FSA Reimbursement Request claim form and the *Dependent* Day Care Flexible Spending Account Reimbursement Request claim form are available on myassurantbenefits.com. Please be sure to sign the Employee Certification section of the form certifying the claim.

When Payments Are Made

The claims administrator has up to thirty (30) days to process claims, with a fifteen (15)-day extension permitted for circumstances beyond the claims administrator's control. If the extension is necessary because the claims administrator requires additional information necessary to decide the claim, you will have 45 days from the date of the notice of extension to provide the additional information. The time period during which the claims administrator must make a determination is tolled until the earlier of the date the information is provided or 45 days from the date of the notice. Generally, though, claims will be processed within three to five (3-5) business days after receipt of the form. You may check the status of your claim by logging into your account at anthem.com.

Health Care FSA

You can submit a claim for eligible health care expenses and receive reimbursement up to the amount of your annual election, regardless of the amount you have actually contributed at the time you file the claim. For example, you elect to contribute $600 for the year to your Health Care FSA. Each pay period $23.08 or 1/26th of $600 will deducted from your pay. In February, you have surgery and your out-of-pocket expenses equal $600. You could submit the claim and be reimbursed for the entire $600, even though you only contributed $100 at this point. The company will continue to deduct $23.08 per pay period for the balance of the calendar year.

***Dependent* Care FSA**

Under IRS regulations, you only can be reimbursed for *dependent* day care expenses up to the amount you've already contributed to your account at the time you submit the claim. If you have an eligible expense of $750 but only have $500 in your account, you only will be reimbursed $500. The remaining $250 will be carried forward to the next payment date. Then you'll receive another reimbursement up to the new balance available in your account.

If you have a balance in your *Dependent* Care FSA when you leave the company, you can continue to claim expenses for eligible services received through the end of the year in which you terminate.

Appealing a Claim

Refer to **Claim Appeals** for an explanation of the procedures and the time frames in which to file an appeal.

When Participation Ends

Your participation In the Health Care and/or *Dependent* Care Flexible Spending Account ends on the last day of the pay period in which the first of the following events occur:

- The end of the calendar year, unless you make an election to participate in the Health Care and/or *Dependent* Care FSA for the next plan year.
- The date you retire, terminate or die. See **COBRA** to learn about continuing Health Care FSA participation on an after-tax basis.
- The date you take an unpaid personal leave of absence.
- The date you stop contributing to your account.
- The date your employee status changes to an ineligible status (e.g., your work schedule is reduced to less than 20 hours per week).
- The date you take a leave of absence greater than two weeks (*Dependent* Care FSA only).
- The date the Plan is terminated or amended to exclude from coverage the individual or the class of *dependents* of which the individual is a member.

Further, your eligible *dependent's* participation in a FSA ends on the earliest of the following to occur:

- The date your FSA participation ends.
- The date that your *dependent* no longer meets the definition of an eligible *dependent*.

- The date your spouse is unemployed and not actively looking for work, unless he/she is a full-time student or disabled. (*Dependent* Care FSA only) and
- When the remaining amount of your election exceeds your projected earned income for the plan year. (*Dependent* Care FSA only).

Forfeitures

It's very important that you estimate your eligible expenses carefully. If your expenses for the year are less than the amount you contribute to your FSA, you'll lose the remainder. This is known as the "use it or lose it" rule. Claims and the supporting documentation must be filed by March 31 of the calendar year following the one in which they were incurred or the funds will be forfeited. If your participation terminates midyear, you still have until March 31 of the calendar year following the year in which your eligible expenses were incurred to request reimbursement. The IRS does not allow you to transfer funds from one account to another. Forfeitures are used to offset or pay the administrative expenses of the Plan, in accordance with applicable rules and regulations.

Life and Accident Insurance

The benefits described in this section are insured by a carrier. This SPD provides a summary of these insured benefits. To the extent that information in this SPD for an insured benefit conflicts with the insurance policy and/or certificate booklet, the insurance policy and/or insurance booklet govern. To request a copy of the insurance policy and/or certificate booklet for any of the insured benefits, contact the People Experience Center at 1-866-324-6513.

It's a question no one likes to ask. But how would your family afford to live if you were to die during your earning years? Your family likely depends on your income for security and for the future. Life insurance helps your family if you die and accident insurance helps your family if you experience certain specified injuries. That is why Assurant offers a wide range of coverage for you and your family members.

The fact is life insurance isn't really a benefit for you. It's for those you leave behind. Its purpose is to provide your family and others who depend on you for support with the financial resources they need to go on with their lives.

How much life and accident insurance do you need? That depends on your particular circumstances. If, for example, you have a young, growing family, you'll probably want more life insurance than someone who is unmarried or whose children are grown.

With the Assurant benefit program, you can choose the *coverage level* that's right for you and your family.

Life and Accident Benefits At-a-Glance

Insurance	
Basic Life	1 x plan pay (employees who earn more than $50,000 can choose between 1 times plan pay and $50,000) Maximum of $3 million, Basic and Supplemental Life coverage combined
Supplemental Life	1 through 8 x plan pay (levels of 3 to 8 times plan pay require SOH)

	Maximum of $3 million, Basic and Supplemental Life coverage combined (combined amounts over two times your annual plan pay or $500,000 require a Statement of Health (SOH)) *Premiums* are age-rated and based on tobacco use/non-use
Dependent Life	Spouse: $10,000, $25,000, $50,000, $75,000, and $100,000 Amounts over $50,000 require SOH Child: $5,000, $12,500, and $25,000 Spouse Life coverage cannot exceed 50% of your combined Basic and Supplemental Life coverage or $100,000
Basic Accidental Death & Dismemberment (AD&D)	1 x plan pay Maximum of $1.5 million (Basic and Supplemental AD&D coverage combined)
Supplemental Accidental Death & Dismemberment	1 through 8 x plan pay Maximum $1.5 million (Basic and Supplemental AD&D coverage combined)
Business Travel Accident	5 x plan pay Maximum $5 million

How the Life and Accident Insurance Plans Work

Basic Life, Supplemental Life, Basic AD&D, Supplemental AD&D, and Business Travel Accident Insurance are based on plan pay. If your plan pay changes throughout the year, the amount of insurance and cost can change.

Electing Coverage

Initial Enrollment Period

You automatically are enrolled in Basic Life, Basic AD&D and BTA Insurance on the date you become an eligible employee. To participate in Supplemental Life, Supplemental AD&D and *Dependent* Life Insurance you must make your election during your initial 15-day enrollment period.

If you're not at active work on the day your Basic and Supplemental Life, Basic and Supplemental AD&D and *Dependent* Life insurance would otherwise be effective, insurance will not take effect until you return to active work.

Dependent Life Insurance does not take effect until your insurance under this policy becomes effective. If your *dependent* is in a hospital or similar facility on the day his/her insurance would otherwise take effect, it will not take effect until the day after the *dependent* leaves the hospital or similar facility. This exception does not apply to a child born while *dependent* insurance is in effect.

Basic Life Insurance can be reduced from one times plan pay to $50,000 at any time. Supplemental Life, Supplemental AD&D and *Dependent* Life Insurance also can be reduced or cancelled at any time during the year. The reduction or cancellation is effective as of the date you request the change.

Life Insurance

Basic Life Insurance

Basic Life Insurance is provided by Assurant at no cost to you. If your plan pay is $50,000 or less, your Basic Life Insurance equals one times *plan pay*.

If your plan pay is more than $50,000, you can choose Basic Life coverage of 1 times plan pay or cap your Basic Life coverage at $50,000. If you choose to cap your Basic Life coverage at $50,000, you'll avoid *imputed income* on the company contribution on amounts in excess of $50,000, and you also will receive a credit in your semimonthly pay for the company's cost of Basic Life coverage in excess of $50,000 that the company would have paid if you chose not to cap your coverage. This credit is included in your taxable income.

Supplemental Life Insurance

Supplemental Life Insurance benefits are in addition to your Basic Life Insurance benefits. You can purchase Supplemental Life Insurance equal to one through eight times your plan pay. The combined maximum amount of Basic and Supplemental Life Insurance coverage is $3 million. A Statement of Health (SOH) is required if your Supplemental Life Insurance coverage exceeds two times your annual plan pay or $500,000. Amounts will not be effective until you submit SOH, and the insurer, MetLife, accepts proof of your Statement of Health.

You pay the full cost of Supplemental Life Insurance. *Premiums* are age-rated and based on whether you use tobacco products. *Premiums* are deducted from your pay on an after-tax basis.

Dependent Life Insurance

Assurant also offers the option to purchase life insurance for your eligible *dependent*s. You can choose from the following *coverage levels* on your spouse/*domestic partner* and/or child. The amount of coverage on your life (Basic and Supplemental Life Insurance combined) must be at least twice the amount of Spouse/*Domestic Partner* Life coverage you elect.

Spouse/*Domestic Partner*	Eligible Child
$10,000	$5,000
$25,000	$12,500
$50,000	$25,000
$75,000	
$100,000	

SOH is required for spouse/*domestic partner* Life Insurance coverage greater than $50,000. Amounts up to $50,000 will be effective as of the day you make your election. Amounts greater than $50,000 will not be effective until your spouse/*domestic partner* submits SOH, and the insurer, MetLife, accepts your spouse/*domestic partner's* Statement of Health.

Your *dependent's* coverage is effective on the latest of the following:

- His/her eligibility date.
- The date you elect coverage on your *dependent(s)*; and

- The date MetLife approves your *dependent's* SOH, if required.

You cannot be covered under the Assurant Life Insurance program as both an employee and a *dependent*. So if you and your spouse/*domestic partner* or former spouse/*domestic partner* are both employees, you cannot elect *dependent* coverage on each other and only one of you can cover a *dependent* child.

Your first child will be covered from birth for the coverage amount you choose as long as the election is made within 30 days of the birth. Subsequent children are automatically covered from birth at the same *coverage level* and *premium*.

Life Insurance Statement of Health form (SOH)

You can change your Basic Life, Supplemental Life and *Dependent* Life Insurance elections at any time during the year. You must provide *evidence of insurability* by filling out a SOH form with MetLife before an increase in Life Insurance becomes effective. You can also increase your Supplemental AD&D Insurance throughout the year - no SOH is required.

You must provide SOH if:

- You elect the greater of more than two (2) times plan pay or $500,000 for Supplemental Life Insurance during your initial enrollment period.
- You increase your Basic Life Insurance after your initial enrollment period from $50,000 to one (1) times plan pay.
- You request coverage on your spouse/*domestic partner* of $75,000 or $100,000 during your initial enrollment period.
- You increase your Supplemental Life Insurance during the year or during Open Enrollment.
- You increase your Spouse or Child Life Insurance during the year or during Open Enrollment.

You have until December 31 to provide SOH during Open Enrollment. Otherwise, proof must be submitted to MetLife within 30 days of your election.

An increase in Life Insurance coverage is effective on the later of:

- The date you elect to increase the coverage; and
- The date MetLife approves your SOH, if required.

If you experience a qualified life event, you can add *Dependent* Life Insurance within 30 days of the life event. Assurant will allow an additional 30 calendar day grace period to make changes to your elections if, for some reason, you are unable to make your changes within the designated 30 calendar day qualified life event enrollment period. *Dependent* Life insurance on your spouse/*domestic partner* in amounts greater than $50,000 requires SOH; however, if you do not make the change by the end of the grace period, you must submit SOH regardless of coverage amount.

If your enrollment requires *evidence of insurability*, you will receive an email notification to your Assurant email box and a direct link to MetLife's online SOH will appear in the External Links section of your MyHR Benefits worklet once the enrollment period has ended. You must complete the online form within 31 days of your election.

You and your *dependents* will be insured for the level of coverage available without SOH until the online form is received and approved by MetLife.

Accelerated Life Insurance Benefits

If MetLife receives proof that you or your enrolled spouse/*domestic partner* has a qualifying medical condition and meets certain criteria, the Plan may pay a part of that person's Basic and Supplemental Life Insurance or *Dependent* Life Insurance as an accelerated benefit. The amount of life insurance will be reduced by the amount of accelerated benefit paid and by any interest charge, if applicable. The purpose is to help pay for medical and living expenses if you become terminally ill. The benefit allows you to receive, under certain circumstances, part of your life insurance coverage before the insured person dies.

The insured person can receive up to 80% of his/her life insurance coverage as an accelerated benefit; with the beneficiary's consent, the insured person can receive up to 80% as an accelerated benefit. The minimum accelerated payment is $5,000; the maximum is $500,000. The maximum benefit for your spouse or *domestic partner* is $80,000. MetLife will deduct any accelerated benefit payment and the interest on the accelerated benefit payment from the death benefit payable.

You or your covered spouse or *domestic partner* will be considered terminally ill if your doctor determines that you or your spouse or *domestic partner* have a life expectancy of 12 months or less.

Life Insurance Exclusions

If you take your own life or your covered *dependent* takes his or her own life within one year of becoming insured, the amount of Supplemental Life Insurance payable will be limited to the amount of *premiums* paid for the coverage.

If you take your own life or your covered *dependent* takes his or her own life within one year after you elect to increase the coverage amount, the amount of insurance payable will be limited to the previously elected amount plus the *premiums* paid for the increased amount of coverage.

Imputed Income

The IRS requires the cost of Basic Life Insurance in excess of $50,000 be included in your annual gross income for federal tax purposes. This is called "*imputed income*." This cost is based on the Table I rates found in Reg. 1.79-3(d) (2) of the Internal Revenue Code. *Imputed income* is subject to federal income and FICA (Social Security and Medicare) taxes.

If you want to avoid paying taxes on this *imputed income*, you can cap your Basic Life Insurance coverage at $50,000. Note - if you reduce your Basic Life coverage and want to increase it at a later date, you'll have to provide SOH.

Currently, only Basic Life Insurance greater than $50,000 is subject to *imputed income*. If *premium* rates for Supplemental Life Insurance change, Supplemental Life also may be impacted. Notice of rates subject to *imputed income* will be included with Open Enrollment information.

Accidental Death & Dismemberment Insurance (AD&D)

Basic AD&D Insurance

Assurant provides Basic AD&D insurance at no cost to you. Your Basic AD&D coverage amount is one times your plan pay.

If you die in an accident, your Basic AD&D insurance pays 100% of your coverage amount to your *beneficiary*. If you lose a limb or sight due to an accidental injury, benefits are paid to you. The Plan pays the following amounts based on the loss:

Type of Loss	Percentage of Coverage Amount
One hand, one foot, or the sight in one eye	50%
Any two (or more) of the above losses	100%
Thumb and index finger of the same hand	25%

AD&D insurance will pay for losses that occur within one year of a covered accident. The one-year limit will not apply if you're in a coma or being kept alive by life support at the end of one year. The maximum benefit for all losses you suffer in one accident is 100% of your coverage amount.

Supplemental AD&D Insurance

You can purchase Supplemental AD&D insurance equal to one (1) through eight (8) times your *plan pay*. The combined maximum benefit of your Basic and Supplemental AD&D insurance is $1.5 million. Supplemental AD&D benefits are paid in addition to Basic AD&D benefits.

Automobile Accident Benefit

If your death is the direct result of an injury received in an automobile accident while you're properly wearing an unaltered seatbelt installed by the automobile's manufacturer, MetLife will pay your *beneficiary* an additional 20% of the amount of your AD&D coverage, up to $100,000. There is a separate $100,000 maximum benefit if you elect Supplemental AD&D.

The insurance will be paid only if death occurs within 365 days after the automobile accident.

The automobile accident benefit will not be paid if the accident occurs when:

- The automobile is being used for racing, stunting, exhibition work, sport or test driving.
- You're breaking any traffic laws of the jurisdiction in which the automobile is being operated; or
- You're not properly wearing an unaltered seat belt installed by the automobile's manufacturer.

The exclusions listed under **Accidental Death and Dismemberment** also apply to the Automobile Accident Benefit.

Higher Education Benefit

If your death is the direct result of an injury and an AD&D benefit is payable, MetLife will pay a higher education benefit of $3,000 per year for up to four consecutive years. This benefit will be payable to each unmarried *dependent* under the age of 26 who is enrolled full-time at an accredited school at the time of your death or who is at the 12th grade level and enrolls as a full-time student in an accredited school within 12 months of your death.

Eligible children include your own and your spouse's or *domestic partner's* biological and adopted children (including children placed for adoption and children born through a surrogacy arrangement). "Children" also include any children for whom you're the legal guardian, who reside with you on a permanent basis and depend on you for support and maintenance.

AD&D Exclusions

Basic and Supplemental AD&D insurance does not pay benefits for certain losses, including those resulting from:

- War or any act of war, whether declared or undeclared.
- Taking part in a riot or insurrection or an act of riot or insurrection.
- Service in the armed forces of any country, combination of countries or international organization at war, whether declared or not.
- Any physical or mental disease.
- Any infection, except a pyogenic infection that occurs from an accidental wound.
- An assault or felony you commit.
- Suicide or attempted suicide, while sane or insane.
- Intentional self-inflicted injury, while sane or insane.
- The use of any drug, unless you use it as prescribed by a doctor.
- Your intoxication, which includes, but is not limited to, operating a motor vehicle while you're intoxicated.
- Any incident related to:
    - Travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
    - Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
    - Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
    - Travel in an aircraft or device used:
        - For testing or experimental purposes;
        - By or for any military authority; or
        - For travel or designed for travel beyond the earth's atmosphere.

Potential Waiver of *Premium* for Life and AD&D under certain circumstances of Disability

If you stop active work before age 65 due to a disability and remain disabled under the terms of the Plan, the company will continue to pay for your Basic Life Insurance and Basic AD&D coverage for the first six months of your leave of absence. You also will be given the opportunity to continue your Supplemental Life, *Dependent* Life and Supplemental AD&D during this period by paying the required *premiums* in a timely manner. You may be eligible to continue your Basic and Supplemental Life Insurance, Basic and Supplemental AD&D and *Dependent* Life Insurance beyond the initial six months of your disability if you qualify for the waiver of *premium* feature under the Plan. MetLife automatically reviews each case. If you're approved for a waiver of *premium* for these coverages, effective with the date of approval, you'll no longer be required to make *premium* payments for the contributory coverage. MetLife will notify you in writing if you're approved for waiver of *premium*.

Disabled means that you're under the regular care and attendance of a doctor and prevented by injury or physical or mental disease from performing the material duties of any occupation for which education, training or experience qualifies you.

If you're approved for a waiver of your Life Insurance *premiums*, *premiums* for AD&D and *Dependent* Life, as applicable, will also be waived.

If you become disabled before age 60, your Basic Life, Supplemental Life and *Dependent* Life *premiums* will be waived until the earliest of the following dates:

- You're no longer disabled under the terms of the Plan.
- You begin receiving retirement benefits under the Assurant Pension Plan.
- You begin receiving retirement benefits under a government plan, as defined by the Plan and
- You attain Social Security normal retirement age as stated in the 1983 version of the Social Security Act.

Basic and Supplemental AD&D insurance will continue for up to one year from the date you become disabled.

If you become disabled at or after age 65, you're not eligible for the waiver of *premium*.

Exclusions

You'll not be eligible for the *premium* waiver if your disability results from:

- Intentionally self-inflicted injury, while sane or insane.
- War or any act of war, whether declared or not.
- Service in the armed forces of any country, combination of countries or international organization at war, whether declared or not; and
- Taking part in a riot or insurrection or an act of riot or insurrection.

How Benefits Are Paid

Benefits under $5,000 are paid out in a lump sum directly to the *beneficiary*. If the benefit is $5,000 or more, MetLife will set up a Total Control Account. The Total Control Account (TCA) is a draft account that works like a checking account:

- When your account is opened, MetLife will send you a package that includes additional details about the TCA. We pay the full amount owed to you by placing your proceeds into the TCA and providing you with a book of drafts. You can use the drafts like you would use checks.
- You can use a single draft to access the entire proceeds or several drafts for smaller amounts (as little as $250). There are no limits on the number of drafts you can write. Processing time is similar to check processing.
- You earn interest on the money in your account from the date your account is open.
- We'll send you an account statement each month when there is activity in your account. If you have no activity, we'll send you a statement once every three months.
- You can name a *beneficiary* for your account. We'll include a *beneficiary* form in the package we send you when we open your account.

When Coverage Ends

Basic Life, Supplemental Life, Basic AD&D and Supplemental AD&D Insurance coverage ends on the earliest of the date:

- The policy(ies) are terminated.
- The policy(ies) are amended to exclude your eligible class.
- You're no longer in an eligible class.
- You retire or terminate employment; and
- A *premium* is not paid.

Dependent coverage ends on the earliest of:

- The date your coverage ends.
- The date the policy terminates or the *dependent* life insurance coverage terminates.
- The date your spouse, *domestic partner* or child(ren) no longer meet the eligibility requirements; or
- The date a *premium* is not paid.

Conversion to an Individual Policy

If Basic Life, Supplemental Life and/or *Dependent* Life Insurance terminates, you can apply for any individual policy offered by Massachusetts Mutual Insurance company through MetLife. You must apply and pay the *premium* within 31 days of the date coverage terminates. The individual policy may be any they offer for conversion. No SOH is required. The amount of coverage that can be converted depends on the reason your insurance ended.

If your insurance ends because you're no longer eligible or because of a change in age or other status, you may convert the full amount that ended. However, if your insurance ends as the result of a change in the policy, you may not convert the full amount that ended. If the policy ends or is changed to reduce or end your life insurance and if you have been insured for at least five years under the policy, you may convert the lesser of:

- $10,000; and
- The amount of life insurance that ended minus the amount of any group life insurance for which you become eligible within 31 days.

If you die within 31 days after your life insurance ends, MetLife will pay to your *beneficiary* the amount you could have converted, whether or not you applied or paid the *premium*.

You cannot apply for a conversion policy if your life insurance ends because you do not pay your *premiums* on time.

Basic and Supplemental AD&D Insurance cannot be converted to private policies.

MetLife will reach out to you to start the conversion process.

Business Travel Accident Insurance

Business Travel Accident (BTA) insurance is provided through National Union Fire Insurance Company, a subsidiary of American International Group, Inc. (AIG). BTA provides financial protection against death and certain physical injuries resulting from a covered accident while you travel on company business. At the Company's cost, you're insured for five (5) times plan

pay, up to $5 million. Your spouse/*domestic partner* and all *dependent* children are insured when they accompany you on a business trip or during travel for relocation when authorized by Assurant. Insurance is also provided for Personal Deviations - non-business travel or activities unrelated to Assurant business undertaken while on an authorized business trip. The maximum length of a personal deviation is 14 days.

Accidental Death and Dismemberment Benefits

BTA benefits depend on the type of covered loss as outlined in the chart below and are a percentage of the insured's principal sum. Your principal sum is five (5) times your *plan pay*, up to a maximum of $5 million. The principal sum on your *dependents* is as follows:

- Spouse - $100,000.
- *Dependent* child - $25,000.

Accidental Death and Dismemberment Includes Loss of:	Percent of Principal Sum
Life	100%
Both hands or feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and sight of one eye	100%
One foot and sight of one eye	100%
Speech and hearing in both ears	100%
One hand or one foot	50%
Sight of one eye	50%
Speech or hearing in both ears	50%
Hearing in one ear	20%
Thumb and index finger of the same hand	20%

Paralysis includes	Percentage of Principal Sum
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Uniplegia	25%

For additional information, refer to the Policy.

If an insured person sustains more than one covered loss as a result of the same covered accident, AIG will pay the benefit for the covered loss for which the largest benefit is payable.

Aggregate Limit of Indemnity Per Air Accident: $25 Million

The Aggregate Limit is the maximum amount payable under the Business Travel Accident Policy when more than one insured person suffers a covered loss as a result of the same aircraft accident. If the combined benefits payable exceed the Aggregate Limit, individual benefit amounts will be reduced proportionately, as provided under the Policy.

Additional BTA Benefits

In addition to accidental death and dismemberment coverage, BTA insurance provides the following benefits, subject to the terms and conditions of the Policy:

Benefit	Description
Attendor Benefit	Covers transportation for one person to accompany an insured person's remains home following a covered death, up to the cost of round-trip economy airfare, plus lodging and meals for up to seven days ($1,000 daily maximum). Arrangements and expenses must be approved in advance by Travel Guard.
Bedside Visitor Benefit	If an insured person is hospitalized for at least three days due to a covered illness or injury more than 100 miles from home, covers round-trip economy airfare for one designated visitor, plus up to three days of lodging ($200/day) and meals ($100/day). Advance Travel Guard authorization is required.
Bereavement and Trauma Counseling	Provides up to 10 counseling sessions combined for the insured person and immediate family members following a covered accidental death, dismemberment, paralysis, or coma, up to $250 per session. Expenses must be incurred within one year of the accident.
Carjacking Benefit	Provides an additional benefit following a covered accidental death, dismemberment, paralysis, or coma resulting from a carjacking, up to the lesser of $50,000 or 10% of the applicable principal benefit.
Coma Benefit	If a covered accident causes a coma lasting at least 30 consecutive days, provides monthly benefits equal to 2% of the Principal Sum for up to 11 months, with the remaining Principal Sum payable in the 12th month if the coma continues, subject to Policy limits.
Home Alteration and Vehicle Modification	Reimburses up to $50,000 for qualifying home modifications or vehicle alterations following a covered accidental dismemberment or paralysis. Expenses must be incurred within one year of the accident.
Rehabilitation Benefit	Reimburses up to $50,000 for covered rehabilitation expenses resulting from accidental dismemberment or paralysis, incurred within two years of the accident.
Repatriation of Remains	Covers eligible expenses to return an insured person's remains home following a covered accidental death or emergency sickness occurring at least 50 miles from home. Arrangements must be coordinated through Travel Guard.
Seatbelt and Airbag Benefit	Provides an additional benefit of up to $50,000 for a covered accidental death while wearing a seatbelt in a private passenger automobile, plus an additional benefit of up to $50,000 if protected by an airbag that inflates upon impact. Each benefit is limited to the lesser of $50,000 or 10% of the Principal Sum.
Security Evacuation Benefit	Covers up to $100,000 in eligible evacuation expenses when an insured person traveling internationally on Assurant business must be evacuated due to qualifying security threats, political or military events, natural disasters, or other covered circumstances. All arrangements must be made through Travel Guard.

Travel Guard Assistance Services

BTA coverage also includes access to Travel Guard's worldwide travel assistance services, available 24 hours a day, seven days a week. Services include:

- Emergency medical, travel, and security assistance, including help locating medical providers worldwide.
- Travel advisories, destination information, and security alerts.
- Assistance coordinating emergency medical care and eligible direct payments to providers.
- Security consultation, emergency evacuation coordination, and online travel security awareness training.

Access: Visit aig.com/us/travelguardassistance or download the AIG Travel Assistance mobile app. Register using Policy Number 9154105.

Travel Guard must arrange and authorize expenses in advance where required under the applicable benefit. Charges for services not covered by the insurance policy may be the traveler's responsibility.

Exclusions to BTA Insurance

Unless otherwise provided by the Policy, no coverage shall be provided under the Policy and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the loss is an accidental bodily Injury:

- Suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
- Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, whether as a passenger, pilot, operator or crew member, unless specifically provided by the Policy.
- Declared or undeclared war, or any act of declared or undeclared war unless specifically provided by the Policy.
- Sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these, unless specifically provided by this Policy.
- Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes, unless specifically provided by this Policy.
- Full-time active duty in the armed forces National Guard or organized reserve corps of any country or international authority. (Unearned *premium* for any period for which the Insured Person is not covered due to his or her active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.)
- The Insured Person being under the influence of intoxicants while operating any vehicle or means of transportation or conveyance.

- The Insured Person being under the influence of drugs unless taken under the advice of and as specified by a Physician.
- The Insured Person's commission of or attempt to commit a felony.

When BTA Insurance Coverage Ends

BTA ends on the earliest of:

- The date the person is no longer in an eligible class.
- The date the person enters full-time active duty in any Armed Forces (active duty does not include Reserve or National Guard duty for training unless it extends beyond 31 days).
- The end of the period for which the last *premium* is paid.
- The date the BTA policy ends; or
- The date the business segment with which the insured person is affiliated ceases to be covered under this policy.

Naming a Beneficiary

You can name anyone you choose to be your *beneficiary*. Your *beneficiary* will receive benefits from your Basic and Supplemental Life Insurance coverage, plus any death benefits payable from your Basic AD&D, Supplemental AD&D and Business Travel Accident Insurance. You're the *beneficiary* for *Dependent* Life Insurance.

Beneficiaries can be added and/or changed at any time in MyHR in the Benefits Worklet > Change Benefits > Benefits Event > Add/Change *Beneficiary*.

You can choose one or more persons to be your *beneficiary* by individual plan. Benefits may be distributed among several people equally or you can divide according to a percentage (e.g., 60% to one person and 40% to another).

You also can have a primary and contingent *beneficiary*. A primary *beneficiary* is the person who is "first in line" to receive benefits. A contingent *beneficiary* will receive benefits only if your primary *beneficiary* dies before you do or is otherwise ineligible to receive benefits.

If you don't name a *beneficiary* or the person you've named is no longer living when you die (or is ineligible to receive benefits), MetLife will pay the Basic and Supplemental Life Insurance and any death benefits payable under the Basic and Supplemental AD&D policies in the following order:

- Your legal spouse.
- Your *domestic partner*.
- Your or your *domestic partner's* children, in equal shares.
- Your parents, in equal shares; or
- Your estate.

If there is no named *beneficiary* or surviving *beneficiary* or if the insured person dies while benefits are payable to him/her, company Business Travel Accident Insurance benefits will be paid in equal shares to the survivors in the first surviving class that follow: The insured's 1) spouse; 2) children; 3) parents; or 4) brothers and sisters. If no class has a survivor, the *beneficiary* is the insured's estate.

Disability Benefits (STD and LTD)

NOTE: The Long-Term Disability benefits described in this section are insured by a carrier. This SPD provides a summary of these insured Long-Term Disability benefits. To the extent that information in this SPD for the Long-Term Disability benefit conflicts with the insurance policy and/or certificate booklet, the insurance policy and/or insurance booklet govern. To request a copy of the insurance policy and/or certificate booklet for any of the insured benefits, contact the People Experience Center at 1-866-324-6513.

Assurant's Disability Plan replaces a portion of your earnings if you're unable to work because of your own serious health condition, pregnancy or following a qualifying accident or injury, providing a level of financial safety that could make a big difference to you and your family.

The Disability Plan has three components:

- Short-Term Disability (STD) coverage.
- Core Long-Term Disability (LTD) Insurance.
- LTD Buy-Up option (Core option + 10% Buy-Up option).

Lincoln Financial is the disability manager for STD and the insurer for LTD benefits.

Eligibility and Enrollment

You must be employed by Assurant for at least 60 calendar days and be a benefits-eligible employee for Short-Term Disability (STD) and Long-Term Disability (LTD) coverage to be effective. Your coverage is effective on the 61st day.

You're automatically enrolled for STD coverage and LTD (Core option) insurance when you're eligible. If you're not actively working on the day STD or LTD would otherwise be effective, coverage will not take effect until you return to work.

Newly eligible employees may elect the LTD Buy-Up option for an additional 10% of coverage without providing *evidence of insurability*. Enrollment after thirty days of eligibility (late enrollment) or any future enrollment changes require *evidence of insurability* through MyHR. The LTD Buy-Up option coverage is subject to a Pre-Existing Condition Exclusion. "Pre-Existing Condition" means a condition resulting from an injury or sickness for which the covered person is diagnosed or received treatment within six months prior to the covered person's effective date of coverage. This policy will not cover any disability or partial disability:

- Which is caused or contributed to by, or results from, a Pre-Existing Condition; and
- Which begins in the first 12 months immediately after the covered person's effective date of coverage.

Cost of Coverage and Taxes

Short-Term Disability and Long-Term Disability (Core option) coverage is fully paid by Assurant. You have the option of buying an additional 10% of LTD coverage that would bring your LTD benefit to a total of 60% of income replacement.

You pay *imputed income* on the cost of the coverage for the Core LTD coverage. If you purchase the additional 10%, the *premium* will be deducted from your pay on an after-tax basis. As a result, you're still responsible for paying any state/and or local income taxes that

may apply. Any LTD benefits you receive are not subject to federal income tax or FICA taxes (Social Security and Medicare).

You do not pay *imputed income* on the cost of coverage for STD coverage, though you will be fully taxed on any STD benefits you receive.

Disability Benefits At-a-Glance

	Short-Term Disability	**Long-Term Disability (Core Option)**	**Long-Term Disability (Core + 10% Buy-Up Option)**
Eligibility Period	60 days	60 days	60 days
Qualifying Period	7 consecutive calendar days	180 days	180 days
Benefit Amount			
60 days of service or less 61 days of service or more	No pay 66.67% of your base pay (Weeks 2-26) for all disability leaves except if you go out on leave due to pregnancy. Enhanced Pregnancy Leave Benefit: 100% of your base pay for 6 weeks (up to 8 if approved for medical necessity)	No pay 50% of plan pay	No pay 60% of plan pay
Imputed income on employer-paid benefits	No	Yes	N/A
Benefit is taxed	Yes	No	No
Maximum Benefit Period	25 weeks	Normal retirement age	Normal retirement age

Authority to Determine Eligibility

For Short-Term Disability benefits, Lincoln Financial has discretionary authority to determine eligibility for Short-Term Disability benefits. Determinations made by Lincoln Financial are conclusive and binding on all parties, unless appealed to and approved by the Benefit Plans Committee. See **Claim Appeals** for more information.

For Long-Term Disability benefits, Lincoln Financial has discretionary authority to determine eligibility for participation and for benefits and to interpret the terms of the Long-Term Disability Plan. Determinations and interpretations made by Lincoln Financial are conclusive and binding on all parties. See **Claim Appeals** for more information.

Short-Term Disability - Lincoln Financial

The Short-Term Disability program is managed by Lincoln Financial. If your disability leave is expected to be longer than seven consecutive calendar days, you must notify your manager immediately and file a claim with Lincoln Financial as soon as the need for a disability leave is known, but no later than 30 days from your first date of disability. To initiate a disability claim, call Lincoln Financial at 1-800-213-1939 or submit your claim online at LincolnFinancial.com

(use the company code ASSURANT), and your disability case manager will contact you within two business days.

When applicable, STD is taken concurrently with FMLA Leave.

If Lincoln Financial does not approve your leave, no benefits are payable.

When You Call Lincoln Financial

You'll be asked some basic questions about yourself, your job, your disability and contact information for your physician. You'll need to sign a form authorizing your doctor's office to release information about your condition. The form will be included in the disability material that Lincoln Financial mails to your home. This release must be signed by you and faxed or mailed to Lincoln Financial as soon as possible. The fax number and mailing address are shown on the medical release form.

You should let your doctor know that he or she will be contacted to certify your disability.

If your physician does not provide Lincoln Financial with medical information that objectively supports your disability, your claim will be pending for 30 days from the date you call Lincoln Financial. If the data to certify your disability is not provided by the end of this period, your claim will be denied. Information on how to *appeal* Lincoln Financial's decision as claims administrator will be in your claim denial letter.

Definition of Disability

Generally, you're considered *disabled* if you're unable to perform the material duties of your regular job with Assurant due to an illness, injury or pregnancy, or if you're partially disabled and still working and your disability prevents you from earning more than 80% of your base pay in your regular job with Assurant.

Lincoln Financial may require that you be examined by a *physician* or other health care provider. If Lincoln Financial determines that an independent medical examination is needed, they'll arrange this at no cost to you. Failure to attend an independent medical examination could result in a loss of benefits.

Note: Even if Assurant has approved your leave of absence, made an accommodation (per ADA rules), or does not allow you to return to work in another position as a result of injury or illness, this does not mean that you're "disabled" as defined by the Disability Plan. You should call your local People Partner if you're requesting an accommodation.

Short-Term Disability Benefit Amount

Your Short-Term Disability benefit is based on your *base pay* as shown in the Disability Benefits-At-a-Glance chart.

Your STD benefit is equal to the Benefit Amount less any Offset Amount you receive or are eligible to receive. As a condition of receiving STD benefits, you are required to apply for any applicable governmental benefits (PFML, DI, etc.) to be taken concurrently with your STD and applied as an Offset Amount.

Offset Amount

If you're eligible for any of the following benefits, the total of all weekly benefits plus the pro-rated amount of any lump sum payments will be subtracted from the Benefit Amount:

- Any salary, wages, partnership or proprietorship draw, commissions or similar pay from any work you do.
- Social Security disability benefits, including *dependent* benefits payable because of your *injury*, sickness or pregnancy.
- Disability benefits from workers compensation or a government plan, other than Social Security.
- Retirement, disability or similar benefits (not including your contributions from a retirement plan sponsored by Assurant).
- Retirement benefits from a *retirement plan* or a *government plan* will be included only if you choose to receive them.
- Any no-fault motor vehicle coverage, unless:
    - State law or regulation does not allow group disability benefits to be reduced by benefits from no-fault motor vehicle coverage.
    - The no-fault motor vehicle coverage determines its benefits after benefits have been paid under the policy; or
- The benefits are provided under optional coverage.

STD Exclusions

- Any disability that begins before your STD coverage becomes effective and any disability that begins after your coverage is terminated.
- An occupational injury or illness.
- A disability caused by war or any act of war, whether declared or not.
- Intentionally self-inflicted injury, while sane or insane.
- A disability that results from taking part in committing an assault or felony.
- A disability resulting from elective cosmetic procedures. The following instances of reconstructive surgery do not count as elective cosmetic procedures:
    - Surgery required because of a previous surgical procedure that was necessary to treat an infection or disease.
    - Surgery following a medically necessary mastectomy.
    - Medically necessary surgery to correct damage caused by an accident or injury.
    - Surgery to correct a congenital defect.
    - Gender change does not count as elective cosmetic procedures.
- Any vague or unidentifiable condition that cannot be described by a standard medical nomenclature diagnosis and for which you're not undergoing tests or receiving treatment.
- A disability that begins while you're not at work because of a disciplinary action or administrative suspension.

- Any period during which you are incarcerated or otherwise confined to a correctional or similar penal facility as a result of a criminal conviction or public offense.

You cannot receive Short-Term Disability benefits for the same time period you receive Paid Time Off, banked essential absence days or alternate holidays.

When STD Benefits Begin

You must be actively at work for at least 60 days before you're eligible for STD benefits. You must be disabled under the terms of the Plan for seven consecutive calendar days before you can receive STD benefits. This is called your qualifying period. If you remain disabled and your disability is approved by Lincoln Financial, benefits begin on the eighth day. If Lincoln Financial has not received the information required to approve your disability by the end of the qualifying period, your pay will be suspended until it is received and approved by Lincoln Financial.

If you have banked essential absence days, alternate holidays or accrued PTO remaining in the calendar year, you'll be required to use them in that order as allowed by law to continue your pay during the qualifying period.

If you do not have any paid time available, the qualifying period will be unpaid.

Enhanced Pregnancy Leave

After you have been employed by Assurant for 60 days and are otherwise eligible under the Plan, you will be eligible for six weeks of enhanced Pregnancy Leave related to the birth of a child, paid at 100% of base pay. Up to eight weeks may be approved based on *medical necessity*, as determined by Lincoln Financial.

When Benefits End

Short-Term Disability benefits end on the earliest of the following dates:

- You reach the Short-Term Disability maximum benefit period.
- You're no longer disabled under this plan as determined by Lincoln Financial
- You return to work at your regular, pre-disability schedule.
- Your employment is terminated by the company for cause, or you have a change in employment status rendering you ineligible for benefits under the terms of the plan.
- You die.
- The day you refuse to follow a treatment plan.
- The day you cease to be under the care of a licensed physician (excluding yourself).
- The day you refuse to participate in a requested independent medical examination, testing and/or interview.
- The day you refuse to adhere to the modifications made to accommodate your disability; and
- The day you do not submit requested medical evidence of your disability.

If You Become Disabled Again If you become disabled again, the same disability period will continue, and you'll not need to satisfy an additional elimination period if:

- You return to active full duty work for less than 30 days and you then become disabled due to the same or related cause; or

- You return to active full duty for less than one day and become disabled due to a different cause.

If you return to active work for more than the time shown above and then become disabled again, you'll start a new period of disability. You'll be required to file a new claim and satisfy a new elimination period in order for benefits to begin.

In either of the above situations, you must call Lincoln Financial to let them know that you're disabled again. If you do not call within 14 days, your benefits may be reduced (as outlined above).

Long-Term Disability

Long-Term Disability Insurance is based on plan pay. If your plan pay changes throughout the year, the amount of insurance can change.

Definition of Disability

For the Long-Term Disability Plan, you're considered disabled if you satisfy either the Occupation Test or Earnings Test as determined by Lincoln Financial (the claims administrator for Long Term Disability).

Occupation Test -During the six-month qualifying period and the following 24 months, you must be

- Under the regular care and attendance of a doctor; and
- Unable to perform at least one of the material duties of your regular occupation due to injury, illness or pregnancy.

After that, you must be unable to perform at least one of the material duties of each gainful occupation for which your education, training, experience, age, physical and mental capacity qualifies you.

Earnings Test - You'll be considered disabled even if you're actually working, sickness or pregnancy prevents you from earning more than 80% of your indexed plan pay in any occupation for which your education, training or experience, age, physical and mental capacity qualifies you.

On each anniversary of the date your disability started, Lincoln Financial will use your indexed monthly pay to decide whether you're disabled under this test. If your actual earnings during any month are more than 80% of your indexed monthly pay, you'll not be considered disabled under the Earnings Test during that month. In making this determination salary, wages, partnership or proprietorship draw, commissions, bonuses or similar pay and any other income you receive or are entitled to receive will be included. However, sick pay and Short-Term Disability for periods not at work will not be included. Any lump sum payment will be pro-rated, based on the time over which it accrued or the period for which it was paid.

Lincoln Financial may require you to be examined by a physician periodically (at no cost to you) to confirm your continuing disability.

Long-Term Disability Schedule Amount and Benefit

The Benefit Amount up to 60% of your monthly plan pay, up to $15,000 per month. For each day of a period less than a full month, the Benefit Amount will be 1/30th of this amount. The LTD Core option is provided by Assurant at no cost to you and covers 50% of your plan pay, up to $15,000 per month. You have the opportunity to enroll in the LTD Core + Buy-Up option which covers 60% of your plan pay at the time of disability, up to $18,000. If you elect the LTD Core + Buy-Up option, you pay the *premium* for the Buy-Up option on an after-tax basis each pay period.

Your LTD benefit is the lesser of:

- The Benefit Amount minus the Offset Amount (listed below); or
- The monthly payment limit minus the sum of the Offset Amount and the Other Sources (listed below).

The minimum monthly benefit is the greater of $100 and 10% of your Benefit Amount. If your period of disability is less than a full month, the Disability benefit is 1/30th of $100 for each day of disability after the qualifying period ends.

Offset Amount

If you're eligible for any of the following benefits or other amounts, the total of all monthly benefits and other amounts plus the pro-rated amount of any lump sum payments will be subtracted from your gross LTD benefit:

- If you're eligible to receive any salary, wages, partnership or proprietorship draw, commissions or similar pay from any work you do, the Plan will not consider such income for the 12 consecutive months starting on the day you become entitled to it, as long as the sum of:
    - The income described above.
    - Gross LTD benefit; and
    - Benefits from any sources described in Other Sources is not more than 100% of your monthly plan pay. If the sum is more than 100% of your monthly plan pay, the Plan will subtract the amount over 100% when determining your benefit under this policy.

Proportionate Loss Monthly Calculation with Work Incentive Benefit

For the first 12 months, the work incentive benefit will be an amount equal to the Covered Person's Basic Monthly Earnings multiplied by the benefit percentage shown in the Disability Benefits, without any reductions from earnings. The work incentive benefit will only be reduced, if the Monthly Benefit payable plus any earnings exceed 100% of the Covered Person's Basic Monthly Earnings. If the combined total is more, the Monthly Benefit will be reduced by the excess amount so that the Monthly Benefit plus the Covered Person's earnings does not exceed 100% of his Basic Monthly Earnings.

Thereafter, to figure the Amount of Monthly Benefit the formula (A divided by B) x C will be used.

A = The Covered Person's Basic Monthly Earnings minus the Covered Person's earnings received while he is Partially Disabled. This figure represents the amount of lost earnings.

B = The Covered Person's Basic Monthly Earnings.

C = The Monthly Benefit as figured in the Disability provision of this policy plus the Covered Person's earnings received while he is Partially Disabled, (but, not including adjustments under the Cost of Living Adjustment Benefit, if included).

On the first anniversary of benefit payments and each anniversary thereafter, for the purpose of calculating the benefit, the term "Basic Monthly Earnings" is:

- Replaced by "Indexed Basic Monthly Earnings"; and
- Increased annually by 7%, or the current annual percentage increase in the Consumer Price Index, whichever is less.

The Monthly Benefit payable will not be less than the Minimum Monthly Benefit shown in the Disability Benefits. However, if an overpayment is due to Lincoln Financial, the Minimum Monthly Benefit otherwise payable under this provision will be applied toward satisfying the overpayment.

Other Income Benefits and Other Income Earnings

Other Income Benefits means:

- The amount for which the Covered Person is eligible under:
    - Workers' or Workmen's Compensation Laws.
    - Occupational Disease Law.
    - Title 46, United States Code Section 688 (The Jones Act).
    - Any work loss provision in mandatory "No-Fault" auto insurance.
    - Railroad Retirement Act.
    - Any governmental compulsory benefit act or law; or
    - Any other act or law of like intent.
- The amount of any Disability benefits which the Covered Person is eligible to receive under:
    - Any other group insurance plan of the Sponsor.
    - Any governmental retirement system as a result of his employment with the Sponsor; or
    - Any individual insurance plan where the *premium* is wholly or partially paid by the Sponsor. However, Lincoln Financial will only reduce the Monthly Benefit if the Covered Person's Monthly Benefit under this policy, plus any benefits that the Covered Person is eligible to receive under such individual insurance plan exceed 100% of the Covered Person's Basic Monthly Earnings. If this sum exceeds 100% of Basic Monthly Earnings, the Covered Person's Monthly Benefit under this policy will be reduced by such excess amount.
- The amount of benefits the Covered Person receives under the Sponsor's Retirement Plan as follows:
    - The amount of any Disability Benefits under a Retirement Plan, or Retirement Benefits under a Retirement Plan the Covered Person voluntarily elects to receive as retirement payment under the Sponsor's Retirement Plan; and
    - The amount the Covered Person receives as retirement payments when he reaches the later of age 62, or normal retirement age as defined in the Sponsor's plan.

- The amount of Disability and/or Retirement Benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act, which:
    - The Covered Person receives or is eligible to receive; and
    - His spouse, child or children receives or are eligible to receive because of his Disability; or
    - His spouse, child or children receives or are eligible to receive because of his eligibility for retirement benefits.
- Any amount the Covered Person receives from any unemployment benefits.

Other Income Earnings means:

- The amount of earnings the Covered Person earns or receives from any form of employment including severance; and
- Any amount the Covered Person receives from any formal or informal sick leave or salary continuation plan(s).
  Other Income Benefits, except retirement benefits, must be payable as a result of the same Disability for which Lincoln Financial pays a benefit. The sum of Other Income Benefits and Other Income Earnings will be deducted in accordance with the provisions of this policy.

If You Don't Apply for Offset Amounts or Sources of Income

If you're eligible for any Offset Amounts or Other Sources or would be if you applied for them on a timely basis, Short-Term Disability or Long-Term Disability benefits will be determined as if you were receiving them.

Lincoln Financial will estimate the amount payable from these other sources. Your disability benefit will not be reduced by the estimated amount if you:

- Provide satisfactory proof of application for other income benefits;
- Sign a reimbursement agreement under which, in part, you agree to repay Lincoln Financial for any overpayment resulting from the award or receipt of other income benefits;
- If applicable, provide satisfactory proof that all appeals for other income benefits have been made on a timely basis to the highest administrative level unless Lincoln Financial determines that further appeals are not likely to succeed; and
- If applicable, submits satisfactory proof that other income benefits have been denied at the highest administrative level unless Lincoln Financial determines that further appeals are not likely to succeed. It will reduce your LTD benefits by this estimate until Lincoln Financial receives proof that such benefits or other amounts are not payable or are denied. It will continue to offset your LTD benefit by its estimate of your Social Security benefit until it receives a notice of denial of the first level of appeal after an initial denial. (See Social Security Assistance under Special Features of the LTD Plan).

If the actual amount payable from an Offset Amount or Other Sources is different from Lincoln Financial's estimate, it will adjust your LTD benefit. If you were paid a lower benefit than you should have, you'll be paid the difference. If you were paid a higher benefit than you should have, you must pay back the difference. Any future LTD benefits that are due, including the minimum benefit, will be applied to the overpayments until it is reimbursed in full.

Lump Sum Benefits

If you receive benefits from any source in a lump sum, Lincoln Financial will pro-rate it on a monthly basis over the time in which it accrued, based on information from the source of the payment. If such period cannot be determined, it will be prorated at the lesser of the remainder of the Maximum Benefit Period or five years.

LTD Exclusions

The Disability Plan will not pay benefits for any time you're confined to any facility because you were convicted of a crime or public offense. In addition, the Plan will not provide benefits for a disability caused by:

- War or any act of war, whether declared or not.
- Intentionally self-inflicted injury, while sane or insane.
- Active participation in a riot.
- Committing or attempting to commit a felony or misdemeanor.
- Cosmetic surgery unless such surgery is in connection with an injury or sickness sustained while you're covered under this plan.
- No benefit will be payable during any period of incarceration.

The Plan will not pay benefits if:

- Assurant offers you the opportunity to return to limited work while you're disabled.
- You're functionally capable of performing the limited work that is offered; and
- You do not return to work when scheduled.

Benefits will end as of the date you were first scheduled to return to work. Subject to the terms of the LTD policy, benefits will recommence on the earlier of the date you return to such work, if you remain disabled or the date your disability worsens so that you're no longer capable of such work.

If You Receive a Cost of Living Increase

Your LTD benefit will not be reduced further if an Offset Amount or Other Source changes because of a cost-of-living increase.

When Benefits Begin

LTD benefits begin on the later of the completion of the six-month qualifying period and the day after you have exhausted your STD benefits. You must remain disabled as defined by the Plan throughout the qualifying period.

Duration of Benefits

After you meet the six-month qualifying period, Long-Term Disability benefits may continue until the earlier of:

- The date you're no longer disabled.
- The date you reach the maximum benefit period shown below

Maximum Benefit Period:

Age at Disability	Maximum Benefit Period
Less than age 60	Greater of SSNRA* or to age 65 (but not less than 5 years)

60	60 months
61	8 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69	and over 12 months

* SSNRA means the Social Security normal retirement age as figured by the 1983 amendment to the Social Security Act and any subsequent amendments and provides:

Year of Birth	normal retirement age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months 1958 66 and 8 months
1959	66 and 10 months
1960	and after 67

Minimum Monthly Benefit:

The Minimum Monthly Benefit is $100 or 10% of the Covered Person's Gross Monthly Benefit, whichever is greater.

Alcoholism, Drug Addiction, Chemical Dependency and Mental Illness

If you're disabled because of alcoholism, drug addiction, chemical dependency or mental illness, your maximum benefit period is 24 months. This is a combined maximum for all periods of disability and for all of these conditions.

Your period of disability is considered due to alcoholism, drug addiction, chemical dependency or mental illness if:

- You're limited by one or more stated conditions and
- You do not have other conditions which, in the absence of the stated conditions, would continue to exist, limit your activities and lead Lincoln Financial to conclude that you're disabled.

Benefits may be payable for more than 24 months, but not beyond the Maximum Benefit Period shown in the above chart, if you're hospital confined at the end of the 24-month period and you remain disabled. Benefits will continue for the length of your confinement If you're

not confined in a Hospital or Institution for Mental Illness and/or substance abuse, but you're fully participating in an Extended Treatment Plan for the condition that caused Disability, the Monthly Benefit will be payable for up to a combined period of 36 months.

When Benefits End

Your Long-Term Disability benefits end on the earliest of the following dates:

- You're no longer disabled as determined by Lincoln Financial.
- You reach the maximum benefit period.
- You die.
- You're determined to have perpetuated fraud on the Plan.
- You do not meet the claim requirements.
- You fail to comply with an independent medical examination, functional capacity evaluation, vocational assessment or other evaluation as may be required by the claims administrator.
- It is determined you're not following an appropriate medical plan as determined by the claims administrator.
- You fail to fully cooperate with an appropriate medical plan or rehabilitation plan without good cause.
- You refuse to accept a work opportunity with Assurant where workplace modifications or accommodations were made to allow you to perform the material and substantial duties of the job.
- You do not submit medical evidence of your disability when asked to do so by the claims administrator or you fail to provide objective medical documentation of a disability. Lincoln Financial can request additional medical documentation of an ongoing disability as often as it deems reasonably necessary).
- You're determined by the claims administrator to be able to work in your own occupation on a part-time basis, but choose not to.
- You refuse to fully participate in a Rehabilitation Program recommended by Lincoln Financial according to the individually written Rehabilitation Program.
- Your current partial disability earnings exceed 80% or your Indexed Basic Monthly Earnings. Because your earnings may fluctuate, Lincoln Financial will average earnings over three consecutive months rather than immediately terminating your benefit once 80% of indexed basic monthly earnings has been exceeded.

If You Become Disabled Again

If you become disabled again after you return to active work, the same period of disability will continue if:

- You return to your own occupation on an active employment basis for less than six continuous months and you become disabled due to the same or related cause; and you perform all the material and substantial duties of your own occupation; and you experience more than a 20% loss of covered earnings.

If your return to active full duty meets either of these conditions, your Long-Term Disability benefits will resume immediately. The maximum benefit period will continue on the day you become disabled again.

If you return to active full duty for more than the time shown above and become disabled again, you'll start a new period of disability.

Special Features of the Long-Term Disability Plan

Lincoln Financial
The Disability Plan is designed to encourage you to remain working as long as possible and return to work as soon as possible after a disability. Rehabilitation is an important part of the LTD Plan. Lincoln Financial will pay an increased Monthly Benefit while a covered person is fully participating in a Rehabilitation Program. Lincoln Financial must first approve the Rehabilitation Program in writing before a covered person can be considered for this benefit. If Lincoln Financial does not approve a Rehabilitation Program, the regular disability benefit will be payable provided the covered person is disabled under the terms of this policy. To be eligible for a Rehabilitation Incentive Benefit, the covered person must:

- Be disabled and receiving benefits under this policy; and
- Be fully participating in a Rehabilitation Program approved by Lincoln Financial.

Rehabilitation Increased Monthly Benefit

If the covered person is eligible for a Rehabilitation Incentive Benefit, the benefit percentage shown in the Disability Benefits, will be increased by 10%. The increased benefit will begin on the first day of the month after Lincoln Financial receives written Proof of the covered person's full participation in the Rehabilitation Program.

Disability Benefits Termination

If the covered person, at any time, declines to fully participate in an approved Rehabilitation Program recommended by Lincoln Financial, his Disability benefits will terminate on the first day of the month following the covered person's having declined to fully participate in the approved Rehabilitation Program. If Lincoln Financial recommends rehabilitation, no benefit will be paid from the date recommendation is made until Lincoln Financial receives the covered person's written agreement to fully participate in the Rehabilitation Program.

Discontinuation of the Rehabilitation Incentive Benefit

The Rehabilitation Incentive Benefit will cease:

- When the covered person is no longer fully participating in a Rehabilitation Program approved by Lincoln Financial.
- In accordance with the provision[s] entitled "Discontinuation of the Long-Term Disability Benefit"; or
- When the Rehabilitation Program ends.

For the purpose of this provision, "Rehabilitation Program" means a comprehensive individually tailored, goal-oriented program to return a disabled covered person to gainful employment. The services offered may include, but are not limited to, the following:

- Physical therapy.
- Occupational therapy.
- Work hardening programs.
- Functional capacity evaluations.

- Psychological and vocational counseling.
- Rehabilitative employment; and
- Vocational rehabilitation services.

Workplace Modification Benefit If a covered person is disabled or partially disabled and receiving a benefit from Lincoln Financial, a benefit may be payable to the Sponsor as part of the covered person's benefit for modifications to the workplace to accommodate the covered person's return to work or to assist the covered person in remaining at work.

Lincoln Financial will reimburse the Sponsor up to 100% of reasonable costs the Sponsor incurs for the modification, up to the greater of:

Long Term Disability Workplace Modification

- $2,000 or
- The equivalent of two (2) months of the covered person's Monthly Benefit.

To qualify for this benefit:

- The disability or partial disability must prevent the covered person from performing some or all of the material and substantial duties of his occupation; and
- Any proposed modifications must be approved in writing and signed by the covered person, the Assurant and Lincoln Financial; and
- Assurant must agree to make the modifications to the workplace to reasonably accommodate the covered person's return to work or to assist the covered person in remaining at work. Assurant's costs for the approved modifications will be reimbursed after:
- The proposed modifications have been made; and
- Written proof of the expenses incurred by Assurant has been provided to Lincoln Financial; and
- Lincoln Financial has received proof that the covered person has returned to and/or remains at work.

Social Security Assistance

Lincoln Financial may help a covered person in applying for Social Security Disability Benefits. In order to be eligible for assistance the covered person must be receiving a monthly benefit from Lincoln Financial. Such assistance will be provided only if Lincoln Financial determines that assistance would be beneficial. Lincoln Financial may reduce any overpayment calculated in your LTD benefit.

Three Month Survivor Benefit

Lincoln Financial will pay a lump sum benefit to the eligible survivor when proof is received that a covered person died:

- After disability had continued for 180 or more consecutive days; and
- While receiving a monthly benefit.

The lump sum benefit will be an amount equal to three times the covered person's last monthly benefit.

If the survivor benefit is payable to the covered person's children, payment will be made in equal shares to the children, including stepchildren and legally adopted children. However, if any of said children are minors or incapacitated, payment will be made on their behalf to the court appointed guardian of the children's property. This payment will be valid and effective against all claims by others representing or claiming to represent the children.

If there is no eligible survivor, the benefit is payable to the estate.

If an overpayment is due to Lincoln Financial at the time of a covered person's death, the benefit payable under this provision will be applied toward satisfying the overpayment.

How LTD Benefits Are Paid

Lincoln Financial pays benefits at the end of each month after it receives the required proof of your disability.

You owe no Federal income and Social Security taxes on LTD benefits. Depending on where you live, state and local taxes may be owed on your benefits.

All benefits are payable to you unless medical evidence indicates that a legal guardian should be appointed. In this case, Lincoln Financial will hold further benefits due until such time as a guardian of your estate is appointed; it will pay benefits to the guardian at that time. If any amount remains unpaid when you die, Lincoln Financial will pay your estate.

Filing a Claim

Lincoln Financial automatically starts to transition your STD claim to Long-Term Disability case manager internally approximately two months before the end of your STD claim if it appears you'll remain disabled by the end of your STD period. The Lincoln Financial claim team will review your file and requests additional information, if necessary.

Generally, Lincoln Financial makes a decision on your claim within 45 work days after it receives the required proof of your disability. Circumstances beyond Lincoln Financial's control may require an extension of time to process the claim.

Right of Recovery Provision

Assurant has the right to recover any Short-Term Disability benefits that are deemed to be paid incorrectly by either direct payment from you or as an offset of future benefits.

Pre-Existing Condition Exclusion

This policy will not cover any disability or partial disability:

- Which is caused or contributed to by, or results from, a Pre-Existing Condition; and
- Which begins in the first 12 months immediately after the covered person's effective date of coverage.

"Pre-Existing Condition" means a condition resulting from an injury or sickness for which the covered person is diagnosed or received treatment within six months prior to the covered person's effective date of coverage.

Termination of Coverage

Your eligibility under the Disability Plan automatically ends on the first of the following dates:

- You terminate, retire or die.
- The Plan is changed to eliminate coverage for your eligible class.
- You cease to be an eligible employee.
- You stop active work (See Continuing Coverage During Approved Leaves of Absence).
- The insurance policy ends.

If you're disabled on the day your coverage terminates and you remain disabled long enough to satisfy the qualifying period, benefits will be payable under the terms of the Plan.

Conversion

You do not have option of converting to a private policy to continue your LTD benefits when you leave your employment with Assurant.

Family-Friendly Benefits

Assurant believes in the importance of providing benefits and programs that support its employees, both in their professional and personal lives. As a part of this belief, Assurant strives to promote a positive work-life balance, which allows employees to succeed in their professional life while also spending important time away from work, whether with their friends and family or staying involved in activities and organizations important to them.

Paid Parental Leave

The arrival of a new family member is an exciting event in an employee's life and Assurant wishes to encourage the celebration of such an important event. This Paid Parental Leave benefit has been developed to support employees in this effort by providing paid leave for the birth or placement of a child.

Eligibility

You must have completed 90 days of employment and be actively employed at the time of the qualifying birth, adoption or placement for adoption or surrogacy.

For Paid Parental Leave, an eligible parent is defined as an employee who is eligible to receive benefits under the Plan and who:

- Who gives birth to a child.
- Whose spouse or partner has given birth to a child.
- Who adopts a child who is under the age of 18. Paid Parental leave benefits are not available in circumstances in which a child is not newly matched for adoption (e.g., when a stepparent is adopting a partner's child).
- Who has a child placed in their home in cases of adoption or surrogacy when the employee is the intended parent.

Employees may only use Paid Parental Leave benefits once every rolling 12-month window.

If both parents work for the company, each eligible employee may take Paid Parental Leave.

Duration

Effective for a qualifying birth, adoption, or surrogacy placement occurring on or after January 1, 2027, eligible employees may receive up to six weeks of Paid Parental Leave at 100% of pay.

You can take the time off in 6 consecutive weeks or split it into two separate 3-week increments. Parental leave must be taken within 12 months of the birth or placement of a child and is in addition to any pregnancy leave taken under the Short-Term Disability plan. Any leave beyond the six weeks under this benefit must be taken pursuant to the Company's PTO policy, FMLA policy, STD benefits, or be approved in advance by the employee's manager.

Birth, adoption, or surrogacy of multiples (e.g., twins, triplets) does not increase the length of Paid Parental Leave granted for that event.

Cash, cash equivalents, or other benefits may not be substituted for this offering in the event that the employee chooses not to use the entire six weeks provided by this policy.

Administration

When an employee is eligible for FMLA leave as defined in the FMLA policy, Paid Parental Leave will be taken concurrently with FMLA leave. When applicable, STD is also taken concurrently with FMLA Leave.

In situations where the employee is eligible for Pregnancy Leave STD and completes the process to receive such benefits, Paid Parental Leave will be applied after STD benefits are exhausted. When the employee is not eligible for Pregnancy Leave, Paid Parental Leave will be applied before any paid or unpaid time off.

Employees must apply for Paid Parental Leave as soon as they know of their intention to take this leave. Employees must contact Lincoln Financial to apply for Paid Parental Leave in advance. Employees who were not eligible for Pregnancy Leave under the STD Plan will be required to provide proof of birth or placement of a child to Lincoln Financial before the requested leave can be approved. In addition, if the leave is foreseeable, the employee must provide their manager 30 days' notice of their intention to take Parental Leave. Otherwise, notice must be given as soon as practicable.

Compensation

For employees whose annual salary review occurs during a Paid Parental Leave, that review will occur as soon as practicable upon the employee's returning to work. Salaries will not be changed during a Paid Parental Leave. In the event that an employee is eligible for short-term disability (STD) benefits, the Paid Parental Leave will be applied after the STD benefits have ended.

Adoption Assistance

The adoption of a child is a significant decision and employees who build families through adoption often incur sizable expenses in addition to the lengthy, sometimes stressful adoption process. Assurant's Adoption Assistance benefits provide financial reimbursement of adoption-related expenses for employees who adopt a child. These benefits are in addition to the leave of absence provided by the Company's Paid Parental Leave benefit.

Eligibility

You must be employed by Assurant for at least 90 calendar days and be a benefits-eligible employee for Adoption Assistance benefits. If you and your spouse or *domestic partner* both work at Assurant, only one employee can utilize the financial benefit. You must be actively employed at the time of the adoption and when any financial reimbursement is made.

Temporary or leased employees and independent contractors are not eligible for Adoption Assistance benefits.

Financial Reimbursement

Eligible adoption-related expenses will be reimbursed to a lifetime maximum of $20,000 (combined with the Surrogacy Assistance benefit limit). Most expenses directly related to the adoption are reimbursable. These include:

- Application fees.
- Home studies.
- Agency and placement fees.
- Legal fees and court costs
- Immigration, immunization and translation fees.
- Transportation and lodging.
- Parent, child and family adoption counseling.
- Medical expenses for the adoptive child prior to placement for adoption.
- Medical expenses for the adoptive child's birth mother.
- Temporary foster care costs.

Expenses not eligible for reimbursement include:

- Expenses paid or incurred before you became an Eligible Employee under this benefit.
- Expenses reimbursed or reimbursable under a federal, state, or local program.
- Expenses reimbursed under another employer-sponsored program;
- Expenses that violate federal or state law.
- Expenses associated with a surrogate parenting arrangement.
- Compensation to the birth mother.
- Voluntary donations or contributions to the adoption agency.
- Cost of living expenses and personal items such as: rent, utilities, food, clothing, over-the-counter supplements, toys, furniture, etc.
- Loss of income, including but not limited to, loss of income due to complications of pregnancy such as bed rest for the birth mother.

To qualify for reimbursement under this Program, the adopted child must be under the age of eighteen and may not be a stepchild of the eligible employee.

Procedure for Reimbursement

Assurant has retained WINFertility, Inc. (WIN) to administer the program. WIN will review and validate reimbursable adoption expenses submitted by eligible employees who want to take advantage of this benefit.

Eligible employees MUST enroll with WINFertility by completing the Initial Notification & Benefit Verification Form provided by WINFertility. WINFertility will verify the applicant's eligibility with Assurant's Benefits Department. You can reach a WINFertility Service Team Member at 1-866-227-2690, Monday - Friday 9:00 a.m. - 7:30 p.m. EST.

Eligible employees may apply for reimbursement for eligible expenses once the adoption has been legally finalized, but no later than 90 days from the date the adoption is legally finalized.

Required Documentation: Notarized copy of the adoption decree or a notarized court order. In addition, for all foreign adoptions, proof the adopted child legally resides with the eligible employee in the U.S., such as U.S. Passport, U.S. Visa, or U.S. Birth Certificate; copies of original itemized bills on company letterhead, along with itemized receipts and proof of payment, such as cancelled checks or bank statements, showing payment has been made for all eligible expenses being submitted for reimbursement.

Complete and submit your Adoption Reimbursement Application, available from WINFertility, along with the Required Documentation and Itemized Receipts to:

WINFertility, Inc.
Greenwich American Center
One American Lane, Terrace Level
Greenwich, CT 06831
Attn: WINFertility Specialty Services

OR email to: winspecialtyservices@win-healthcare.com

The legality of an adoption agreement may vary from the locale from which you are adopting. It is *your responsibility* to make sure the adoption arrangement you are entering into conforms with all laws and regulations before submitting eligible expenses for reimbursement under the program. Assurant will only provide this benefit to support adoption arrangements that comply with all applicable laws.

Income Tax

It is intended that benefits paid under the Adoption Assistance benefit may be excludable from your income for federal income taxes to the extent permitted under Internal Revenue Code §137. It will be the Employee's responsibility to determine any income tax implications of adoption. While Assurant may provide resources and information for employees, this shall not be construed as tax guidance nor will Assurant assume any additional tax liabilities. Employees are encouraged to consult with a qualified tax professional to discuss any tax implications. Employees should refer to Internal Revenue Service instructions entitled Qualified Adoption Expenses regarding taxation of financial benefits, tax credits and tax exclusions.

Surrogacy Assistance

A surrogacy journey is a significant decision and employees who build families through surrogacy often incur sizable expenses in addition to the lengthy, sometimes stressful surrogacy process. Assurant's Surrogacy Assistance benefits provide financial reimbursement of surrogacy-related expenses for employees who build their family through the surrogacy process. These benefits are in addition to the leave of absence provided by the Company's Paid Parental Leave benefit.

Eligibility

You must be employed by Assurant for at least 90 calendar days and be a benefits-eligible employee who is the intended parent for Surrogacy Assistance benefits. If you and your spouse or *domestic partner* both work at Assurant, only one employee can utilize the financial benefit. You must be actively employed at the time of the surrogacy and when any financial reimbursement is made. Temporary or leased employees and independent contractors are not eligible for Surrogacy Assistance benefits. Note: Benefits will not be provided under the program for an Assurant employee or spouse/*domestic partner* acting as a surrogate to another family who is not covered under the Assurant health plan. Under this scenario, neither the intended child or services related to the pregnancy are covered under the Assurant health plan.

Financial Reimbursement

Eligible surrogacy-related expenses will be reimbursed to a lifetime maximum of $20,000 (combined with the Adoption Assistance benefit limit). Most expenses directly related to the surrogacy are reimbursable. These include:

- Court costs, legal costs, and attorney's fees.
- U.S.-based surrogacy agency fees.
- Travel expenses for the Intended Parents or gestational carrier specifically related to the surrogacy occurrence.
- Egg/sperm donation agency fees.
- Fees charged by the surrogacy agency to administer the surrogacy occurrence.
- Screening costs for gestational carrier and egg or sperm donor.
- Egg or sperm retrieval fees, IVF, and medical costs, if not covered by another source.
- The cost of transfer of the embryo to the gestational carrier.
- Donor fertility costs and fees not covered by another source.
- Egg or sperm shipping and transport fees.
- Pregnancy medical expenses related to surrogacy not covered by another source.
- Immigration and immunization fees associated with a surrogacy occurrence.
- Unreimbursed medical expenses of the child(ren) and/or birth mother/surrogate.

Expenses not eligible for reimbursement include:

- Any surrogacy arrangement that is not legally valid and recognized in the U.S.
- Any expenses that violate a state, federal or local law.
- Compensation to gestational carrier.
- Compensation to egg or sperm donor.
- Voluntary donations or contributions to the surrogacy agency.
- Costs paid using funds from any federal, state, or local program for surrogacy.
- Expenses incurred prior to January 1, 2023 or the eligible employee's most recent hire date, whichever is later.
- Expenses submitted later than 90 days following the date the surrogacy becomes final post-birth.
- Guardianship or custody costs that are not associated with the legal surrogacy process for the child.

- Cost of living expenses and/personal items such as: rent, utilities, food, clothing, over-the-counter supplements, toys, furniture, etc.
- Loss of income, including but not limited to, loss of income due to complications of pregnancy such as bed rest for surrogacy.
- Any childcare expenses.
- Any costs associated with transferring and/or terminating a surrogacy arrangement.
- Expenses reimbursed under another employer program.
- Any expenses not expressly stated as included shall be deemed to be excluded.

Procedure for Reimbursement

Assurant has retained WINFertility, Inc. (WIN) to administer the program. WIN will review and validate reimbursable surrogacy expenses submitted by eligible employees who want to take advantage of this benefit.

Eligible employees MUST enroll with WINFertility by completing the Initial Notification & Benefit Verification Form provided by WINFertility. WINFertility will verify the applicant's eligibility with Assurant's Benefits Department. You can reach a WINFertility Service Team Member at 1-866-227-2690, Monday - Friday 9:00 a.m. - 7:30 p.m. EST.

Deadline to Submit Reimbursement: Eligible employees may apply for reimbursement for Eligible Expenses once the surrogacy has been legally finalized post-birth, but no later than 90 days from the date the surrogacy is legally finalized.

Required Documentation to Seek Reimbursement: Copy of the certified birth certificate and copy of notarized court order acknowledging parentage of the Intended Parent(s) as the child's permanent legal parent(s); copies of original itemized bills on company letterhead, along with itemized receipts and proof of payment, such as cancelled checks or bank statements, showing payment has been made for all eligible expenses being submitted for reimbursement.

Complete and submit your Surrogacy Reimbursement Application, available from WINFertility, along with the Required Documentation and Itemized Receipts to:

WINFertility, Inc.
Greenwich American Center
One American Lane, Terrace Level
Greenwich, CT 06831
Attn: WINFertility Specialty Services

OR email to: winspecialtyservices@win-healthcare.com

The legality of a surrogacy agreement may vary from state to state. It is *your responsibility* to make sure the surrogacy relationship you are entering into conforms with all laws and regulations before submitting eligible expenses for reimbursement under the program. Assurant will only provide this benefit to support surrogacy arrangements that comply with all applicable laws and may deny payment for any international surrogacy arrangement.

Income Tax

It is intended that benefits paid under the Surrogacy Assistance benefit may be excludable from your income for federal income taxes to the extent permitted under Internal Revenue

Code §137. It will be the Employee's responsibility to determine any income tax implications of surrogacy. While Assurant may provide resources and information for employees, this shall not be construed as tax guidance nor will Assurant assume any additional tax liabilities. Employees are encouraged to consult with a qualified tax professional to discuss any tax implications.

Legal Assistance

The Legal Assistance benefits offered under the Plan are insured by a carrier, LegalEASE. This SPD provides a summary of these insured Legal Assistance benefits. To the extent that information in this SPD for the Legal Assistance benefit conflicts with the insurance policy and/or certificate booklet, the insurance policy and/or insurance booklet govern. To request a copy of the insurance policy and/or certificate booklet for any of the insured benefits, contact the People Experience Center at 1-866-324-6513.

Enrollment

Enrollment in this plan is for the entire calendar year unless you experience a qualified life event and report it through MyHR within 60 calendar days of the qualified life event (30 calendar days to initially report plus a 30 calendar day grace period). If you enroll, your per pay period cost of coverage will be paid on an after-tax basis.

For more information on LegalEASE:

- Visit legaleaseplan.com/assurant for detailed information on plan benefits, how to use the plan and FAQs.
- Talk to a LegalEASE Customer Care Counselor toll-free from 7 a.m. to 7 p.m. Central, Monday through Friday at 1-800-248-9000.
- E-mail a LegalEASE Customer Care Counselor via "Contact Us" form on legaleaseplan.com/assurant.

Covered Services

The plan provides access to form legal documents and covers a range of services including tax services and representation in certain adoptions, conservatorships, small claims court proceedings, real estate transactions, divorce proceedings, traffic offenses and more. Please contact LegalEASE at 1-800-248-9000 or you can visit legaleaseplan.com/assurant for a more detailed summary of which services are covered, to what extent and whether there are price differences between a Network Attorney and a Non-Network Attorney.

- **Services Not Covered**

The plan does not cover matters against the carrier, the policyholder or a member against the interests of the named plan member under the same Certificate. Pre-existing legal matters are also excluded. Please contact LegalEASE at 1-800-248-9000 or you can visit legaleaseplan.com/assurant for a more detailed summary of which services are not covered.

Waiver of *Premium*

Death Benefit - This waiver of *premium* will cover the surviving spouse or *domestic partner* and insured *dependents* for one year from the date the named insured passed away. After that

year, the spouse, *domestic partner* or insured *dependent* can roll their membership to the conversion plan.

Military Leave - Should a named insured be called to active duty for a period of more than 30 consecutive days for the purposes of military service or of responding to a declared national emergency, coverage for the spouse and the insured *dependents* will continue, without the payment of *premium*, for the length of the named insured's absence and for so long as the named insured remains eligible for benefits through the policyholder.

Conversion

You may continue this insurance when you no longer qualify as an employee or as a member of the group to which this policy is issued. You must notify LegalEASE within 90 days of this disqualifying event to make arrangements for *premium* payment. Any questions regarding the LegalEASE conversion plan, please contact LegalEASE at 1-800-248-9000.

Plan Administrator

If you have any questions or concerns, please contact the plan administrator for the legal assistance program by email at implementation@legalaccessplans.com, 5151 San Felipe, Ste 2300, Houston, TX, 77056 or at 1-800-248-9000.

An Assurant insurance company is the underwriter of the prepaid group legal insurance contracts marketed and administered by LegalEASE throughout the United States. All questions and inquires related to this product should be directed to LegalEASE.

Severance Pay Plan

The Assurant Severance Pay Plan (Severance Plan) is designed to help ease your transition to a new job in the event of an involuntary termination of your employment due to a reduction in force, job elimination, corporate divestiture, corporate reorganization or other qualifying reason as determined by the Plan Administrator (each a "Severance Event" for purposes of the Severance Plan).

In all cases, severance is granted entirely at the discretion of the Plan Administrator. All aspects of the Severance Plan (including eligibility and the amount of benefits) are subject to the interpretation and discretion of the Plan Administrator, whose decisions are final and binding.

As with the remainder of the SPD to the Assurant Health & Welfare Plan (Plan), defined terms in the Severance Plan are in italics and their definitions are found in the Glossary to the SPD. Assurant as used in the Severance Plan refers to Assurant, Inc. or each of its Affiliates authorized to participate in the Plan.

Eligibility

You may be eligible to participate in the Severance Plan if you are eligible to participate in the Assurant Health & Welfare Plan at the time of your termination and your employment is involuntarily terminated by Assurant due to a Severance Event.

Any other person employed by Assurant who is designated by the Plan Administrator, at its sole discretion, as eligible also may participate in the Severance Plan.

Further, you must demonstrate acceptable job performance, return all company property, work through the date given by your manager and timely sign (and not revoke) a Severance Agreement to be eligible for Severance Plan benefits. You may choose not to sign the Severance Agreement or you may choose to revoke an already signed Severance Agreement but doing so will disqualify you from receiving any benefits under the Severance Plan.

How the Plan Works

You'll be notified in writing if you're eligible for severance benefits. The notification will include your Severance Date and the benefit amount. Closer to your Severance Date, you'll receive a Severance Agreement in the form presented by Assurant. You must sign this Severance Agreement within 45 calendar days after receipt, not revoke the Severance Agreement and return it as instructed before benefits can be paid.

Before you can receive a severance payment, you must meet the following requirements:

- Return all property that belongs to Assurant;
- Continue to work in a satisfactory manner during any notice period as required through your Severance Date;
- Cooperate with your manager or supervisor in transitioning all your work; and
- Comply with all the requirements outlined in your Severance Agreement.

Benefits

Subject to all of the eligibility requirements previously provided and the discretion of the Plan Administrator, your severance benefit may have four components:

- Severance payment;
- COBRA offset;
- Outplacement services; and
- Waiver of tuition reimbursement repayment, if any.

The severance payment will be made in a lump sum, less applicable reductions, and will be processed as soon as administratively feasible. You'll be able to sign your Severance Agreement on or after your Severance Date. You'll receive your severance payment in the same manner you have elected to receive your regular paycheck.

Severance Payment

Generally, your severance payment is your weekly base salary multiplied by the number of weeks in your severance period. You may additionally receive a COBRA offset and outplacement services as described below.

The Plan Administrator determines the number of weeks for every eligible completed year of service measured from your original hire date or adjusted service date (as described in the Rehire Severance Calculation below) through to your Severance Date. This is called your severance period.

For most employees, the severance period is 2 weeks for every completed year of service, or the severance minimum outlined in the chart below, whichever is greater. For certain employees, their severance period is based on their position with Assurant regardless of their years of service, as outlined in the chart below.

Tier	Group	Severance (2 weeks per full year of service)[1]
1	Job Grades 1 - 8	4 weeks minimum
2	Job Grades 9 - 13	13 weeks minimum
3	Job Grades 14 - 17	26 weeks minimum
4	Job Grades 18+	52 weeks minimum

The minimum severance period is 4 weeks; the maximum is 52 weeks.

All severance awards are subject to the discretion of the Plan Administrator, and the Severance Plan is subject to amendment or termination at any time as further detailed in this SPD.

Rehires

If you're rehired by Assurant before the end of your severance period, you must repay that portion of your severance payment that represents the period between your rehire date and the end of your severance period, less $500, which you keep as consideration for your release of claims in the Severance Agreement.

You must make such repayment within 30 calendar days after your rehire date or within a period of time approved by the People Business partner for the business segment from which your severance was paid. If you accept a position that begins after your severance period, you will not be required to repay any portion of your severance payment.

Rehire Severance Calculation

If you're a rehired employee, the calculation of your years of service will include prior service period(s) provided you were rehired within five years. Assurant will not give any credit for the gap in employment. If you previously received severance upon departure from Assurant, any service included in the calculation of the prior severance payment(s) will not be included in the calculation of this or any subsequent severance payment.

[1]For employees who receive commission, severance pay is calculated using current salary plus total commissions paid in the twelve (12) months prior to the date the severance calculation is requested

COBRA Offset

The COBRA offset is a lump sum payment comprised of the company's contribution to your Health and/ or Dental coverage plus the 2% COBRA administrative fee to help offset any COBRA costs you may incur. The company subsidy will be grossed up for taxes, but the COBRA offset is subject to any applicable tax withholding. The COBRA offset will equal two months of the company contribution. Please note that notwithstanding the foregoing, a COBRA offset may not be paid if or to the extent that COBRA benefits are being subsidized under a government-sponsored program at the time of your employment termination.

If you waived health and/or dental coverage, no COBRA offset will be paid. You must participate in the Assurant Health and/or Dental Plan on the day before your Severance Date to be eligible for the COBRA offset; however, you do not need to elect to continue your coverage under COBRA in order to receive this payment.

Outplacement Services

Outplacement services will be provided by an external company specializing in these services. The tier of outplacement services is based on the following:

Tier	Group	Outplacement
1	Job Grades 1 - 8	Workshop
2	Job Grades 9 - 13	3 month program
3	Job Grades 14 - 17	6 month program
4	Job Grades 18+	12 month program

What happens if you are receiving tuition reimbursement at the time of your Severance Event?

If you're receiving tuition reimbursement, your eligibility for the Tuition Reimbursement Program ends on your Severance Date. However, as a severance benefit, you can be reimbursed for eligible expenses for courses begun before your Severance Date if your termination is due to a Severance Event. You must submit all required documentation to the People Experience Center within 45 days of the end of your courses(s). In addition, you'll not be required to reimburse Assurant for amounts, if any, paid to you in the six months (undergraduate level) or 12 months (graduate level) prior to your Severance Date.

WARN Act Implications

Severance payments may be reduced dollar-for-dollar by the amount you are paid to satisfy the Worker Adjustment and Retraining Act (WARN) or similar state/local law if:

- The reduction in force triggers the advance employee notification of the loss of employment requirement under WARN or similar state/local law and
- The Plan Administrator or its designees determine that you are not needed to work through the full WARN notice period.

You will be kept on payroll until the end of the WARN notice period as may be needed to comply with the requirements of WARN or similar state/local law to keep you "whole" in regard to employee benefits.

Reduction in Severance Pay

Payments under the Severance Plan may be reduced by the following:

- Applicable federal, state, local income or employment taxes, tax levies, and any legally enforceable garnishments;
- Amounts you may owe to Assurant including, but not limited to, overpayments related to leaves of absence or PTO; and
- Amounts paid to you under WARN, or any similar state or local law.

Special Features

Short-Term Incentive Plan (STIP)

If you're a participant in the STIP and your Severance Date is:

Between Jan. 1 – March 15:
You'll be eligible for the prior year's STIP award based on actual results, your STIP target percentage, and your prior year's eligible earnings, subject to the terms of the STIP. This will be paid at the same time payment is made to active participants, generally on or around March 15. You will not be eligible for the current year's STIP award.

April 1 or later and meet the definition of retirement in the STIP program summary: You'll be eligible for the STIP award for the year in which you terminate, based on actual results, your STIP target percentage, and your eligible STIP earnings for the portion of the year during which you were an active employee, subject to the terms of the STIP. This will be paid at the same time payment is made to active participants, generally on or around March 15 of the following year.

Fourth quarter: You'll be eligible for the STIP award for the year in which you terminate, based on actual results, your STIP target percentage, and your eligible STIP earnings for the portion of the year during which you were an active employee, subject to the terms of the STIP. This will be paid at the same time payment is made to active participants, generally on or around March 15 of the following year.

Assurant Long Term Equity Incentive Plan (ALTEIP)

If you're eligible for ALTEIP, you'll be vested in your awards on a pro-rata basis as set forth in your award agreement unless you are retirement eligible under the terms of that plan on your Severance Date, in which case you may fully vest in certain shares as provided in your award agreement. Restricted Share Units (RSUs) shares will be issued as soon as administratively feasible after your termination date. Performance Share Units (PSUs) shares will be issued at the end of the three-year performance cycle, as applicable, based on actual results.

Impact of Severance on Other Benefits

Your participation in all other employee benefit plans sponsored by Assurant will end as of your Severance Date unless continued according to the terms of the plan, program or policy (for example, health coverage under COBRA). Any benefits received under the Severance Plan will not be included as eligible compensation under any other benefits.

Exclusions

You'll not be eligible for benefits under the Severance Pay Plan if:

- You resign or voluntarily terminate employment, even if you do so in anticipation of an involuntary termination;
- You're involuntarily terminated and are offered Substantially Similar Employment with Assurant, whether or not you accept the offer;
- You're involuntarily terminated in connection with the sale or transfer of any portion of Assurant and you're offered Reasonably Comparable Employment with the buyer or transferee, whether or not you accept the offer;

- You’re involuntarily terminated and are offered an opportunity to interview for Substantially Similar Employment with Assurant and you refuse to interview or participate meaningfully in the process;
- You’re involuntarily terminated in connection with outsourcing or the sale or transfer of any portion of Assurant and you’re offered the opportunity to interview for Reasonably Comparable Employment with the buyer or transferee and you refuse to interview or participate meaningfully in the process;
- You’re involuntarily terminated for cause;
- You’re transferred or reassigned to a position of Substantially Similar Employment;
- You’re an intern; • You’re eligible to receive benefits under a separate severance plan, an individual Severance Agreement or Change in Control Agreement; or
- You have otherwise waived participation under this Plan.

For purposes of the Severance Plan, “cause” means you engaged in one or more of the following:

- Neglect or misconduct in the performance of your employment duties and responsibilities;
- A material breach of fiduciary duty;
- Conduct that could injure the integrity, character or reputation of Assurant; or
- Unsatisfactory job performance.

The Plan Administrator, in its sole discretion, determines whether you are terminated for cause. In addition, please note, the Severance Plan should not be construed or interpreted as guaranteeing employment through any date or altering your at-will employment status. You remain an at-will employee and either you or Assurant can terminate this employment relationship at any time, with or without reason and with or without notice.

If, based on information received after your Severance Date, the Plan Administrator discovers that you could have been terminated for cause, you will be treated as having been terminated for cause for purposes of the Severance Plan.

Payment Upon Your Death

If you die after your Severance Date, but prior to being paid severance benefits, payment will be made to your estate. No severance payment shall be available if you die prior to your Severance Date, even if you have already been given notice that you will receive a severance payment upon termination.

Claims Procedures Right to File a Claim

If you believe you are entitled to a severance benefit which has not been received or which is different than that which has been communicated to you, you may file a claim in writing with the most senior People Business Partner at your former employing Assurant entity. You must explain the basis for your claim and provide any supporting facts and evidence then known to you. You must file your claim within 180 days of your Severance Date. Claims filed beyond this timeframe will result in the denial of your claim and may result in your disqualification for payment of benefits under the Severance Plan.

Initial Review of Claim

Your claim will be reviewed and if the initial determination is a denial, in whole or in part, of your claim, you will be notified within 90 calendar days of the date the claim is submitted unless an extension of time is required to make the initial determination. If an extension of time is required, you will be notified in writing of the extension within the initial 90-day period after receipt of the claim. The extension notice will also include the date by which the determination is expected to be made. Any needed extension will not extend more than an additional 90 calendar days from the end of the initial 90-day period. Notice of the full or partial denial of your claim will set forth the specific reasons for such denial including specific references to the Plan provisions on which the denial was based and, if applicable, what information or materials would be required in order to reverse the denial, and an explanation of the procedure for review of the denial.

Final Review of Claim

You may appeal the denial to the Plan Administrator in writing within 60 days after receiving the initial notice of the denial. The request for review must explain the basis for the appeal, together with supporting facts and evidence. You will be given the opportunity to review relevant Plan documents in preparing your appeal. The Plan Administrator may require you to submit such additional facts, documents or other material as it deems necessary or advisable in making its review.

The Plan Administrator will provide you with a written or electronic notice of the decision within 60 days after receipt of the request for review, except that, if there are special circumstances requiring an extension of time for processing, the 60-day period may be extended for an additional 60 days. If the Plan Administrator determines that an extension of time is required, you will be notified in writing of the extension within 60 days after the Plan Administrator's receipt of the request for review. The extension notice will also include the date by which the Plan Administrator expects to complete the review.

The Plan Administrator will communicate its decision to you in writing, and if the denial is confirmed, in whole or in part, the communication will explain the reasons for the decision and specific references to the Plan provisions on which the decision is based. Any suit for benefits must be brought within one year after the date the Plan Administrator has made a final denial (or deemed denial) of the claim.

Requirement to Follow Claims Procedure

Utilization of these claims procedures is a condition of payment of benefits under the Severance Plan. Failure to follow the claims procedure will result in the denial of your claim, and may result in your disqualification for payment of benefits under the Plan.

Other Severance Benefit Information You Should Know

Plan Information

The Severance Plan is one of the benefit plans provided through the H&W Plan. The Assurant Benefit Plans Committee as Plan Administrator shall have the exclusive right and discretion to interpret the terms and conditions of the plans, and to decide all matters arising in their administration and operation, including questions of fact and issues pertaining to eligibility for, and the amount of, benefits to be paid by the plans. Any such interpretation or decision

shall, subject to the claims procedure described herein, be conclusive and binding on all interested persons, and shall, consistent with the Plans' terms and conditions, be applied in a uniform manner to all similarly situated participants and their covered *dependents*.

Your participation in the Severance Plan does not guarantee your continued employment at the company. If you quit, are discharged or laid off, the Severance Plan does not give you a right to any interest in the Severance Plan except as specifically provided for in the plan documents.

The Plan Administrator is authorized to delegate its administrative duties to one or more individuals or committees within Assurant or its affiliated companies, or to one or more outside administrative service providers.

Severance benefits under the Severance Plan are an employee welfare benefit covered by the Employee Retirement Income Security Act of 1974 (ERISA). The Plan shall be construed, administered, and governed under the laws of the State of Georgia, to the extent not preempted by ERISA or other federal law. If you participate in an ERISA-covered plan, you have certain rights and protections based on ERISA. Those are detailed under the separate **Your Rights Under ERISA** section of this H&W SPD.

Except as may otherwise be required by law, the benefits under the Severance Plan will be paid solely from the assets of the employing Assurant entity and nothing herein will be construed to require Assurant or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any participant. No participant or other person shall have any claim, right or entitlement to, or interest in, any fund, account, or asset of Assurant from which any payment under the Severance Plan is made.

The records of Assurant with respect to employment history, years of service, base pay and all other relevant matters shall be conclusive for all purposes of the Severance Plan.

The benefits payable under the Severance Plan shall not be subject to assignment, execution, attachment, pledge or bankruptcy, and any attempt to cause any benefits to be so subjected shall not be recognized.

Neither the establishment of the Severance Plan, not any modification thereof, nor the payment of any benefits hereunder, shall be construed as giving to any participant, employee (or any *beneficiary* of either), or other person any legal or equitable right against Assurant or any officer, director or employee thereof; and in no event shall the terms and condition of employment by Assurant of any employee be modified or in any way affected by the Severance Plan. Nothing contained in the Severance Plan shall be held or construed to create any liability upon any employer company to retain any employee in its service or to terminate employment only for cause. All eligible employees shall remain subject to discharge or discipline to the same extent as if the Severance Plan had not been put into effect.

This Severance Plan is intended to meet the exemption for severance benefits plans, short-term deferrals, reimbursement arrangements and in-kind benefits, and the COBRA exemption. Accordingly, the Severance Plan shall be interpreted and administered in a manner so that any amount payable or benefit provided hereunder shall be paid or provided in a manner and at such time and in such form that is either exempt from or compliant with the applicable requirements of Section 409A of the Internal Revenue Code of 1986, as amended, and applicable guidance and regulations issued thereunder ("Section 409A"). Nevertheless,

the tax treatment of the benefits provided under the Severance Plan are not warranted or guaranteed. Neither Assurant nor any of its directors, officers, employees, or advisors shall be held liable for any taxes, interest, penalties or other monetary amounts owed by the participant as a result of the application of Section 409A.

Plan Administration

The Assurant Benefit Plans Committee as Plan Administrator (or its delegates, including third-party administrators and insurers deciding claims and appeals) shall have the exclusive right and discretion to interpret the terms and conditions of the Assurant Health and Welfare Plan, and its component benefit options, to decide all matters arising in their administration and operation, including questions of fact and issues pertaining to eligibility for, and the amount of, benefits to be paid by the Plan. Any such interpretation or decision shall, subject to the claims procedure described herein, be conclusive and binding on all interested persons, and shall, consistent with the Plan's terms and conditions, be applied in a uniform manner to all similarly situated participants and their covered *dependents*. Benefits will be paid only if the Plan Administrator (or a delegate) determines in its sole discretion that the claimant is entitled to them.

Contact Information

The table below shows contact information for the insurance companies and service providers that administer Assurant benefits for the purpose of filing claims and for questions or comments. For general information regarding any of your benefits, contact:

The People Experience Center
P.O. Box 16368
Atlanta, GA 30321
1-866-324-6513
Ask ERIN. ERIN can be accessed across multiple channels, including your desktop, MS Teams, the web, MyHR and via mobile app.

The People Experience Center representatives are available Monday through Friday, 8:30 a.m. – 6:30 p.m. ET.

Plan	Address for Claims	Phone	Web Address
Health (including behavioral health and substance abuse claims)	Anthem BlueCross BlueShield P.O. Box 105187 Atlanta, GA 30348-5187 Group # 270144	1-855-285-4212	anthem.com
Anthem 24/7 Nurseline	Not applicable	1-800-700-9184	anthem.com
Prescription Drug	CVS Caremark Inc. P.O. Box 52196 Phoenix, Arizona 85072-2196 Plan Code – RXBIN# 610029	1-866-587-4799	caremark.com

LiveHealth Online	Not applicable	1-855-603-7985	livehealthonline.com (use code "assurant" if not enrolled in the Assurant Health Plan
Health Savings Account	Not applicable	1-855-285-4212	anthem.com
Flexible Spending Account	Anthem BlueCross BlueShield Claims PO Box 161606 Altamonte Springs, FL 32716	1-855-285-4212 Fax: 1-978- 856-6604	anthem.com
COBRA	Anthem BlueCross BlueShield P.O. Box 14292 Lexington, KY 40512	1-877-775-9393	Online Enrollment: benefitadminsolutions.com/anthem
Employee Assistance Program	Lyra Wellbeing	1-800-634-6433	lyrawellbeing.health Access Code: ASSURANT
Dental	MetLife	1-800-942-0854	metlife.com/mybenefits
Vision	Anthem (EyeMed)	1-877-635-6403	anthem.com
Short-Term Disability	Lincoln Financial	1-800-213-1939	LincolnFinancial.com
Long-Term Disability	Lincoln Financial Policy # GF-3-860-067019-01	1-800-213-1939	LincolnFinancial.com
Basic Life and AD&D, Supplemental Life and AD&D, *Dependent* Life Insurance	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100	1-800-638-6420 Option 2	N/A
Accident Insurance	N/A	1-800-438-6388	mybenefits.metlife.com
Critical Illness Insurance	N/A	1-800-438-6388	mybenefits.metlife.com
Legal Assistance Plan	LegalEASE 5151 San Felipe, Ste 2300, Houston, TX, 77056	1-800-248-9000	legaleaseplan.com/assurant
Commuter Plan	HealthEquity P.O. Box 60010 Phoenix, AZ 85082-0010	1-877-924-3967	healthequity.com/wageworks
Personify Health Wellbeing Program	N/A	1-888-671-9395	join.personifyhealth.com/Assurant

Coverage During Approved Leaves of Absence

Continuation of your benefits in the Assurant Health and Welfare Plan during an approved leave of absence depends on several factors, including:

- The type of leave;
- The length of the leave; and
- Whether you pay the required *premium*, if any, on a timely basis.

Assurant will continue to contribute toward the cost of your benefits while you're on an approved leave of absence, subject to the specific terms of this section below. You can continue your Health, Dental, Health Care FSA, Supplemental Life, Supplemental Accidental Death & Dismemberment and *Dependent* Life Insurance while on an approved leave of absence by paying your portion of the *premium* on a timely basis.

Note as to BTA and Dependent Day Care FSA- Business Travel Accident Insurance ends on the day before your approved leave of absence starts and your participation in the *Dependent* Day Care Flexible Spending Account (FSA) is suspended if your leave is for more than two weeks. Otherwise eligible expenses under the *Dependent* Day Care FSA that you incur while on leave cannot be reimbursed under the *Dependent* Day Care FSA.

Note as to potential QLE related to Unpaid Leaves- The Internal Revenue Service considers commencement of or return from an *unpaid* leave of absence that affects eligibility for benefits to be a qualifying life event. The Plan Administrator will have the discretion to determine whether an unpaid leave of absence affects eligibility. If the leave is determined to affect eligibility, you will have the opportunity to change your election to terminate coverage while on the approved leave of absence. Your coverage can be reinstated when you return to work. If you decide to discontinue all or part of your coverage, you must submit the election change request in MyHR within 60 days of your leave start date.

Approved leaves of absence include the following:

- Disability leaves (including short-term and long-term disability leaves)
- FMLA Leave (i.e., leave qualifying under the Family and Medical Leave Act, paid or unpaid)
- Enhanced Pregnancy Leave
- Paid Parental Leave
- Qualifying Exigency Leave
- Military Caregiver Leave
- Military Leave (USERRA)
- Personal Leave (paid or unpaid).

The availability of coverage under the Plan for each type of leave is discussed below, as well as your obligation to make *premium* payments.

Short-Term Disability

If you receive Short-Term Disability (STD) benefits, deductions will continue to be taken from your pay.* If your STD benefits are not enough to cover your deductions (garnishments, benefit costs, etc.) or you're not yet eligible for STD, you'll receive a bill from Anthem for your portion of the *premiums*.

If your disability leave ceases to be approved by Lincoln Financial and you do not return to work, your benefits will end as outlined in When Benefits End.

**STD benefits are payable on a pre-tax basis. Deductions will be withheld on an after-tax basis.*

Long-Term Disability

If you continue to be disabled under the terms of the Plan after STD benefits are exhausted, you may be eligible for Long-Term Disability (LTD) benefits. If approved, Lincoln Financial pays

LTD benefits at the end of the month. For example, if you're approved for LTD effective January 7, your benefit payment for the period January 7 – January 31 will be made at the end of January.

You also may qualify for a waiver of *premiums* for your Basic Life, Supplemental Life, Basic AD&D, Supplemental AD&D and *Dependent* Group Life Insurance if you're approved for LTD benefits. See the Disability Benefits section under Life Insurance for more information.

Your portion of your *premiums* for benefits such as health, dental and vision, will be billed to you directly from WageWorks. If you're not approved for waiver of *premiums* as described above, your Supplemental Life, Supplemental Accidental Death & Dismemberment and *Dependent* Life Insurance *premiums* will also be deducted.

Your health, dental and vision coverage can continue under the Assurant Plan until you terminate employment. You'll be offered the opportunity to continue coverage under COBRA if you terminate employment due to disability, Assurant will subsidize the cost of your COBRA coverage. Alternatively, coverage may be available through the Group Insurance Marketplace, but it will not be subsidized.

If you do not qualify for waiver of *premiums* as outlined above, you can convert your Basic, Supplemental and *Dependent* Life Insurance to private policies upon termination of employment. Basic and Supplemental Accidental Death and Dismemberment Insurance cannot be converted to private policies.

It is important that you stay up-to-date with your *premium* payments as you transition from Short-Term Disability (benefits are paid semi-monthly through payroll) to Long-Term Disability (Lincoln Financial pays benefits monthly at the end of the month). Your benefit coverage may terminate if premiums are not received on time. If Health, Dental and Vision coverage terminates for failure to pay the *premium*, you'll not be eligible for COBRA.

FMLA Leave

If you take an approved family leave that meets the requirements of the Family and Medical Leave Act of 1993 (FMLA) or similar state legislation, your benefits can continue for up to 12 weeks, provided you make timely payments for your share of the contribution. While on approved paid FMLA leave, if your payroll deductions are unable to be taken on two consecutive pay periods, you will be directly billed and must make full and timely payments, or your coverage will terminate. Unpaid FMLA leave is also a qualified life event, meaning you can terminate your coverage when you start the leave and reinstate it when you return to work.

Enhanced Pregnancy Leave

Enhanced Pregnancy Leave is paid leave under the STD benefit. See Enhanced Pregnancy Leave for more information. If applicable, Enhanced Pregnancy Leave runs concurrent with FMLA.

Paid Parental Leave

Effective for a qualifying birth, adoption, or surrogacy placement occurring on or after January 1, 2027, eligible employees may receive up to six weeks of Paid Parental Leave at 100% of pay. See the **Paid Parental Leave** section of this SPD for more information.

Qualifying Exigency Leave

If you're approved for a qualifying exigency leave that meets the requirements of FMLA or similar state legislation, your benefits can continue for up to 12 weeks, as long as you make timely payments for your share of the contribution.

Military Caregiver Leave

If you take an approved Military Caregiver Leave, your benefits can continue for up to 26 weeks when the leave is due to care for an injured or ill service member, as long as you make timely payments for your share of the contribution. (Leave to care for an ill service member when combined with other FMLA-qualifying leave may not exceed 26 weeks in a single 12-month period.)

Military Leave

If your leave meets the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA), and your military service is less than 31 days, your health and welfare benefits will continue as if you remained employed during that period.

If you meet the requirements of USERRA and take military leave of more than 30 days, you can continue your benefits provided you continue to make timely payments for your share of the cost. Assurant will continue to contribute toward the cost of your coverage. If you receive a military pay differential, deductions may continue to be taken from your pay. If the military pay differential is not enough to cover your deductions (taxes, garnishments, benefit costs, etc.) or you're not eligible for the military pay differential, you'll receive a bill for your portion of the *premium* from Anthem.

Note: The disability benefit under Basic and Supplemental Life and *Dependent* Life Insurance, Basic and Supplemental Accidental Death and Dismemberment and Long-Term Disability Insurance and Short-Term Disability coverage have exclusions for a death or disability that results from your service in the military. See AD&D Exclusions; LTD Exclusions; STD Exclusions.

If your military leave extends beyond one year, your benefits under the Assurant Health and Welfare Plan end as described under each of the plans. You can continue Health, Dental and EAP coverage for yourself and your enrolled eligible *dependents* through COBRA for an additional 18 months. The company will continue to contribute toward the cost of your coverage as if you were an active employee during this period. Your Basic and Supplemental Life and *Dependent* Life Insurance can be converted to private policies within 30 days of the date coverage ends. You cannot convert AD&D insurance or Short-Term Disability or Long-Term Disability.

Approved Personal Leave (Paid or Unpaid)

If you are approved for a Personal Leave of Absence, you may be eligible to continue certain benefits for the duration of the approved leave, subject to the terms of the Plan and timely payment of any required employee contributions.

During an approved Personal Leave of Absence:

- Medical, dental, vision, and other elected coverages may continue for the duration of the approved leave, provided you pay any required employee premiums when due.

- If premium payments are not made on a timely basis, coverage may be terminated in accordance with Plan provisions.
- Participation in the Health Care Flexible Spending Account (Health Care FSA) and Dependent Day Care Flexible Spending Account (Dependent Day Care FSA) will be administered in accordance with applicable Plan and Internal Revenue Service requirements.
- Benefit coverage will end if the approved leave expires and you do not return to active employment, unless otherwise required by law or provided under another Plan provision.
- Upon return to active employment, benefit elections in effect immediately prior to the leave will be reinstated in accordance with Plan rules and applicable law.

Assurant reserves the right to modify benefit continuation provisions for approved Personal Leaves of Absence as permitted by law and the terms of the Plan.

Premium Payments while on a Leave of Absence

If you terminate coverage during your leave or you do not pay your portion of the *premiums* within 30 days of the due date, your health, dental and vision coverage will terminate retroactive to the last day of the month for which the company received your last *premium* payment. Supplemental Life, Supplemental AD&D and *Dependent* Life Insurance end on last day of the pay period for which you last paid *premiums*. Health Care FSA coverage will terminate retroactively to the last day of the pay period for which your last contribution was received. Any claims you incur while you're not participating in a plan (including Flexible Spending Accounts) will not be covered and you may be responsible for any associated expenses.

If benefits are terminated because the *premiums* were not received within 31 days of the due date, they cannot be reinstated more than one time until you return to an active status. Any benefits paid on your behalf must be returned. Any claims you incur while you're not participating in a plan (including Flexible Spending Accounts) will not be covered and you may be responsible for any associated charges. See Subrogation and Right of Recovery for more information.

When You Return to Work from a Leave

Generally, if your leave of absence was for 30 days or less, you'll "step back" into the benefits you had prior to the start of your leave, and any missed *premiums* will be deducted from your pay.

If you go on a leave of absence and miss any Health Care or *Dependent* Day Care FSA contributions, your annual goal amount will be adjusted so that your deductions per pay period remain the same. For example, if your total contribution for the year was $2,400 and you missed $400 in contributions while on leave, your new annual contribution will be adjusted to $2,000. Note: If you're on a leave of absence for two weeks or longer, you cannot

contribute to or receive reimbursements from a *Dependent* Day Care FSA for any expenses incurred while on leave.

You'll need to make new elections upon your return to work if:

- Your unpaid leave is longer than 31 days;
- Your leave crosses over into a new calendar year, regardless of the length of the leave.
- You cancel your benefits at the start of the leave; or
- You do not pay for your portion of your benefit cost.

SOH will be required if you decide to re-enroll in Supplemental Life or *Dependent* Life Insurance. Contact the People Experience Center at 1-866-324-6513 or ask ERIN for information on reinstating your benefits. ERIN can be accessed across multiple channels, including your desktop, MS Teams, the web, MyHR and via mobile app.

If You Do Not Return at the End of a Leave

Your benefits will terminate if you do not return to work after:

- 12 weeks of Family and/or Qualifying Exigency leave under FMLA;
- 26 weeks of approved Military Caregiver Leave;
- You no longer are considered disabled under the terms of the Plan as determined by the applicable Plan Administrator; and
- An approved, unpaid leave under the Americans with Disabilities Act or similar, applicable state law has been exhausted.

Your benefits will also terminate if you advise Assurant that you'll not be returning to work before the end of your leave. You may be eligible for COBRA coverage.

Health, dental and EAP coverage ends on the last day of the month that your employment ends. Flexible Spending Account coverage will terminate retroactive to the last day of the pay period for which your last contribution was received. See COBRA for details on how you may be able to continue this coverage after termination.

All other benefits end on the day your employment ends. See **Conversion to an Individual Policy** and **Conversion** for information on converting your Life Insurance.

Benefits Eligibility Request for Review

If you believe that an incorrect decision has been made regarding your eligibility to enroll in, change, terminate, or timely pay your share of any of the Assurant benefits available to you, you may ask the Assurant Benefit Plans Committee, or its delegate, to review the decision.

You have 60 days in which to submit a request for review to the Assurant Benefit Plans Committee. Your appeal must:

- Be in writing;
- Provide specific information regarding the basis for your appeal; and
- Include all supporting documentation.

Your written request for review must be received no later than 60 days after the date on which your benefits were affected. If you miss a deadline and your benefits are affected or your

enrollment is denied, you may submit a request for review that must be received within 60 days after the date on which your benefits were affected. Requests that are received late are not eligible for review.

The Assurant Benefit Plans Committee, or its delegate, will provide you with written notice of its decision within 60 days of the date it receives your appeal. If special circumstances require an extension of time, you'll be notified of the extension within the initial 60-day review period. An extension will provide the Assurant Benefit Plans Committee an additional 60 days within which to respond.

If, upon review, the eligibility determination is upheld, you'll be provided with an explanation of the reason(s), references to applicable plan provisions on which the decision is based, and a statement of your right to bring a civil action under ERISA. The decision of the Assurant Benefit Plans Committee is final and is not subject to further internal review or appeal. The eligibility review process does not permit you, your *beneficiary* or authorized representative, the opportunity to appear in person before, or meet with the Assurant Benefit Plans Committee, or any of its representatives.

Claim Appeals

A claim is any request for a benefit under the Plan made in accordance with the claim procedures described in the section(s) of this SPD for the applicable benefit option. A request for benefits not made according to the procedures described in the section(s) for the applicable benefit will not be treated as a claim. Questions regarding eligibility and casual inquiries, including requests for prior approval where prior authorization is not required, are not claims for benefits. All questions relating to eligibility as well as inquiries regarding payment of required employee contributions are subject to the eligibility review procedures discussed above in **Benefits Eligibility Request for Review**.

For fully insured plans, to the extent that information in the following appeals sections conflict with the insurance policy and/or certificate booklet, the insurance policy and/or insurance booklet govern.

Your Right to Appeal

If your claim for benefits under the Plan with respect to any benefit option listed in **Where to Submit an Appeal** is denied, you are entitled to a full and fair review procedure.

For purposes of these appeal provisions, "claim for benefits" or "claim" means a request for benefits under the Plan.

The term includes both pre-service and post-service claims.

- A pre-service claim for benefits under the Plan for which you have not received the benefit and for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the Plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

Although the procedure the claims administrator will follow will satisfy the requirements for a full and fair review under ERISA §503 and any other applicable federal regulations, not all of these benefit options are subject to ERISA. The following steps describe your appeal procedures for the benefit options listed in **Where to Submit an Appeal**.

Step 1: Notice of Adverse Benefit Determination from Claims Administrator

If your claim is denied, you will receive a notice of the adverse benefit determination (denial) from the claims administrator. The time frame in which you will receive this notice is described in the section for the applicable benefit and will vary depending on the type of benefit option for which the claim is filed. The contact information for the claims administrator is provided in the **Where to Submit an Appeal** chart at the end of this section. In addition, the claims administrator may request an extension of time in which to review your claim for reasons beyond the claims administrator's control. If the reason for the extension is that you need to provide additional information, you will be given a certain amount of time in which to obtain the requested information (it will vary depending on the type of claim as provided in the section for the applicable benefit). The time period during which the claims administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the applicable information gathering period.

Step 2: Review Your Notice Carefully

Once you have received your notice from the claims administrator, review it carefully. The notice will contain, at a minimum, the following information:

- Information sufficient to identify the claim involved;

Step 3: If you disagree with the decision, file a 1st Level Appeal with the Claims Administrator.

If you do not agree with the decision of the Claims Administrator, you have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You must file your appeal within 60-180 calendar days after you are notified of the denial or rescission, depending on the type of benefit option for which the appeal is filed as provided in section for the applicable benefit. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The claims administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

The claims administrator shall offer a single mandatory level of appeal and an additional voluntary second level of which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the claims administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the claims administrator's decision, can be sent between the claims administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact

the claims administrator at the number shown on your Member Identification Card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought, and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by you or your authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g., Urgent Care). You or your authorized representative must submit a request for review to the claims administrator, whose contact information is provided in the **Where to Submit an Appeal** chart at the end of this section.

You must include your Member identification number when submitting an appeal. Upon request, the claims administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly situated claimants; or
- for group health plans or plans providing disability benefits, is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

For group health plans or plans providing disability benefits, the claims administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, for group health plans or plans providing disability benefits, before you receive an adverse benefit determination or review based on a new or additional rationale, the claims administrator will provide you, free of charge, with the rationale.

For Out of State Appeals you have to file provider appeals with the Host Plan. This means providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When the claims administrator considers your appeal, the claims administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Step 4: 1st Level Appeal notice is received from Claims Administrator.

If the claim is again denied, you will be notified by the claims administrator within the time period described below, depending on the type of claim.

If you appeal a claim involving urgent/concurrent care (for medical plan, prescription drug, dental, or vision), the claims administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim (for medical plan, prescription drug, dental, or vision), the claims administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim (for medical plan, prescription drug, dental, or vision), the claims administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

If you appeal a disability claim, the claims administrator will notify you of the outcome of the appeal within 45 days after receipt of your request for appeal.

If you appeal any other claim listed under **Where to Submit an Appeal**, the claims administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the claims administrator will document a full and fair review, explaining the basis for the decision and informing you of your rights for further action.

Step 5: Review Your Notice Carefully.

You should take the same action that you took in Step 2 described above. The notice will contain the same type of information, at a minimum, that is provided in the first notice of denial provided by the claims administrator. For group health plans or plans providing disability benefits, if, after the Plan's denial, the claims administrator considers, relies on or generates any new or additional evidence in connection with your claim, the claims administrator will provide you with that new or additional evidence, free of charge. For group health plans or plans providing disability benefits, the claims administrator will not base its appeal decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. For group health plans or plans providing disability benefits, if the claims administrator fails to follow the appeal procedures outlined under this section, the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond the claims administrator's control.

Step 6: If you still disagree with the Claims Administrator's decision, file a 2nd Level Appeal, if available, with the applicable Claims Fiduciary.

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed in the **Where to Submit an Appeal** chart for level 2 appeals for the applicable benefit option. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review. Some benefit options have a third level of appeal. See Final Third Level Appeal for more information.

External Review (Group Health Plans). for group health plans, if the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the claims administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the claims administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the claims administrator's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the claims administrator's decision, can be sent between the claims administrator and you by telephone, facsimile or other similar method. To proceed with an expedited External Review, you or your authorized representative must contact the claims administrator at the number shown on your Identification Card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the claims administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by your or your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

You must include your Member identification number when submitting an appeal. This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent

External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA, if this Plan is subject to ERISA.

Requirement to File an Appeal Before Filing a Lawsuit; Deadline to Bring Legal Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan.

The claims administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

Final Third-Level Appeal

Health, Dental and Short-Term Disability benefits allow for a third-level appeal. If the denial of your claim has been upheld after two levels of appeal, you may file a final third-level appeal with the Assurant Benefit Plans Committee (BPC). An appeal to the BPC is voluntary; you're not required to file an appeal with the BPC before bringing suit against the Plan under ERISA.

Your request for a third-level appeal must be made in writing and received by the BPC no more than 60 days from the date you received your second-level appeal decision.

Your written appeal must include copies of the initial claim decision, first-and second-level appeal letters and their denials along with any additional documentation that you have supporting your claim for benefits.

Within 60 days of the date the BPC receives your request for a review, the BPC will notify you in writing of its decision or request additional time to reach a decision based on the existence of special circumstances (but no more than 120 days from the day your completed application for appeal is received).

Remember, this third-level appeal is voluntary. You're not required to submit such a request before bringing any legal action or requesting an external review.

Where to Submit an Appeal

Appeals should be sent to the following addresses:

Type of Appeal (By Plan)	1st and 2nd Level Appeal	3rd Level Voluntary Appeal
Medical Plan (Purple, Blue, Green, and Orange Health Plan)	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187	Assurant Benefit Plans Committee P.O. Box 16368 Atlanta, GA 30321
Prescription Drugs under the Health Plan	CVS Caremark Appeals Department MC109 PO Box 52084 Phoenix, AZ 85072-2084	Assurant Benefit Plans Committee P.O. Box 16368 Atlanta, GA 30321
Dental Plan	MetLife Dental Claims P.O. Box 14588	Assurant Benefit Plans Committee

	Lexington, KY 40512	P.O. Box 16368 Atlanta, GA 30321
Vision Plan	Blue View Vision Insight Attention: Appeals 555 Middle Creek Parkway Colorado Springs, CO 80921	Assurant Benefit Plans Committee P.O. Box 16368 Atlanta, GA 30321
Short-Term Disability	Lincoln Financial Market Disability Claims 55 Capital Boulevard Rocky Hill, CT 06067	Assurant Benefit Plans Committee P.O. Box 16368 Atlanta, GA 30321
Long-Term Disability	Lincoln Financial Market Disability Claims 55 Capital Boulevard Rocky Hill, CT 06067	N/A
Basic Life and AD&D, Supplemental Life and AD&D, *Dependent* Life Insurance	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100	N/A
Business Travel Accident Insurance	AIG Accident & Health P.O. Box 25987 Shawnee Mission, KS 66225 Attn: Personal Accident Claims Department	N/A
Flexible Spending Accounts	Anthem PO Box 161606 Altamonte Springs, FL 32716	Assurant Benefit Plans Committee P.O. Box 16368 Atlanta, GA 30321
Severance Pay Plan	1st Level Appeal: Business Segment Senior HR Executive 2nd level Appeal: Assurant Benefit Plans Committee	N/A

Special Claims

The table below reviews how to appeal special types of group health plan claims and the applicable time limits for those special appeals.
Note: this table does not apply to appeals under the Severance Pay Plan, which are covered under the **Severance Pay Plan**.

Type of Claim	Level 1 Appeal	Level 2 Appeal
Medical care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function, or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	72 hours Review provided by claims administrator personnel not involved in making the adverse benefit determination.	72 hours Review provided by the claims administrator.
Pre-service claim: a claim for a benefit that requires the claims administrator's approval of the benefit in advance of obtaining medical care.	30 calendar days Review provided by claims administrator personnel not involved in making the adverse benefit determination.	30 calendar days Review provided by claims administrator.

Concurrent care claim extension: a request to extend a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.
Post-service claim: a claim for a benefit that is not a pre-service claim	60 calendar days Review provided by claims administrator personnel not involved in making the adverse benefit determination	60 calendar days Review provided by claims administrator.

You also may choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to the claims administrator. However, in case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

Consolidated Omnibus Budget Reconciliation Acts (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives you and your covered *dependents* the right to continue health care coverage at group rates if your Assurant coverage ends due to one of the following qualifying events:

- Termination of employment for any reason other than gross misconduct;
- Reduction in the number of hours you work;
- Non-payment of *premiums*;
- Death of employee;
- Divorce or legal separation;
- *Dependent* child attaining the limiting age (end of the month in which he/she turns age 26);
- Commencement of a bankruptcy proceeding concerning an employer from whose employment the covered employee retired;or
- Retirement.

Although federal law limits the definition of a qualified *beneficiary* to include only covered employees, spouses (as defined by federal law) and *dependents*, Assurant allows you to continue coverage for your *domestic partner* and his/her children as well. Generally, your COBRA *premium* for the first 18 months of coverage will be 102% of the total (both employer and employee) cost of the coverage.

Note: There may be other more cost-effective coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Medicare, or another group health plan (such as a spouse's plan) through what is called a "special enrollment period." You can learn more about these options at healthcare.gov.

What Benefits Does COBRA Cover?

If you and/or your enrolled *dependents* lose health coverage as a result of certain qualified events, COBRA allows you to continue health coverage (including medical, prescription drug, employee assistance program and dental and vision) for up to 36 months. Further, if you have a positive balance in your Health Care Flexible Spending Account at the time your participation ends, you can continue to participate through the end of the calendar year in

which your participation in the Assurant Plan ends by making after-tax contributions to the COBRA Administrator.

Your coverage under COBRA will be the same benefits as you were eligible to receive as an active employee. If the coverage or *premiums* change for active employees under the Plan, the same changes will apply to you and/or your enrolled *dependents*.

A child born, adopted or placed for adoption during your COBRA continuation period is considered a qualifying *beneficiary*.

Generally, if you drop your spouse from coverage during Open Enrollment, it is not a qualifying event. However, if you later divorce or legally separate, your spouse may be entitled to COBRA as of the date of the divorce or legal separation even if it is later than 60 days after the loss of coverage. The termination of the coverage at Open Enrollment may be deemed by the Plan Administrator to be "in anticipation of" the divorce or legal separation. You or your former spouse must notify Anthem within 60 days of the divorce or legal separation to elect COBRA continuation coverage. Anthem can be reached at 1-877-775-9393.

Enrolling in COBRA Coverage

When you terminate employment, your hours are reduced or you pass away, Anthem will send a COBRA Coverage Election Notice (COBRA Notice) to your home address. If you choose to elect COBRA coverage, please complete the COBRA Coverage Election Form and mail the completed COBRA Coverage Election Form by United States Postal Service ("USPS") to Anthem at PO Box 660350 Dallas, TX 75266-0350. You may also fax the completed COBRA Coverage Election Form to Fax #: 1-866-735-8191.

If you wish to elect online, you can complete your enrollment on the Anthem website at benefitadminsolutions.com. You'll need to provide your name, date of birth, valid e-mail address, and Social Security number or your designated Anthem account number to register for an Anthem "user name." The information you provide in connection with your online enrollment is kept confidential in accordance with Anthem's privacy policy, which you can find at benefitadminsolutions.com.

If you have a *dependent* who loses coverage due to a qualified event, for example due to divorce or a child reaching the maximum age limit, you, your spouse/*domestic partner* or your former spouse/*domestic partner* must notify the People Experience Center within 60 days of the qualified life event. Your notification must include your name and Social Security number, the qualifying *beneficiary's* name, Social Security number, address, the type of event and the date of the qualified event. When the People Experience Center receives your notification via MyHR powered by Workday, they will send the COBRA Notice and COBRA Application to the qualifying *beneficiary*. Failure to notify the People Experience Center within 60 days of the qualified life event could result in a loss of COBRA eligibility. You can reach the People Experience Center at 1-866-324-6513 or by asking ERIN. ERIN can be accessed across multiple channels, including your desktop, MS Teams, the web, MyHR and via mobile app.

You or the qualifying *beneficiary* will have 60 days from the date of the COBRA Notice or the date the coverage terminated, whichever is later, to elect COBRA. If elected, coverage will be reinstated retroactive to the date your group coverage ended provided the initial *premium* is paid within 45 days of the date on the invoice. If you do not return your COBRA notice within the time frame outlined above, you'll forfeit your rights to COBRA coverage.

You'll be required to make all current and past due COBRA payments before your coverage will become effective. Failure to make these payments by the payment due date will result in cancellation of your COBRA coverage. Once canceled for failure to timely pay, coverage may be reinstated one time provided all past due and current payments are timely made. Once coverage is canceled a second time for failure to timely pay, it may only be reinstated if you appeal to the Assurant Benefit Plans Committee for possible reinstatement, the appeal is determined in your favor based on the circumstances, and provided all past due and current payments are timely made. Payments for continuation coverage must be sent to the address provided on the continuation application.

Your *premium* is due by the first of the month for that month of coverage. For example, April's *premium* is due by April 1. There is a 30-day grace period for all *premium* payments after the initial payment. If your *premium* payment is not postmarked by the end of the grace period, your coverage will be terminated retroactive to the last day of the month for which the last *premium* was paid.

Extended Coverage

COBRA coverage may be extended for up to an additional 11 months if the qualified *beneficiary* is disabled at any the time during the first 60 days of continuation coverage if the qualifying event is the termination of your employment or reduction in hours. Coverage can continue for up to a total of 29 months (maximum continuation period + disability extension) for the disabled *beneficiary* and any other qualified *beneficiary* who became entitled to COBRA as a result of the same qualifying event.

The disabled *beneficiary* must receive a determination from the Social Security Administration that he or she was disabled as of the qualifying event or within 60 days of the date coverage is lost due to the qualifying event. For example, if you terminate employment on Nov. 17, your coverage under the Assurant plan ends on Nov. 30. The Social Security Administration must determine that the Qualified *Beneficiary* is disabled as of Nov. 17 or within 60 days of Nov. 30 to be eligible for the extension of coverage.

Further, the disabled *beneficiary* must notify Anthem of the Social Security Administration's determination:

- Within 60 days of the Social Security Administration's determination; and
- Before the end of the first 18 months of COBRA continuation

If the Social Security Administration determines that a disabled *beneficiary* is no longer disabled, he or she must contact Anthem within 31 days of the determination. Extended COBRA coverage will end as of the month that begins more than 31 days after the Social Security Administration's decision, or until coverage would otherwise end, if earlier.

COBRA *premiums* increase from 102% to 150% of the total *premium* for the additional 11 months of extended coverage.

You can get additional information about COBRA coverage from Anthem at 1-877-775-9393.

Changing COBRA Coverage

You and the qualified *beneficiary* have the right to change coverage options and *coverage levels* during Open Enrollment or if you or the qualified *beneficiary* experiences a qualified life

event. Refer to **Qualified Life Events** and **Special Enrollment Rights** or contact Anthem for more information regarding your enrollment rights. If the addition of a spouse or *dependent* child will result in a higher contribution, COBRA rates will reflect the higher amount. You can reach Anthem at 1-877-775-9393.

When COBRA Coverage Ends

The maximum continuation period under COBRA depends on the qualified event that caused the loss of coverage under the active employee plan as outlined below:

Qualified Event	Maximum Continuation Period
Termination of employment for any reason other than gross misconduct	18 months
Retirement	18 months
Reduction in scheduled work hours	18 months
Death of employee	36 months
Divorce or legal separation	36 months
Domestic partner no longer meets eligibility requirements	36 months
Child attains age 26	36 months

COBRA coverage will end earlier if:

- The required payments have not been made on a timely basis;
- You or a qualified *beneficiary* begins coverage under any other group plan, after the date you or the qualifying *beneficiary* elects COBRA continuation coverage;
- You or a qualified *beneficiary* become entitled to Medicare, after the date you or the qualified *beneficiary* elects COBRA;
- Your coverage would be terminated as an active employee for any other reason (e.g., submitting fraudulent claims); or
- The company terminates the Plan.

If you (or a qualified *beneficiary*) fail to re-enroll for COBRA coverage during Open Enrollment, and you have not yet reached your maximum continuation period, your current COBRA elections will continue in the following year (with the exception of any Flexible Spending Account elections).

You or the qualifying *beneficiary* is obligated to contact the COBRA Unit within 30 days after you or the qualifying *beneficiary* becomes entitled to Medicare or begins coverage another group health plan. If you fail to contact the COBRA Unit within 30 days and the Plan pays benefits on behalf of you or the qualifying *beneficiary*, the Plan may recoup any amounts paid in error from you or the qualifying *beneficiary*.

Employee Retirement Income Security Act (ERISA)

Plan Information

Plan Name:	Assurant Health and Welfare Benefit Plan
Plan Number:	501
Employer ID Number:	39-1126612

Type of Plan:	An employee welfare plan providing self-insured benefits as follows: Health, Prescription Drug, *Health Savings Account*, Dental, Employee Assistance Program (EAP), ShortTerm Disability and insured benefits: Life, Accidental Death and Dismemberment, *Dependent* Life, LongTerm Disability, Business Travel Accident and LongTerm Care.
Type of Administration:	Health, Prescription Drug, Dental, EAP, and *Health Savings Account* benefits are administered by Anthem Blue Cross and Blue Shield, CVS Caremark, MetLife, Lincoln Financial, Lyra Wellbeing and HealthEquity, respectively. The benefit administrators function as plan service providers, for a fee, and not as insurers. Life, Accidental Death and Dismemberment and *Dependent* Life Insurance are insured through MetLife and Long-Term Disability is insured through Lincoln Financial. Business Travel Accident is insured through AIG Insurance Company. Flexible Spending Accounts, Tuition Reimbursement Plan and the Severance Pay Plan are administered by Assurant.
Plan Year:	Jan. 1 – Dec. 31
Plan Sponsor:	Assurant, Inc. P.O. Box 16368 Atlanta, GA 30321 770-763-1000
Plan Administrator:	Assurant, Inc. Benefit Plans Committee P.O. Box 16368 Atlanta, GA 30321

Your participation in the Assurant Health and Welfare Plan and any of the benefit options discussed in this document do not guarantee your continued employment at the company. If you quit, are discharged or laid off, the Plan does not give you a right to any interest in the Plan except as specifically provided for in the plan documents.

The Plan is administered by the Plan Administrator. The Plan Administrator has discretion to delegate some or all of its fiduciary responsibility to a third party. The Plan Administrator has delegated fiduciary responsibility for determinations of benefit claims and appeals under the self-funded benefit components to third-party administrators. For insured benefit components, insurers have a fiduciary responsibility for determinations of benefit claims and appeals. The **Claims** section in this SPD identifies the specific third party, including insurers that administer claims and appeals for the respective benefits.

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that plan participants are entitled to:

Receive Information

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

You may obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the plans, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated Summary Plan Descriptions. The Plan Administrator may make a reasonable charge for the copies. You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Health Coverage

Under COBRA, you may continue health care coverage for yourself, spouse or *dependents* if there is a loss of coverage as a result of a qualifying event. You or your *dependents* will have to pay for such coverage. You should review this Summary Plan Description for information concerning your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay 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 federal court. In addition, if you disagree with the plan's decision or lack thereof concerning a medical child support order, you may file suit in federal court. If the plan fiduciaries misuse the plan's money, or if you're 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're 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 considered frivolous.

Assistance with Your Questions

If you have questions about your plans, you should contact the People Experience Center. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration listed in your telephone directory, or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210.

You also may contact EBSA's toll-free participant assistance number, 1-866-444-3272, or visit their website at dol.gov/ebsa.

Reservation of Rights to Plan Sponsor

Assurant, Inc. reserves the right to suspend, amend, modify, or terminate the Plan and/or any benefit options in any manner at any time, including the right to modify or eliminate any cost-sharing between the company and participants. Participants will be notified in due course concerning material changes and claims paid out post-modification or termination pursuant to Plan terms and applicable law.

Other Benefits

Assurant offers a range of benefits that complement the benefits offered under the Plan's health and welfare program but are not part of the ERISA plan.

Tuition Reimbursement Program

If eligible, you're encouraged to take advantage of the Tuition Reimbursement Program, one of the additional benefits offered by Assurant outside of the Plan. The purpose of the Program is to help share the cost of continuing your education so that you may gain, maintain or improve your business-related knowledge.

All courses must be part of a business-related degree program. Generally, courses in business administration, accounting, marketing, or other programs that are related to the company's operations qualify.

Courses must be provided by an accredited college or university. A list of institutions accredited by the U.S. Secretary of Education is available through the U.S. Department of Education Website.

All courses should be scheduled outside of normal work hours and should not interfere with your work.

Eligibility

All employees must be actively at work to participate in the Tuition Reimbursement Program. There are other eligibility requirements that vary for the undergraduate and graduate level courses.

To be eligible for reimbursement of eligible expenses under an undergraduate degree, you must be an active, full- or part-time regular employee who:

- Is regularly scheduled to work at least 20 hours a week;
- Has completed at least six months of service prior to the start of the academic term;
- Has a good attendance record; and
- Demonstrates job performance of "Performing" or better for six months prior to the start of the academic term and continues performing at that level for the duration of the program.

To be eligible for reimbursement of eligible expenses under a graduate level program, you must be an active, full time regular employee who:

- Has completed at least 12 months of service prior to the start of the academic term; and
- Demonstrates job performance of "Performing" or better for the six months prior to the start of the academic term and continues performing at that level for the duration of the program.

Rehires

If you leave Assurant and are later rehired, your eligibility for the Tuition Reimbursement Program will be based on the following:

- If you're rehired within 30 days of your termination date, you'll be given credit for your prior service with Assurant; and
- If you're rehired more than 30 days after your termination date, you must complete at least six months of service from the date of your rehire before becoming eligible.

Eligible Expenses

Eligible expenses include:

- The cost of tuition for business or business-related undergraduate or graduate degree programs at an accredited institution, provided that you complete the course and receive a grade "C" or better for an undergraduate program and a grade "B" or better for a graduate program;
- Expenses for proficiency exams for credit, provided the exam is passed; and
- The cost of textbooks you are required to purchase to attend a course.
- Note: see **Exclusions** below for what is not included

Exclusions

The following expenses are not eligible for reimbursement under the Tuition Reimbursement Program:

- The cost of education involving sports, games or hobbies unless such educational expense involves the business of the employer or is required as part of a degree program;
- Tools or supplies (other than textbooks) that you may retain after the course has ended;
- Fees, meals, lodging and transportation;

- Expenses for courses that you do not complete;
- Expenses for undergraduate courses for which you do not receive a grade of “C” or better;
- Expenses for graduate courses for which you do not receive a grade of “B” or better;
- Executive MBAs (EMBAs) or Ph.D.’s;
- Expenses for courses begun while you’re on a leave of absence (if, however, you are already taking a course when you commence a leave and you return from leave within the first half of the course, you’ll be eligible for the reimbursement of tuition costs upon successful completion of that course);
- Educational expenses that can be reimbursed from other sources, such as scholarships, grants or veterans’ benefits;

Individual departments and teams may need certification courses and other continuing education coursework. These expenses may be covered by your cost center manager but are not covered under the Tuition Reimbursement Program. Some examples include insurance associations, CPA, CFA, CLE, actuarial certifications, and other professional designations.

In addition, employees, together with management, may elect to pursue continuing education courses to meet job requirements. Examples may include business writing courses, financial-related courses and business-related seminars and conferences. These types of courses also may be covered by your cost center manager but are not covered under the Tuition Reimbursement Program.

Taxes

Reimbursements for undergraduate degree programs, up to the IRS excludable limits (currently $5,250 per calendar year), are not included in your income for federal and Social Security tax purposes.

Reimbursements for graduate degree programs up to the IRS excludable limit (currently $5,250 per calendar year) are also not included in your taxable income if the program:

- Is a requirement for your present position; or
- Maintains or improves skills needed for your current position.

How the Program Works

Before You Register

You must obtain approval from your manager and HR Business Partner. Expenses for courses that begin before your formal acceptance date into the Program will not be reimbursed. You may apply for acceptance into the Program by submitting the Assurant Tuition Reimbursement Program Application, which is available in MyHR.

After Course Completion

After you complete the course requirements, you must complete an Assurant Tuition Reimbursement Program claim form available to you in MyHR within 45 days of each course module for which you are requesting reimbursement. The People Experience Center will then review and process reimbursement. If you have questions, contact the People Experience Center at 1-866-324-6513 or by asking ERIN. ERIN can be accessed across multiple channels, including your desktop, MS Teams, the web, MyHR and via mobile app.

Documentation required with the Request for Tuition Reimbursement form includes:

- Proof of payment for tuition, which must include detail of the cost per class or per credit hour;
- Detailed receipts for any required textbooks purchased;
- Financial assistance, such as grants, scholarships, awards, bonuses, and any pay for work that was deducted from the tuition cost;
- Term enrollment and completion dates;
- Class grades;
- Manager's signature signifying you're performing your job at least at an acceptable level; and
- Manager's signature supporting (as applicable) for reimbursement at the graduate level, where the intention is to have the reimbursement be excludable from taxable income, that taking the course was a requirement for your present position or maintained or improved skills needed for your current position.

If your claim and the required documentation for undergraduate courses are not submitted by that year's claim filing deadline (announced by Payroll each December), your reimbursement will be applied against the following year's non-taxable maximum reimbursement amount. Note: the filing deadline announced by Payroll each December simply affects which year's nontaxable maximum your reimbursement will be applied against and does not extend the 45-day deadline within which you must submit your claim for reimbursement following the last day of the course.

Following Course Completion

You must complete 6 months and 12 months of employment after you receive reimbursement for undergraduate and graduate level courses, respectively. See **When Benefits End** below for additional information.

When Benefits End

Your benefits under the Tuition Reimbursement Program will end on the earliest of the following:

- The date your employment ends;
- The date your employment status changes to an ineligible status (e.g., your work schedule is reduced to less than 20 hours per week); or
- The date you're determined to have perpetuated fraud on the Plan.

When you terminate employment for any reason, you must repay to Assurant any reimbursements you received under the Tuition Reimbursement Program within 6 months prior to your termination for undergraduate courses and 12 months prior to your termination for graduate level courses.

If, however, your termination is as a result of a Severance Event as defined in the Severance Pay Plan and you timely sign, return, and do not revoke a release under the Severance Pay Plan, you can be reimbursed for eligible expenses for courses begun before your Severance Date if your termination is due to a Severance Event. To take advantage of this severance benefit, you must submit all required documentation to the People Experience Center within 45 days of the end of each course for which you seek reimbursement.

Commuter Benefits Program

The Commuter Benefit is a pre-tax benefit account used to pay for public transit - including train, subway, bus, ferry and eligible van pool – and qualified parking as part of your daily commute to work.

How it Works

Simply decide how much to contribute up to the allowed monthly limit. Funds are withdrawn from your paycheck for deposit to your account before taxes are deducted. Pause or cancel contributions to your account at any time. There's no "use it or lose it" so long as you're enrolled in the program.

How Much You Can Contribute

Contribute pretax up to a maximum of $325 per month for transit and eligible van pools and $325 per month for qualified parking. If you exceed the pre-tax limits, the balance will be deducted from your paycheck on a post-tax basis. These limits are set by the Internal Revenue Service and are subject to change each year.

How to Enroll

You can enroll by visiting the HealthEquity website at: healthequity.com/wageworks. New users can register by selecting "Log In/REGISTER" and then "Employee Registration." You'll need to answer a few simple questions and create a username and password. You can enroll, change or terminate your pre-tax deductions at any time on a prospective basis. Generally (though it may have some variations by state), elections and changes must be in by the 10th of the month to be effective for the following month.

Federal tax laws allow employees to save taxes on parking at work and transit or vanpooling expenses incurred to get to work. Employees can save by setting up a pre-tax payroll deduction that reduces taxable income. Qualified expenses are exempt from federal income and FICA (Social Security and Medicare) taxes. Your tax savings will vary, depending on your deduction amount and your tax bracket.

The Commuter Benefit Program is a qualified transportation benefit program authorized by Internal Revenue Code (IRC) Section 132.

Back-Up Care and Virtual Tutoring

Back-Up Care

Assurant has teamed up with Bright Horizons to offer a high-quality back-up care program for child and elder care, giving you access to a nationwide network of high-quality, licensed childcare centers and in-home care providers.

Assurant will subsidize the cost of care and you pay the balance for up to seven (7) days of care per year for your *dependent* children or *dependent* adults through Bright Horizons' national network of qualified facilities and caregivers.

Back-up care is available at the following *copayment* cost to an employee:

- Center-based childcare: $15 per child per day or $25 per family per day.
- In-home child or adult/elder care: $6 per hour (a four-hour minimum is required for in-home care).

Each use of care for each child or adult is one use regardless of the hours used (or number of times in and out during that same day) up to a maximum of one day. For center care, age limits will vary by location. Most centers can serve children from six weeks to six years of age; some serve children through age 12. For in-home care, there is no age limit.

Virtual Tutoring

Employees may exchange each back-up care use for up to four (4) hours of one-on-one tutoring by highly qualified tutors.

- Tutoring is available to children ages 5 – 18.
- You can schedule tutoring in 1-hour increments based on your child's needs.
- Help is available for 300+ subjects, including access to math and reading experts.
- The *copay* for virtual tutoring is $15 for every four hours of tutoring due to the Assurant subsidy.
- You can reserve tutors (via virtual sessions) through your Bright Horizons Back-Up Care account.

Pre-register to Access Benefits

You will need to register to access these benefits. Visit backup.brighthorizons.com/assurant.

To get started, use assurant (lowercase) as the employer username and Assurant123 as a password (case sensitive). Then you'll set up a unique username and password and complete an online profile. Explore the site to see available care providers in your area and learn how back-up care works. You can also call 1-877-BH-CARES (242-2737) for more information. Customer service is available 24/7.

Glossary

A

Accidental Injury Bodily injury sustained by a member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any workers' compensation, Employer's liability or similar law.

Ambulance Services A state-licensed emergency vehicle that carries injured or sick persons to a hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Appeal A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Appropriate Medical Plan An appropriate plan to arrive at a more accurate or more supported diagnosis of your medical condition(s) or an appropriate plan of treatment of your medical conditions(s) or both.

Approved Clinical Trial An approved clinical trial means a phase I, phase II, phase III or phase IV clinical trial that studies the prevention, detection or treatment of cancer or other life-threatening condition. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated. Benefits are limited to the following trials:

- Federally funded trials approved or funded by one of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - Cooperative group or center of any of the four above entities or the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - Any of the following if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines a) to be comparable to the system of peer review of studies and investigation used by the National Institutes of Health and b) assures unbiased review of the highest scientific standards by;
        - The Department of Veterans Affairs.
        - The Department of Defense.
        - The Department of Energy
- Studies or investigation done as part of an investigational new drug application reviewed by the Food and Drug Administration.
- Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Routine patient care costs include items, services and drugs provided to you in connection with an approved clinical trial that would otherwise by covered by this Plan.

All other requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to Anthem's clinical coverage guidelines, related policies and procedures.

Audiologist A person who is:

- Legally qualified in audiology; or
- Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
- Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Authorized Service(s) A covered services rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the claims administrator to be paid at the Network level. The Member may be responsible for the difference between the *Out-of-Network* Provider's charge and the Maximum Allowed Amount, in addition to any applicable Network *coinsurance*, *copayment* or *Deductible* unless your claim is a **Surprise Billing Claim**.

B

Base Pay Your salary on the day before you become disabled. It does not include bonuses, overtime, benefits, short or Long-Term incentive compensation or any other types of compensation.

For sales employees, base pay also includes bonuses, commissions and incentives paid during the calendar year prior to the start of your disability. Sale bonuses, commissions and incentives are updated once per year. If you're a sales person with less than one year of service, base pay includes sale bonuses, commissions and incentives guaranteed in a first-year agreement.

Behavioral Health Care Includes services for Mental Health Disorders and Substance Abuse. Behavioral Health and Substance Abuse are conditions that are listed in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) as a mental health or substance abuse condition.

Blue Distinction Bariatric Surgery Providers

- Blue Distinction Center (BDC) Facility: Blue Distinction facilities have met or exceeded national quality standards for care delivery (quality only).
- Blue Distinction Center+ (BDC+) Facility: Blue Distinction+ facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).
- Designated Bariatric Surgery Provider: A provider who has achieved designation as a Blue Distinction Center+ or Blue Distinction Center for Bariatric Surgery Procedures.

Breast Reconstructive Surgery Covered services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications, including lymphedemas.

C

Centers of Medical Excellence (CME) Transplant Providers:

- Blue Distinction Center Facility: Blue Distinction Facilities have met or exceeded national quality standards for care delivery.
- Centers of Medical Excellence (CME): Centers of Medical Excellence Facilities have met or exceeded quality standards for care delivery.
- Network Transplant Provider: Providers who have achieved designation as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. The Provider has entered into a Transplant Provider Agreement to give covered transplant procedures to You and take care of certain administrative duties for the Transplant Network. A Provider may be a Network Transplant Provider for certain covered transplant procedures or all covered transplant procedures.

A network of health care professionals contracted with the claims administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

Claims Administrator A company Assurant selects to process claims and administer benefits under the Plan. For example, Assurant has selected Anthem Insurance Companies, Inc. as claims administrator for the health benefits. The claims administrator provides administrative claims payment and medical review services only and does not assume any financial risk or obligation with respect to claims.

COBRA Administrator The COBRA Administrator for the Assurant Health and Welfare Plan is Anthem.

Coinsurance If a member's coverage is limited to a certain percentage, for example 80%, then the remaining 20% for which the member is responsible is the *coinsurance* amount. The *coinsurance* may be capped by the *out-of-pocket maximum*.

Concurrent/Continued Stay Review A request for pre-certification or pre-determination that is conducted during the course of treatment or admission.

Copayment A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "*copay*"). The amount can vary by the type of covered health care service.

Cosmetic Surgery Any non-medically necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of cosmetic surgery.

Covered Services Medically necessary health care services and supplies that are: (a) defined as covered services in the member's Plan, (b) not excluded under such Plan, (c) not experimental/investigative and (d) provided in accordance with such Plan.

Covered Transplant Procedure Any medically necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, and including medically necessary preparatory myeloablative therapy.

Custodial Care Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital skilled nursing facility care; (c) is a level such that the member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial care includes, but is not limited to, any type of care the primary purpose of which is to attend to the member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of custodial care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

D

Dentist An individual who is licensed to practice dentistry and is acting within the scope of that license in treating the dental condition.

Detoxification (Detox) The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient to a minimum.

Developmental Delay The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age-appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an injury.

Diagnostic Test Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Domestic Partner Each of two people, one of whom is the covered employee, who: (a) have registered as each other's *domestic partner*, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or (b) are the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other with each being (1) 18 years of age or older; (2) unmarried; (3) the sole *domestic partner* of the other person and have been so for the immediately preceding 6 months; (4)

sharing a primary residence with the other person and have been so sharing for the immediately preceding 6 months and (5) not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

Durable Medical Equipment (DME) Equipment which is (a) made to withstand repeated use; (b) manufactured solely to serve a medical purpose; (c) not merely for comfort or convenience; (d) not normally of use to persons who do not have a disease or injury; (e) ordered by a physician (f) related to the member's physical disorder.

The physician must certify in writing the medical necessity for the equipment. The physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing medical necessity of any item.

Disabled Either physically or mentally incapable of self-care. The disabled person must have the same principal residence as you.

E

Essential Absence Days Essential Absence Days (EADs) was the term legacy Assurant used for its occasional sick day/absences practice prior to Jan. 1, 2008. Earned but unused EADs, up to a maximum of 30, were "banked" for future use.

Employees who had banked EADs on Dec. 31, 2007 can use this time in lieu of PTO in certain situations.

EADs have no cash value and are not paid out upon termination of employment.

Education Expenses In your rehabilitation plan the reasonable costs you incur which are required for your education or training to return to work. These costs may include the cost of tuition, books, computers and other equipment. In your spouse's rehabilitation plan, education expense means the reasonable costs your spouse incurs which are required for your spouse's education or training. These cost may include the cost of tuition, books, computers and other equipment.

Emergency Medical Condition A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

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

Emergency Services Medically Necessary services will be covered whether you get care from a Network or *Out-of-Network* Provider. Emergency Care you get from an *Out-of-Network* Provider will be covered as a Network service and will not require pre-certification. The *Out-of-Network* Provider can only charge you any applicable *Deductible*, *coinsurance*, and/or *copayment* and cannot bill you for the difference between the Maximum Allowed Amount and their billed charges until your condition is stable as described in the Consolidated Appropriations Act of 2021 Notice section at the front of this Benefit Booklet. Your cost shares

will be based on the Maximum Allowed Amount, and will be applied to your Network *Deductible* and Network *Out-of-Pocket Limit*.

Treatment you get after your condition has stabilized is not Emergency Care. Please refer to the Consolidated Appropriations Act of 2021 Notice section at the front of this Benefit Booklet for more details on how this will impact your benefits.

The Maximum Allowed Amount for Emergency Care from an *Out-of-Network* Provider will be determined using the median Plan Network contract rate we pay Network Providers for the geographic area where the service is provided.

Experimental/Investigative Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the claims administrator determines to be unproven.

The claims administrator will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be experimental/investigative if the claims administrator, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted.
- Has been determined by the FDA to be contraindicated for the specific use.
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic product, equipment, procedure, treatment, service, or supply as experimental/investigative, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed experimental/investigative based on the criteria above may still be deemed experimental/investigative by the claims administrator. In determining whether a service is experimental/ investigative, the claims administrator will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service on health outcomes.
- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects.
- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the claims administrator to determine whether a dug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental/ investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof.
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies.
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.
- Documents of an Institutional Review Board (IRB) or other similar body performing substantially the same function.
- Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.
- Medical records; or
- The opinions of consulting providers and other experts in the field.

The claims administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental/investigative.

F

Family Care Expense The amount you spend for care of a family member in order for you to be retrained under a rehabilitation plan. To qualify:

- Your family member must be under age 13 or be physically or mentally incapable for caring for him or herself.
- Your family member must be dependent on you for support and maintenance; and
- The person who cares for your family member cannot be a relative.

Not more than $350 per family member per month will be included. A pro-rated amount will apply to any period shorter.

Freestanding Ambulatory Facility A facility, with a staff of physicians, at which surgical procedures are performed on an Outpatient basis—no patients stay overnight. The facility offers continuous service by both physicians and registered nurses (R.N.s). It must be licensed by the appropriate agency. A physician's office does not qualify as a freestanding ambulatory facility.

Full-time Student An individual who, during five calendar months from January through December, is enrolled as a student for the number of course hours considered to be a full-time course of study at an educational organization. The enrollment for five calendar months need not be consecutive.

G

Gender Affirming Surgery This Plan provides benefits for many of the charges for gender affirming surgery for Members diagnosed with Gender Dysphoria. Gender affirming surgery must be approved by us for the type of surgery requested and must be authorized prior to being performed. Charges for services that are not authorized for the gender affirming surgery requested will not be considered covered services. Some conditions apply, and all services must be authorized by us as outlined in the Health Care Management – Pre-certification section.

Generic Drug Generic drugs must have the same active ingredients as the original brand name drug.

Government Plan The United States Social Security Act, the Railroad Retirement Act, the Canadian Pension Plan, similar plans provided under the laws of other nations and any plan provided under the laws of a state, province or other political subdivision. It also includes any public employee retirement plan or any teachers' employment retirement plan or any plan provided as an alternative to any of the above acts or plans. It does not include any Workers' Compensation Act or similar law or the Maritime Doctrine of Maintenance, Wages or Cure.

H

Health Insurance Portability and Accountability Act of 1996 (HIPAA) A federal law that protects the privacy and security of your personal health information and prohibits health plans from discriminating against participants with regard to eligibility or *premiums* based on a health status-related factor.

Home Health Care Care, by a licensed program or provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending physician.

Home Health Care Agency A provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending physician. It must be licensed by the appropriate agency.

Hospice A provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician. It must be licensed by the appropriate agency.

Hospice Care Program A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. The hospice must be licensed by the appropriate agency and must be funded as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital An institution licensed by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision

of a staff of physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged.
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or disabled children.

Hospital Confined and Hospital Confinement A 24-hour-a-day stay in a hospital.

Hospital Outpatient Care Care in hospital that usually does not require an overnight stay.

I

Ineligible Hospital A facility that is not a state- recognized medical hospital

Ineligible provider A provider that does not meet the minimum requirements to become a contracted provider with Anthem Blue Cross and Blue Shield.

Indexed Basic Monthly Earnings Bodily harm from a non-occupational accident.

Injury Bodily harm from a non-occupational accident.

Inpatient A member who is treated as a registered bed patient in a hospital and for whom a room and board charge is made.

Intensive Care Unit A special unit of a hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

M

Maternity Care Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's hospital stay is a covered benefit and the newborn infant is an eligible member under the Plan.

Maximum Allowed Amount The maximum allowed amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies that:

- Meet Anthem's definition of covered services, to the extent such services and supplies are covered under the Plan and are not excluded.
- Are medically necessary; and
- Are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

You'll be required to pay a portion of the maximum allowed amount to the extent you have not met your *deductible* or have coinsurance. In addition, when you receive covered services from an *out-of-network* provider, you may be responsible for paying any difference between the maximum allowed amount and the provider's actual charges. This amount can be significant.

When you receive covered services from a provider, the claims administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those covered services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect claims administrator's determination of the maximum allowed amount. The claims administrator's application of these rules does not mean that the covered services you received were not medically necessary. It means that the claims administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the maximum allowed amount will be based on the single procedure code rather than a separate maximum allowed amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the maximum allowed amounts for those secondary and subsequent procedures because reimbursement at 100% of the maximum allowed amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Medical Necessity or Medically Necessary or Dentally Necessary An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by the claims administrator to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the member's condition, illness, disease or injury.
- Obtained from a provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting).
- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.
- Not experimental/investigative.
- Not primarily for the convenience of the member, the member's family or the provider.
- Not otherwise subject to exclusion under this Summary Plan Description.

The fact that a provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies medically necessary or a covered service and does not guarantee payment.

Medicare A federal government plan paying certain hospital and medical expenses for those who qualify, primarily those over age 65 or disabled.

Member Individuals, including you and your eligible *dependents*, who have satisfied the Plan eligibility requirements, applied for coverage and been enrolled for Plan benefits.

Mental Illness A mental disorder listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association. A mental illness, as so defined, may be related to or be caused by physical or biological factors, or result in physical symptoms or expressions. For the purposes of this policy, mental illness does not include any mental disorder listed within any of the following categories found in the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association:

- Intellectual impairment.
- Motor skills disorder.
- Pervasive developmental disorders.
- Delirium, dementia and amnestic and other cognitive disorders.
- Schizophrenia; and
- Narcolepsy, obstructive sleep apnea and sleep disorder due to a general medical condition.

Monthly Payment Limit 80% of monthly plan pay.

Moving Expenses The costs you incur to move more than 35 miles so that you can attend school or accept gainful work. In a spouse's rehabilitation plan, the costs are those incurred by the family so that the spouse can attend school or accept gainful work.

Multi-source Drug A drug marketed or sold by two or more manufacturers or labelers. Multi-source medicines refer to products from different manufacturers (including the innovator) that have the same active ingredient at the same strength and in the same dose form and are A-rated to each other.

N

Nationally Recognized Authorities The American Medical Association (AMA), the AMA Board of Medical Specialties, the American College of Physicians and Surgeons, the Food and Drug Administration, the Centers for Disease Control, the Office of Technology Assessment, the National Institutes of Health, the Health Care Finance Administration, the Agency for Health Care Policy and Research, the Department of Health and Human Services, the National Cancer Institute, the American Psychiatric Association and any additional organization MetLife chooses that attain similar status.

Network Provider A physician, health professional, hospital, pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the claims administrator to provide covered services to members through negotiated reimbursement arrangements. For Georgia, Florida, Missouri and Wisconsin residents, only providers in Anthem's Alternate Network are network providers.

Network Services When you use a Network Provider or get care as part of an authorized service, covered services will be covered at the Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a covered service. The Plan has the final authority to decide the Medical Necessity of the service. If you receive covered services from an *Out-of-Network* Provider after we failed to provide you with accurate information in our

Provider Directory at anthem.com, or after we failed to respond to your Telephone or web-based inquiry within the time required by Federal law, covered services will be covered at the Network level.

Network Transplant Provider A provider that has been designated as a center of excellence for transplants by the claims administrator and/or a provider selected to participate as a network transplant provider by a designee of the claims administrator. Such provider has entered into a transplant provider agreement to render covered transplant procedures and certain administrative functions to you for the transplant network. A provider may be a network transplant provider with respect to:

- Certain covered transplant procedures; or
- All covered transplant procedures.

Non-Covered Services Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an ineligible provider, or are otherwise not eligible to be covered services, whether or not they are medically necessary.

Non-preferred Brand Drug Brand name drugs not listed on the CVS Caremark *formulary*/covered drug list.

Normal Retirement Age Your normal retirement age according to the Social Security Administration (ssa.gov).

O

***Out-Of-Network* Provider** A provider, including but not limited to, a hospital, freestanding ambulatory facility, physician, skilled nursing facility, hospice, home health care agency, other medical practitioner or provider of medical services or supplies, that does not have an agreement or contract with the claims administrator to provide services to its members at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a member uses the services of *out-of-network* providers. For Georgia, Florida, Missouri and Wisconsin residents, only POS providers are network providers.

***Out-of-Network* Services** When you do not use a Network Provider or get care as part of an authorized service, covered services are covered at the *Out-of-Network* level, unless otherwise indicated in this Benefit Booklet. For services from an *Out-of-Network* Provider:

- There is no limit to what an *Out-of-Network* Provider can charge unless your claim involves a Surprise Billing Claim;
- The *Out-of-Network* Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any *Deductible* and/or *coinsurance*/*Copayments* unless your claim involves a Surprise Billing Claim;
- You may have higher cost sharing amounts (i.e., *Deductibles*, *coinsurance*, and/or *Copayments*) unless Your claim involves a Surprise Billing Claim;
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for Non-covered services;
- You may have to file claims; and

- You must make sure any necessary pre-certification is done. (Please see Health Care Management – Pre-certification for more details.)

Out-Of-Pocket Maximum The maximum amount of a member's coinsurance payments during a given Plan year. When the *out-of-pocket maximum* is reached, the level of benefits is increased to 100% of the maximum allowed amount for covered services for the remainder of the calendar year.

Over-the-counter (OTC) Drugs for which a doctor's prescription is not required.

P

Physical Therapy The care of disease or injury by such methods as massage, hydrotherapy, heat, or similar care.

Physician Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also physicians when acting within the scope of their licenses, and when rendering services covered under this Plan.

Plan Administrator The plan administrator for the Assurant Health and Welfare Plan is the Assurant, Inc. Benefit Plans Committee.

Period of Disability The period of time that you're determined to be disabled in accordance with the Short-Term Disability and/or Long-Term Disability Plan.

Plan Pay For non-sales employees, Plan Pay is equal to your annual base pay plus target short-term incentive (STIP) bonus, if any, in effect as of the last day of active work.

For sales employees with more than one year of service, the Plan Pay also includes any sales bonuses/commissions that were paid in the prior calendar year. For sales employees with less than 1 year of service, the Plan Pay includes any sales bonuses/commissions that were guaranteed to be paid in the first-year agreement.

Plan Pay is updated once each year, on April 1, and does not include overtime, long-term incentive compensation or any other form of pay you may be entitled to receive.

Prior Authorization The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the CVS Caremark Pharmacy and Therapeutics Committee.

Prospective A request for pre-certification or pre-determination that is conducted prior to the service, treatment or admission.

Provider A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any provider rendering services which are required by applicable state law to be covered when rendered by such provider. Providers that deliver covered services are described throughout this Summary Plan Description. If you have a question if a provider is covered, please call the number on the back of your I.D. card.

Prescription Drugs Drugs and medications that by law require a prescription.

Q

Qualified Medical Child Support Order (QMCSO) or Medical Child Support Order (MCSO) A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the employee is entitled under the plan; and includes the name and last known address of the employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- Provides for child support payment related to health benefits with respect to the child of a member or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- Enforces a state law relating to medical child support payment with respect to a group health plan.

Contact the People Experience Center at 1-866-324-6513 for a copy of the Plan's QMCSO procedures.

Qualified Dental Professional Any of the following professionals who are licensed and acting within the scope of their licenses:

- Dentists (D.D.S. or D.M.D.).
- Denturists.
- Dental hygienists.

Qualified dental professional does not include an immediate family member or an employee of the Assurant. Immediate family members include your spouse, *domestic partner*, parents, children, brothers, sisters, anyone who resides in your home, your spouse's or *domestic partner*'s parents, children and siblings.

Qualifying Period The length of time during a period of disability that you must be disabled before benefits are payable.

R

Reasonably Comparable Employment For involuntary terminations connected to the sale or transfer of an Assurant business unit or product line, the Plan Administrator will determine on a case by case basis, in its sole discretion, whether reasonably comparable offers of employment are made taking the following into account:

- How closely aligned the offer is to the business that is being sold;
- Whether the offer is within the employee's skill set, education, job experience, and abilities;
- Whether the offer is for a position with similar total compensation (including bonus/commission and benefits), title and job responsibilities. Similar does not mean identical or even within a particular range; and

- Other factors deemed relevant or material by the plan administrator, in its sole discretion.

Rehabilitation Plan A written statement, developed by Lincoln Financial which describes:

- The vocational rehabilitation goals for you.
- Lincoln Financial's responsibilities, your responsibilities and the responsibilities of any other parties to the plan; and
- The timing of the implementation and expected completion of the plan, to the extent that it can be established, assuming your full cooperation.

The rehabilitation plan will be designed to enable you to return to work in a gainful occupation.

A spouse's rehabilitation plan is a written agreement between you, your spouse and Lincoln Financial in which, at your request, Lincoln Financial agrees to provide, arrange or authorize appropriate vocational or physical rehabilitation services.

Rehire date The date on which an eligible employee is reemployed by Assurant.

Residential Treatment Center/Facility A Provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24-hour availability.
- A staff with one or more Doctors available at all times.
- Residential treatment takes place in a structured facility-based setting.
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a provider, or that part of a provider, used mainly for:

- Nursing care.
- Rest care.
- Convalescent care.
- Care of the aged.
- Custodial Care.
- Educational care.

Retrospective A request for certification that is conducted after the service, treatment or admission has occurred. Post service clinical claims review also is retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Retail Health Clinic A facility that provides limited basic medical care services to members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by physician assistants and nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Retirement Plan A formal or informal retirement plan, whether or not under an insurance or annuity contract. It does not include:

- A plan you pay for entirely.
- A qualified profit-sharing plan.
- A thrift plan. • An individual retirement account (IRA).
- A tax-sheltered annuity (TSA).
- A government plan; or
- A plan that qualifies under Internal Revenue Service Code 401(k).

S

SSA Representative Persons or organizations which specialize in assisting people to obtain disability benefits under the United State Social Security Act. If you appoint an SSA representative and they agree you're a good candidate, they will help you pursue your Social Security claim.

Screening A type of *preventive care* that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Semi-private Room A hospital room that contains two or more beds.

Severance Agreement An agreement between an eligible employee and an Assurant business unit that includes a waiver and general release of all claims that the eligible employee might have against Assurant, a business unit, the Plan Administrator, and any other parties designated in the Severance Agreement through the date on which the Severance Agreement is signed. Signing a Severance Agreement is a condition for receipt of severance benefits. At the sole discretion of the Plan Administrator, the Severance Agreement of some eligible employees may contain release terms that differ from the release terms provided in the Severance Agreements of other eligible employees.

Severance Date The date specified by Assurant as the eligible employee's last date of employment.

Single Source Drug A drug marketed or sold by only one manufacturer or labeler.

Skilled Nursing Care Care required, while recovering from an illness or injury, which is received in a skilled nursing facility. This care requires a level of care or services less than that in a hospital, but more than could be given at the patient's home or in a nursing home not certified as a skilled nursing facility.

Skilled Nursing Facility An institution operated alone or with a hospital which gives care after a member leaves the hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American

Osteopathic Association, or otherwise determined by the claims administrator to meet the reasonable standards applied by any of the aforesaid authorities.

Specialist (Specialty Care Physician / provider or SCP) A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs Drugs that meet a minimum of two of the following characteristics:

- Produced through DNA technology or biological processes.
- Targets a chronic and complex disease.
- Route of administration could be inhaled, infused or injected.
- Unique handling, distribution and /or administration requirements

and/or

Must require a customized medical management program that includes medication use review, patient training, coordination of care and adherence management for successful use such that more frequent monitoring and training may be required.

If you're utilizing a specialty Drug, our goal is to provide you with access to the most clinically appropriate therapy to meet your treatment needs. These Drugs are used to treat complicated and chronic conditions, such as cancer, rheumatoid arthritis, multiple sclerosis and other diseases. Health issues like these can be challenging to manage and we want to assure that you receive safe, effective treatment.

Providing coverage under the best benefit (pharmacy or medical) is the first step. Specialty medications which you can give to yourself are best managed under the pharmacy benefit. Drugs which require a medical professional to give to you will be provided under your medical benefit.

Specialty medications covered under the pharmacy benefit are generally classified as Tier 4 Specialty medications under the Plan's prescription drug benefit. Certain Tier 4 Specialty medications may be eligible for the PrudentRx Specialty Medication Program. See the **PrudentRx Specialty Medication Program** section of this SPD for additional information.

Anthem also requires pre-certification for certain specialty Drugs under the medical benefit. This means that a clinical review is required before the Drug is approved. Pre-certification assures consistent use of effective medications based on our medical policies and treatment guidelines. We also review for correct dose and frequency as well. During this time, our pharmacists will work with your Physician to incorporate additional dose reduction opportunities that are still clinically appropriate for you. Your physician will contact us for pre-certification and provide us with the clinical information needed for us to review the request.

Our final focus is on the setting in which your treatment may occur. There are multiple options available to you typically selected by your physician. Did You know that the outpatient hospital setting can be 2-3 times more costly than other sites? Receiving care in a lower cost site which can meet your specific needs can help you and your employer save money and can also possibly provide you with more convenient options in which to receive your Drug treatment. Anthem's site of care program requires that your prescriber provide information on

the level of care that you need. You may be redirected to receive your care in your physician's office, an infusion center, or from a home infusion provider instead of the outpatient hospital.

All of these approaches work cohesively together to help you with your medical specialty Drug needs.

Certain specialty medications covered under the pharmacy benefit may also be subject to the PrudentRx Specialty Medication Program and related specialty pharmacy requirements. See the **PrudentRx Specialty Medication Program** section of this SPD for additional information.

Social Security Plan The United States Social Security Act, the Railroad Retirement Act, the Canadian Pension Plan or any similar plan provided under the laws of any other nation. It also means any public employee retirement plan or teachers' employment retirement plan provided as an alternative to rather than a supplement for such plans.

Spouse The person to whom you're legally married.

Statement of Health (SOH) Evidence acceptable to MetLife of the good health of a person.

Substantially Similar Employment A position within Assurant (or buyer/transferee in the case of sale or transfer of any portion of an Assurant business unit) that, in the discretion of the Plan Administrator:

- Is of a type for which the eligible employee is, or reasonably can become, qualified by work experience, education and/or training;
- Does not require the eligible employee to relocate or to increase the employee's commute between home and principal office/base by more than 70 miles roundtrip or an additional 90 minutes of daily commute time;
- Does not entail a significant loss of responsibility;
- Provides a total compensation package (including bonus/commission and benefits) that, in the aggregate, is not substantially less than the eligible employee earned on his or her last day of employment with a participating entity; and
- Other factors deemed relevant or material by the plan administrator, in its sole discretion.

The Plan Administrator or its designee has the sole authority to determine whether a position is substantially similar employment.

Surprise Billing Claims Surprise billing claims are described in the **Surprise Billing Notice** posted under Legal Notices on myassurantbenefits.com.

T

Transplant Providers

- Network Transplant Provider - A Provider that has been designated as a "Center of Excellence" for Transplants by the claims administrator and/or a provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such provider has entered into a transplant provider agreement to render covered transplant procedures and certain administrative functions to you for the transplant network. A provider may be a Network Transplant Provider with respect to:
    - Certain Covered Transplant Procedures; or

- All Covered Transplant Procedures.

U

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) A federal law that protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System.

Urgent A request for pre-certification or pre-determination that in the opinion of the treating provider or any physician with knowledge of your medical condition, could in the absence of such care or treatment, seriously jeopardize your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

Urgent Care Services received for a sudden, serious, or unexpected illness, injury or condition. Urgent care is not considered an emergency. Urgent care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

Usual, Customary and Reasonable (UCR) The average fee charged by a majority of dental providers in a given geographic area for a particular service. Whenever you use non-network providers, benefits are paid based on UCR rates. You're responsible for paying amounts above UCR. In-network care is always within UCR guidelines.

W

Workers Compensation A state-based benefit plan that provides medical and income-replacement benefits for work-related illnesses and injuries.