Atlantic Risk

Atlantic Risk HSA Plan

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IMPORTANT INFORMATION ABOUT THE POLICY

This Health Insurance Policy ("Policy") describes all of the benefits available between Atlantic Risk ("Atlantic Risk," "we," "our," or "us") and the Covered Person ("member", "participant", "you," "your", or "yours") under the Atlantic Risk HSA Plan, including eligibility requirements for

coverage, the benefits provided, the conditions that must be met to qualify for Plan benefits, and other special Plan provisions. Although every effort has been made to make the description in this Policy as accurate as possible, this Policy does not include every relevant detail of the Plan. No representations are made regarding any additional or other coverage, nor are additional or other coverages available to a member unless specifically stated in this Policy. No benefits are available to you which are not specifically identified in this Policy.

It is important that you read this Policy in its entirety, so that you can understand the details of the Plan. Many sections of the Policy are related to other sections of the document. You may not have all of the information you need by reading just one section, so it is important that you review all sections that apply to a specific topic. We have made every effort to present the information as clearly and simply as possible. However, sometimes we must use words and phrases that are legal in nature. We have included a glossary at the end of this Policy to help clarify those terms, and terms from the glossary are capitalized throughout this Policy. Whenever the benefits in this Policy materially change, you will be notified of the modifications of your benefits. Keep this Policy and all notices together so you have ready access to the most current information about the Plan.

I – PLAN ADMINISTRATION INFORMATION

NAME OF PLAN	Atlantic Risk HSA Plan
COMMON NAME	"Plan"
POLICY NUMBER	10530
TYPE OF PLAN	This Policy is a contract between Atlantic Risk and you that meets High-Deductible Health Plan Coverage. In exchange for your payment of premium, we provide you with defined healthcare benefits. Please read the Policy

	closely and keep it for future reference. Your Summary of Benefits and Coverage ("SBC") contains a quick summary of the benefits by category of service and is considered a part of this contract.
PLAN ADMINISTRATOR	ARM, LTD
PLAN YEAR	Calendar Year (January 1 – December 31); Coverage Period referenced in the SBC: 01/01/2026 – 12/31/2026
THIRD-PARTY ADMINISTRATOR	A third-party administrator has been hired to process claims under the Plan. The third-party administrator does not serve as an insurer, but as an administrative firm and claims processor. Claims for benefits are sent to the third-party administrator. It processes the claims, requests, and receives funds from Covered Person to pay the claims, and makes payment on the claims to hospitals and other providers according to the documents governing the Plan. Atlantic Risk is ultimately responsible for providing Plan benefits, not the third-party administrator, ARM, LTD. 814 W. Northwest Hwy. Arlington Heights IL 60004 847.394.1700
AGENT FOR SERVICE OF PROCESS	Compliance Officer
MAILING ADDRESS	5301 N Federal Hwy Ste 155
PLAN NUMBER	10530

Certain terms used in this Insurance Policy ("Policy") have specific meanings and are defined in the Definitions Glossary. Understanding the meanings of all the defined terms will help you better understand the information provided in this Policy.

II – BENEFIT SUMMARY

PLAN EFFECTIVE DATE	[Plan Effective Date]
MONTHLY PLAN DAY	1st of the Month
PLAN TYPE	Exclusive Provider Organization (PPO) — High Deductible Health Plan (HDHP), HSA-qualified
PARTICIPATING PROVIDERS	This Plan uses a Provider Network. This Plan **does cover** services or supplies provided by an Out-of-Network Provider. Call [847.394.1700] or see [https://providersearch.multiplan.com/] for a list of Network Providers under PHCS specific services. Non-covered services and supplies provided by a Network Provider will still be entitled to the network discount.
REFERRAL REQUIREMENT	No referral is required to see a Specialist.
BENEFIT YEAR MODE	Except as otherwise specified, "annual" or "year" refer to the Plan Year. Maximum Benefit limitations, Claim Accumulators, and Cost-Sharing features reset each Plan Year, except as otherwise specified.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine your coverage. It is recommended that you review this Policy in its entirety for a description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Benefits listed in this Benefit Summary are applicable for each Covered Person unless otherwise indicated and are active as of the Plan Effective Date shown above. Benefits will be paid for Covered Charges incurred while coverage is in force and is subject to all benefit provisions and other conditions of the Plan.

This Benefit Summary replaces any prior version with an earlier date. Some Covered Charges are limited to items and services that are deemed Medically Necessary and may be subject to limitations and conditions. Please refer to Section VI ("MEDICAL BENEFITS") for more information on Covered Services and Section VIII ("EXCLUSIONS") for a list of services and supplies not covered under the Plan.

DEDUCTIBLE & OUT-OF-POCKET LIMIT

	Network Provider	**Out-of-Network Provider**
Overall Deductible	$5,000 Individual / $6,000 Family	Not Applicable — Out-of-Network services are not covered
Other deductibles for specific services	None	—
Out-of-Pocket Limit	$6,650 Individual / $13,300 Family	Not Applicable
What's excluded from the Out-of-Pocket Limit	Copayments for certain services, premiums, balance-billing charges, and health care this Plan doesn't cover.	—

Generally, you must pay all costs from Providers up to the Deductible amount before the Plan begins to pay, except for Preventive Services and other services identified below as covered before the Deductible.

PHYSICIAN SERVICES (OFFICE VISITS)

Service	Network Provider (least cost)	Out-of-Network Provider	Notes
Primary Care Office Visit (illness/injury)	Deductible, then $20 copay per visit	Deductible, then $20 copay per visit	
Virtual Primary Care	$0 Copay	$0 Copay	Unlimited use
Specialist Visit	Deductible, then $50 copay per visit	Deductible, then $50 copay per visit	No referral required
Service	**Network Provider (least cost)**	**Out-of-Network Provider**	**Notes**
Preventive Care / Screening / Immunization	No Charge — 100% Covered	No Charge — 100% Covered	No out-of-pocket cost when provided by a Network Provider; see https://www.healthcare.gov/coverage/preventive-care-benefits/

DIAGNOSTIC & IMAGING SERVICES

Service	Network Provider	Out-of-Network Provider	Notes
Diagnostic test (x-ray, blood work)	Deductible, then $50 copay per date of service	Deductible, then $50 copay per date of service	Preventive-screening labs (e.g., annual wellness panel) covered 100% with no cost sharing
Imaging (CT, PET, MRI)	Not Covered	Not Covered	

EMERGENCY, URGENT & HOSPITAL SERVICES

Service	Network Provider	Out-of-Network Provider	Notes
Emergency Room Care	Not Covered	Not Covered	
Emergency Medical Transportation	Not Covered	Not Covered	
Virtual Urgent Care	$0 Copay	Not Covered	Unlimited use
Urgent Care Facility	Deductible, then $50 copay	Deductible, then $50 copay	
Hospital Facility Fee	Not Covered	Not Covered	
Service	**Network Provider**	**Out-of-Network Provider**	**Notes**
Hospital Physician/Surgeon Fees	Not Covered	Not Covered	
Outpatient Surgery — Facility Fee	Not Covered	Not Covered	
Outpatient Surgery — Physician/Surgeon Fees	Not Covered	Not Covered	

MENTAL HEALTH, BEHAVIORAL HEALTH & SUBSTANCE USE SERVICES

Service	Network Provider	Out-of-Network Provider	Notes

Virtual Mental and Behavioral Health	$0 Copay	Not Applicable	Unlimited use
Outpatient Mental Health / Substance Use Services	Not Covered	Not Covered	
Inpatient Mental Health / Substance Use Services	Not Covered	Not Covered	

PREGNANCY & MATERNITY SERVICES

Service	**Network Provider**	**Out-of-Network Provider**	**Notes**
Office Visits (pre/post-natal)	Not Covered*	Not Covered	*Certain women's preventive services required by the ACA are covered 100% with no cost sharing — see https://www.hrsa.gov/
Service	**Network Provider**	**Out-of-Network Provider**	**Notes**
			womens-guidelines/index.html
Childbirth/Delivery — Professional Services	Not Covered	Not Covered	
Childbirth/Delivery — Facility Services	Not Covered	Not Covered	

ADDITIONAL SERVICES

Service	**Network Provider**	**Out-of-Network Provider**

Home Health Care	Not Covered	Not Covered
Rehabilitation Services	Not Covered	Not Covered
Habilitation Services	Not Covered	Not Covered
Skilled Nursing Care	Not Covered	Not Covered
Durable Medical Equipment	Not Covered	Not Covered
Hospice Services	Not Covered	Not Covered

PEDIATRIC DENTAL & VISION

Service	**Network Provider**	**Out-of-Network Provider**
Children's Eye Exam	No Charge — 100% Covered	No Charge — 100% Covered
Children's Glasses	Not Covered	Not Covered
Children's Dental Check-Up	No Charge — 100% Covered	No Charge — 100% Covered

OUTPATIENT PRESCRIPTION DRUGS

Drug Category	**Network Pharmacy**	**Out-of-Network Pharmacy**	**Notes**
Generic Drugs	Preventive* — 100% Covered; All Others — Not Covered	Preventive* — 100% Covered; All Others — Not Covered	*ACA "A"/"B"-rated preventive drugs only
Preferred Brand Drugs	Preventive* — 100% Covered; All Others — Not Covered	Preventive* — 100% Covered; All Others — Not Covered	*ACA "A"/"B"-rated preventive drugs only
Non-Formulary Drugs	Discount Only	Not Covered	
Diabetic Supplies	Discount Only	Not Covered	

See Section VII ("OUTPATIENT PRESCRIPTION DRUG BENEFITS") for more detail.

III – COVERED PERSON EFFECTIVE DATE AND TERMINATION DATE

COVERED PERSON ELIGIBILITY AND EFFECTIVE DATE

A person who is eligible may elect coverage under the Plan by completing an approved enrollment form. Verification of eligibility may be required. You will be covered under the Plan on the following dates:

1. Enrollments received up to the last day of the month can have an effective date on the 1st day of the next month.

TERMINATION DATE

1. You may terminate the Policy by giving us advance written notice.
2. We may terminate the Policy, and coverage for you and your Dependent(s), for the below reasons: a. You fail to pay premiums in accordance with the Policy. Partial payment will be treated as nonpayment unless we, at our sole discretion, indicate otherwise in writing. b. If there is fraud or material misrepresentation made by you or with the knowledge of any Covered Person regarding eligibility for this coverage, medical history, or filing a Claim for benefits. c. You no longer live, reside, or work in the Service Area. d. We cease to offer this particular health plan in accordance with applicable state and federal law. In such instance we will give you at least 30 days' advance notice.
3. If you join, on a Full-Time Basis, the military forces of any country or the service of any governmental agency involving employment outside the United States, except to the extent coverage is required by USERRA or other applicable law.

IV – DEPENDENT EFFECTIVE DATE AND TERMINATION DATE

DEPENDENT ELIGIBILITY

If Dependents are eligible for coverage under the Plan, coverage may begin on the latest of the following dates:

1. The date coverage for Dependents is available under the Plan;

2. The date you become eligible for coverage under the Plan; 3. The date on which a person meets the definition of a Dependent; or
4. The date provided in accordance with a Special Enrollment Period.

Verification of eligibility may be required for enrollment.

DEPENDENT EFFECTIVE DATE

A Dependent cannot be covered under this Plan until you are covered under this Plan. To obtain coverage for your Dependent(s), you must apply for Dependent coverage under this Plan by filling out an enrollment form. If approved, coverage for your Dependent(s) will take effect on the next billing due date that coincides with one of the following dates:

1. The Eligibility Date, if you apply for Dependent coverage on or before your Effective Date and the Dependent is included on your initial enrollment form; or
2. The Enrollment Date, if you apply for Dependent coverage within 61 days after the Dependent first becomes eligible for coverage under your Plan.

You must provide written or verbal notification and an enrollment form for any change in Dependent status within 61 days of the change.

ADDING A NEWBORN TO THE PLAN

Coverage for a newborn Dependent child will take effect at the moment of birth, if notification is provided for Dependent coverage and you pay any required monthly contribution within 61 days after the newborn child's birth. If notification and the required monthly contribution are not received within the first 61 days from the newborn child's birth, the newborn child will not be covered from the date of birth, and all coverage for your newborn child is forfeited as of the moment of birth, subject to your ability to enroll during the next Special Enrollment Period or Annual Open Enrollment Period. Notification shall be sent directly to [TPA Name] Member Services in accordance with Section XVII ("CONTACT INFORMATION").

ADDING AN ADOPTED CHILD OR CHILD PLACED FOR ADOPTION TO THE PLAN

Coverage for a newly adopted Dependent child, or such child placed for adoption, will take effect on the date the child becomes a Dependent, if notification is provided for Dependent coverage and you pay any required monthly contribution within 61 days after the child's adoption or placement for adoption. If not timely provided, all coverage for the child is forfeited as of that date, subject to your ability to enroll during the next Special Enrollment Period or Annual Open Enrollment Period.

ADDING A CHILD FOR WHOM A COURT ORDER REQUIRES YOU TO PROVIDE HEALTH COVERAGE

A child for whom a court order requires you to provide health coverage will be covered if we receive a Qualified Medical Child Support Order (QMCSO) and any required contribution within 61 days of the court order. Coverage will take effect on the date of the court order if timely notification and contribution are received; otherwise, coverage is forfeited as of the date of the court order, subject to your ability to enroll during the next Special Enrollment Period or Annual Open Enrollment Period.

COVERAGE FOR DISABLED ADULT CHILDREN OVER THE AGE OF 26

Your Covered Dependent who is permanently mentally or physically disabled is eligible for continued coverage under this Plan after reaching the age of 26 if you provide adequate documentation validating disability. The child must be unmarried, dependent upon you for care and financial support, and have no Dependents of his/her own. We rely on the tax definition under Internal Revenue Code Section 22(e)(3) in determining permanent and total disability.

COVERED DEPENDENT TERMINATION DATE

Coverage and all benefits for a Covered Dependent will terminate on the first day of the Billing Period that commences immediately after the first to occur of the following events:

1. We receive your written request for termination of a Covered Dependent;
2. This Plan terminates;
3. A Covered Dependent no longer meets the Dependent definition in this Plan;
4. Your spouse's coverage, only when you and your spouse are legally divorced; or
5. A Covered Dependent joins, on a full-time basis, the military forces of any country or the service of any governmental agency involving employment outside the United States, except to the extent coverage is required by USERRA or other applicable law.

V – PROVIDER NETWORK

NETWORK REQUIREMENT

This Plan is an Exclusive Provider Organization (PPO). Covered Services can be received from a Network Provider or Out of network provider to be eligible for payment (up to 125% of Medicare’s allowed amount) , **except** for the Virtual Urgent Care benefit and any other benefit expressly identified in this Policy as covered regardless of network status. Services and supplies received from an Out-of-Network Provider are **covered** under this Plan, and amounts you pay to an Out-of-Network Provider will apply toward your Deductible or Out-of-Pocket Limit.

No referral is required to see a Specialist.

Non-covered services and supplies provided by a Network Provider will still be entitled to the negotiated network discount, even though the Plan does not make payment for that service.

FINDING A NETWORK PROVIDER

To confirm whether a Provider participates in the Plan's network, call 847.394.1700 or visit https://providersearch.multiplan.com/ and search under PHCS specific services. Using a listed Network Provider is not a guarantee of coverage — all other requirements of the Plan (including Medical Necessity, and any applicable exclusions in Section VIII) must also be met for a Covered Charge to be considered for payment.

PAYMENT OF PHARMACY BENEFITS

The Network Pharmacy benefit levels are shown in Section II ("BENEFIT SUMMARY") and Section VII ("OUTPATIENT PRESCRIPTION DRUG BENEFITS"). Using a Network Pharmacy is not a guarantee of coverage. Prescription Drugs obtained from a Non-Participating (Out-of-Network) Pharmacy are covered under the Plan.

VI – MEDICAL BENEFITS

The Plan will pay Covered Charges for the services and supplies listed as Medical Benefits in the Summary of Benefits and Coverage (SBC) and this section of the Policy. How Covered Charges are paid, and the Maximum Benefit for Covered Services and supplies, are shown in Section II ("BENEFIT SUMMARY"). The list of specific benefits under each major category heading below is not exhaustive and is intended to give you a general description of expenses for services and supplies covered by the Plan.

Coverage under this Plan is limited to the Covered Services specifically listed in this Policy, and, except where this Policy expressly states otherwise, must be received from a Network Provider to be eligible for payment. Services, supplies, tests, treatments, or procedures not specifically listed as covered are not covered under this Plan.

IMPORTANT: The healthcare service, supply or pharmaceutical product is only considered a Covered Service if it is Medically Necessary. The fact that a Physician or other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, Substance-Abuse and Addictive Disorders, disease or its symptoms, does not mean that the procedure or treatment is a Covered Service under the Plan.

For any services or procedures not specified, call Member Services at 847.394.1700.

OFFICE VISITS

Office Visits include evaluation and management services, as defined in the most recent edition of Current Procedural Terminology. Office Visit coverage does not include Clinical Laboratory Services, X-rays, diagnostic imaging, diagnostic testing, procedures, supplies, or other services performed during or in connection with the Office Visit unless separately covered under this section.

Primary Care Provider Office Visit. Covered only when received from a Network Provider. Subject to the Deductible, then a $20 copay per visit. Not covered Out-of-Network.

Virtual Primary Care. $0 copay, unlimited use.

Specialist Office Visit. Covered only when received from a Network Provider. Subject to the Deductible, then a $50 copay per visit. Not covered Out-of-Network. No referral is required.

Virtual Mental and Behavioral Health. $0 copay, unlimited use. Not applicable Out-of-Network. Outpatient and Inpatient mental health and substance use disorder services other than this virtual benefit are **not covered** (see Section VIII).

PREVENTIVE SERVICES

Clinical Preventive Services as outlined by the Affordable Care Act (ACA) and at www.healthcare.gov are covered 100% with no cost sharing when received from a Network Provider. If a Covered Person receives a Balance Bill for a Clinical Preventive Service, they should contact Member Services in accordance with Section XVII ("CONTACT INFORMATION") for resolution. Covered categories include:

- **Evidence-Based Screenings and Counseling** rated "A" or "B" by the U.S. Preventive Services Task Force (USPSTF): https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.
- **Routine Immunizations** recommended by the Advisory Committee on Immunization Practices (ACIP) of the CDC.
- **Preventive Pediatric Healthcare Services**, per the American Academy of Pediatrics (AAP) periodicity schedule.
- **Preventive Healthcare Services for Women**, per HRSA's Women's Preventive Services Guidelines: https://www.hrsa.gov/womens-guidelines/index.html.
- **Children's preventive eye exam and dental check-up** are each covered 100% when received from a Network Provider. Children's eyeglasses are not covered.

Diagnostic tests or exams performed as part of a preventive screening (for example, blood work drawn as part of an annual adult physical) are covered at 100% with no cost sharing. Benefit assistance for preventive mammography and colonoscopy screening, provided in accordance with applicable preventive care guidelines-based scheduling, is subject to limits of $500 (mammography) and $3,500 (colonoscopy) for members residing outside California, the District of Columbia, Massachusetts, New Jersey, Rhode Island, and Vermont. These limits do not apply to members residing in those jurisdictions. Limits may vary by area of service and are subject to change. When changes are made to the recommendations or guidelines for a covered preventive category, benefits for the new or changed service will be provided for Plan Years beginning on or after the date that is one (1) year after the recommendation or guideline is issued.

DIAGNOSTIC TESTING

Diagnostic test (x-ray, blood work). Covered.
Subject to the Deductible, then a $50 copay per date of service.

Imaging (CT scan, PET scan, MRI). Not covered, Network or Out-of-Network.

URGENT CARE SERVICES

Virtual Urgent Care. $0 copay, unlimited use, covered whether received from a Network or Out-of-Network Provider.

Urgent Care Facility. Covered. Subject to the Deductible, then a $50 copay per visit. Urgent Conditions need prompt medical attention but are not life-threatening; if you visit an Urgent Care Facility for a condition that is not urgent, the Plan may not cover the expense.

SERVICES NOT COVERED UNDER THIS SECTION

The following categories of services described in the SBC are **not covered** under this Plan, whether received In-Network or Out-of-Network, except to the limited extent a Covered Service is separately and expressly listed above or in Section II:

- Emergency Room care and emergency medical transportation
- Hospital facility fees and hospital physician/surgeon fees (Inpatient)
- Outpatient surgery — facility fees and physician/surgeon fees
- Outpatient and Inpatient mental health, behavioral health, and substance use disorder services (other than the Virtual Mental and Behavioral Health benefit above)
- Pregnancy-related office visits, and childbirth/delivery professional and facility services (except certain ACA-required women's preventive services)
- Home health care, rehabilitation services, and habilitation services
- Skilled nursing care, durable medical equipment, and hospice services - Imaging (CT, PET, MRI)

See Section VIII ("EXCLUSIONS") for the full list of services and supplies not covered under the Plan.

VII – OUTPATIENT PRESCRIPTION DRUG BENEFITS

Only Prescription Drugs obtained from a Network Pharmacy and consistent with the tiers described below will be considered Covered Charges. Prescription Drugs obtained from a Non-Participating (Out-of-Network) Pharmacy are **not covered** under the Plan. Benefits are subject to all the terms, limits, and conditions in this Policy.

FORMULARY TIERS

Tier	**Network Pharmacy Cost**	**Notes**
Preventive Generic / Preferred Brand Drugs (ACA "A"/"B"-rated)	100% Covered, $0 cost sharing	See https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations
All other Generic Drugs	Not Covered	
Tier	**Network Pharmacy Cost**	**Notes**
All other Preferred Brand Drugs	Not Covered	
Formulary Tier 1	$0 Copay	
Formulary Tier 2	Under $14.95 Copay	
Non-Formulary Drugs	Discount Only	Plan does not pay a benefit; Covered Person receives the negotiated discount price
Diabetic Supplies	Discount Only	Plan does not pay a benefit; Covered Person receives the negotiated discount price
Specialty Drugs	Not Covered	

Prescription Drugs obtained Out-of-Network are not covered under any tier.

FORMULARY

The list of drugs, medications, and products assigned to each tier (the "Drug List" or "Formulary") is available through RX Valet at https://www.myrxvalet.com/en. The Formulary is subject to change; for example, when a new drug or a generic equivalent comes to market, its tier assignment may be added, expanded, or revised. Review the current Formulary before obtaining a Prescription Drug, and discuss cost-effective treatment options with your doctor.

SUPPLY LIMITS

1. Retail fills are generally limited to a 30-day supply per Prescription Order, unless a lesser amount is required by the Prescription Order, manufacturer packaging, or a Plan limitation.
2. Prescription Drugs are covered only in dosages, dosage forms, dosage regimens, and durations of treatment that are Medically Necessary.
3. Some Prescription Drugs may require prior authorization or step therapy before they will be considered a Covered Charge on the applicable tier.

IDENTIFICATION CARDS

You will receive an identification (ID) card for you and your Covered Dependents to use while covered under this Plan. No benefits are payable for any Prescription Order filled for a Covered Person on or after the date his or her coverage terminates under the Plan.

MISCELLANEOUS PROVISIONS

The amount you pay under this section is a fixed copay, discount, or full retail price as described above, and will not be adjusted based on any retrospective volume drug discounts or manufacturer rebates the Plan may receive. Manufacturer copay assistance cards ("copay cards") are not a Patient Assistance Program and do not affect the Covered Person's obligation to pay the applicable cost share described above.

VIII – EXCLUSIONS

GENERAL EXCLUSIONS

The Plan will not pay benefits for the following services, treatments, or supplies even if they are recommended or prescribed by a Provider or are the only available treatment for your condition. Consistent with the Summary of Benefits and Coverage, this includes (without limitation): cosmetic surgery; adult dental care; infertility treatment; all mental health and substance use disorder services other than the Virtual Mental and Behavioral Health benefit in Section VI; Inpatient and Outpatient Hospital services; private-duty nursing; hearing aids; Inpatient and Outpatient Surgery; adult routine eye care; routine foot care; long-term care; and

pregnancy/maternity services other than ACA-required women's preventive services. In addition, the Plan excludes:

1. Acupuncture/Acupressure, including Rolfing therapy.
2. Administrative costs and miscellaneous charges, including missed/cancelled appointment fees, Provider administrative expenses, concierge or boutique medical practice membership charges, and Direct Primary Care (DPC) membership fees.
3. Adoption expenses.
4. Allergy Services.
5. Alternative therapies, including art, music, dance, and horseback therapy, and other NCCAM-defined alternative treatments.
6. Ambulance: Emergency and Non-Emergency Ground Ambulance; Air Ambulance.
7. Anesthesia Services in connection with care that is not itself a Covered Service.
8. Applied Behavior Analysis (ABA) and related services outside the scope expressly covered under this Policy.
9. Asthma Treatment, therapeutic.
10. Auditory-related treatment, services, or devices, including bone-anchored hearing aids, cochlear implants, hearing aids, and vestibular rehabilitation.
11. Autism Spectrum Disorder services.
12. Automobile Accident-related injuries in specified circumstances (uninsured driver, above legal blood-alcohol limit, driving under the influence, or failure to wear a seatbelt as required by state law).
13. Autopsy services.
14. Bariatric Surgery.
15. Blood and plasma services, including Platelet Rich Plasma (PRP) treatment and stem cell therapy (see item 66).
16. Bone Mass Measurement and Osteoporosis services.
17. Cancer-related therapies.
18. Category II and Category III CPT codes for tracking, performance measurement, data collection, and documentation.
19. Cellular Therapy, including Gene Therapy and CAR-T Therapy.
20. Charges rendered or billed only because health coverage exists; Healthcare Practitioner-assisted suicide; drugs obtained from a pharmacy Provider outside the United States; services incurred outside the United States and its territories; and services provided by an employer of, or an entity in which, the Covered Person or family member has an ownership or other financial interest.
21. Chelation Therapy, except to treat heavy metal poisoning.
22. Chiropractic Care.
23. Complementary and Alternative Medicine (CAM), including aromatherapy, botanicals, homeopathy, hypnosis, thermography, Pilates, and yoga.
24. Congenital Heart Disease (CHD) Surgery.

25. Cosmetic and Reconstructive Procedures, subject to the limited reconstructive exceptions required by the Women's Health and Cancer Rights Act (see Section XV).
26. Dental care, including routine dental care, orthodontics, dental X-rays, dental supplies, dental appliances, and dental services related to accidental injury (adult); pediatric preventive dental check-ups are covered as described in Section VI.
27. Diabetic services, supplies, equipment, and self-care programs, except for the Discount Only pharmacy benefit described in Section VII.
28. Diagnostic imaging, advanced imaging, X-rays, and diagnostic testing other than the Diagnostic Test benefit expressly covered in Section VI.
29. Dietary supplements, vitamins, minerals, and herbs, absent FDA approval for a specific health claim.
30. Durable Medical Equipment, devices, appliances, medical supplies, and prosthetics, except as expressly covered.
31. Elective services or supplies that are not Medically Necessary.
32. Emergency Services, including Emergency Room care and emergency ground or air transportation.
33. Endoscopic Therapies for GERD.
34. Enteral Nutrition.
35. Exams and forms required solely for employment, travel, school/camp admission, sports participation, adoption, licensure, immigration, marriage, incarceration, disability determination, FMLA verification, or workers' compensation attorney purposes.
36. Excess Charges above any Maximum Benefit or the Maximum Allowable Amount.
37. Exercise equipment and fitness training, including gym memberships, hot tubs, saunas, pools, and whirlpools.
38. Insertion or maintenance of an artificial heart.
39. Experimental and/or Investigational procedures, services, and supplies (see Definitions Glossary).
40. Food, nutritional support, and supplements, including appetite suppressants, infant formula, and nutritional counseling (except as expressly covered).
41. Genetic testing and counseling, except BRCA1/BRCA2 testing upon Provider order with qualifying personal or family cancer history.
42. Genomic sequencing procedures and molecular multianalyte assays.
43. Habilitative and Rehabilitative Services, including physical therapy, custodial care, respite care, day care, therapeutic recreation, vocational training, residential treatment, and work hardening programs.
44. Hearing Aids.
45. High-dose chemotherapy requiring bone marrow or stem cell reconstitution, except in limited circumstances described in the Definitions Glossary.
46. Home Health Care Services.
47. Hospice Care Services.
48. Hospitalization, services, and supplies that are not Medically Necessary.

49. Illegal Activity — conditions, disabilities, or expenses resulting from a felony, certain misdemeanors, or driving under the influence.
50. Certain non-routine immunizations/vaccines (Anthrax, BCG, Cholera, Plague, Typhoid, Yellow Fever), except as covered under Preventive Services.
51. Infertility Treatment.
52. Services and supplies received while in the custody of law enforcement, jail, prison, or another detention facility, except as required by state law.
53. Long-term Care.
54. Measurement of Lipoprotein-Associated Phospholipase A2 (Lp-PLA2) for cardiovascular risk assessment.
55. Medical or surgical treatment of excessive sweating (hyperhidrosis).
56. Mental Health and Psychiatric Services, other than the Virtual Mental and Behavioral Health benefit described in Section VI.
57. Microwave Tumor Ablation.
58. Non-emergency care while traveling outside the United States.
59. Occipital Nerve Stimulation.
60. Orthognathic Surgery.
61. Certain over-the-counter products (batteries, health and beauty aids, herbal/homeopathic products, essential oils, minerals, vitamins, and supplements), whether or not prescribed.
62. Pain Management Services, including prolotherapy and radiofrequency ablation.
63. Paternity testing.
64. Pathology consultations, including Tier I and Tier II molecular pathology procedures.
65. Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) and PANDAS evaluation and treatment.
66. Personal Convenience Items and Self-Care, including beauty/barber services, guest services, televisions/telephones, and incontinence products.
67. Postural Tachycardia Syndrome (POTS) evaluation and treatment.
68. Pregnancy and Reproduction, including elective abortion (except where the mother's life is at risk or the fetus is non-viable), elective amniocentesis for sex determination, home births, all infertility and Assisted Reproductive Technology (ART) services, surrogacy arrangements, and sterilization/reversal.
69. Prescription overdose, self-administered and accidental (see Self-Inflicted Injuries below for non-accidental cases).
70. Private-duty Nursing.
71. Provider charges in excess of the Maximum Allowable Amount.
72. Services of a Healthcare Practitioner not properly licensed in the state where rendered, or acting beyond the scope of their license; concierge or boutique medical practice membership fees.
73. Psychiatric and Psychological Treatment and Services, other than the Virtual Mental and Behavioral Health benefit.
74. Routine eye care (Adult).

75. Routine foot care, except for Covered Persons with diabetes or other qualifying conditions identified in the Definitions Glossary.
76. Sales tax and gross receipts tax.
77. School Injuries — secondary to any applicable school insurance.
78. Screenings for speech and language delay in children age five or younger.
79. Self-Administered drugs dispensed by a Physician.
80. Self-Inflicted Injuries, including certain suicide-related injuries and injuries from specified high-risk recreational activities (e.g., BASE jumping, bungee jumping, free soloing, hang gliding, skydiving).
81. Sensory Integration Therapy and Auditory Integration Therapy.
82. Services, supplies, or items provided where there is no evidence of pathology, dysfunction, or disease; that are not Medically Necessary; provided by a foreign or sign language interpreter; related to faith or energy healing; or not specifically listed as covered.
83. Services or supplies for an Illness or Injury arising out of employment for which Workers' Compensation benefits are available.
84. Sexual Disorders, including treatment of sexual dysfunction and gender-affirming surgery.
85. Skilled Nursing Facilities.
86. Sleep Disorders and Snoring treatment (except as part of documented obstructive sleep apnea treatment).
87. Smoking cessation, except as covered under Preventive Services.
88. Speech Therapy.
89. Stem Cell and other Regenerative Medicine Therapies, except FDA-approved therapies for FDA-specified conditions.
90. Surgical Deactivation of Headache Trigger Sites.
91. Telehealth appointments other than the Virtual Primary Care, Virtual Urgent Care, and Virtual Mental and Behavioral Health benefits expressly covered in Section VI.
92. Temporomandibular Joint Syndrome (TMJ) treatment and related diagnostic services.
93. Topical Hyperbaric Oxygen Therapy (THBOT), including off-label uses and home chamber purchase.
94. Transplant Services, including donor harvesting/storage not intended for use within 12 months.
95. Treatment of superficial varicose veins, unless Medically Necessary.
96. Ultrasound therapy for wound healing and chronic wound pain.
97. Unproven Procedures lacking sufficient scientific evidence of safety and effectiveness.
98. Vision services, including contact lenses, adult prescription eyeglasses, refractive surgery (e.g., LASIK, PRK), orthoptics, routine vision care, and non-prescription eyewear. (Pediatric preventive eye exams are covered as described in Section VI.)

99. Weight Control Services, including bariatric surgery, weight-loss programs, appetite suppressants, and related supplies.
100. Imaging services (CT, PET, MRI), as shown in Section II.

EXCLUSIONS TO OUTPATIENT PRESCRIPTION DRUG BENEFITS

In addition to the exclusions above, the following apply only to Section VII ("OUTPATIENT PRESCRIPTION DRUG BENEFITS"). The Plan will not pay benefits for:

1. Drugs not on the Formulary.
2. Drugs paid under another plan sponsor or payor as primary payor.
3. Charges in excess of the Maximum Allowable Amount.
4. Illegal medications or supplies, even if prescribed.
5. Over-the-counter medications available without a prescription, except injectable insulin or as specifically authorized on the Formulary.
6. Bulk powder/chemical drugs; compounded medications containing a non-covered active ingredient; and combination drug products containing a non-covered active ingredient, unless pre-authorized.
7. Refills in excess of the number specified on the Prescription Order, or refilled more than one year after the original order.
8. Drugs administered at a Provider's office or dispensed for take-home use from a non-pharmacy setting (except Specialty Drugs requiring professional administration, which remain excluded under this Plan per Section II).
9. Duplicate prescriptions and replacement of lost, stolen, destroyed, spilled, or damaged prescriptions.
10. Drugs or drug categories exceeding a Maximum Benefit limit.
11. Gene therapy drugs and drugs used to diagnose, treat, or alter genetic makeup, unless pre-authorized.
12. Prescriptions or dosage forms used for the convenience of the Covered Person, family member, or Practitioner.
13. Charges incurred outside the United States, except Covered Charges for Emergency Care (subject to Section VIII exclusion #58/#32 above).
14. Postage, handling, and shipping charges.
15. Specialty pharmaceuticals dispensed by a non-Network Pharmacy.
16. Vaccines and other immunizing agents, except as covered under Preventive Services.
17. Drugs requiring prior authorization that is not obtained.
18. Prescription Drugs previously classified with non-prescription status.
19. Prescriptions obtained from a Non-Participating Pharmacy.
20. Duplicate services or inappropriate billing.
21. Hair growth stimulants and cosmetic-use-only products.
22. Prescription products dispensed abroad if imported/reimported for use in the United States.

23. Prescription products available without charge under local, state, or federal programs, including workers' compensation.

IX – COORDINATION OF BENEFITS (COB)

Coordination of Benefits ("COB") applies when you have health care coverage through more than one group program. When a person is covered by two or more health plans, COB determines how costs are shared so you receive the full coverage to which you are entitled, but no more than the actual cost of care. It is your obligation to notify the Plan of any other group coverage.

Coordination with Other Plans. Benefits payable under this Plan are coordinated with benefits payable from other plans; you cannot receive duplicate payment for the same service. The primary plan pays first, without regard to any other plan; the secondary plan adjusts its payment so total benefits do not exceed 100% of allowable expenses. In no event will this Plan pay more than it would have paid had it been primary.

Order of Payment.

Situation	**Primary Plan**
Dual coverage — employee plan and spouse's plan	The plan covering you as an employee is primary (federal law may reverse this order for Medicare beneficiaries)
Situation	**Primary Plan**
Dependent child, parents married/together	The plan of the parent whose birthday falls earlier in the calendar year
Dependent child, parents divorced/separated	The custodial parent's plan; then the custodial parent's spouse's plan; then the non-custodial parent's plan or spouse's plan; a court decree naming a responsible parent controls if applicable
COBRA continuation	Secondary to any other applicable coverage

Active vs. retired/laid-off employee	The plan covering you as an active employee is primary

Effect on Benefits. If this Plan is secondary, it may reduce benefits so that combined payments from all plans do not exceed 100% of allowable expenses for the claim.

School Plans. This Plan is secondary to any school insurance for injuries sustained on school property during a school program.

Rights Under This Section. The Plan may release or obtain Claim information from any other plan or entity, and may recover any overpayment from the person or entity to whom it was made. You must inform the Plan if you or your Covered Dependents have coverage under any other Medical Plan.

X – CLAIM PROVISIONS

Proof of Loss. Most Providers file Claims directly with the Plan; you are responsible for filing if the Provider does not. We must receive notice of services within 90 days after a covered loss occurs, or as soon as reasonably possible. Proof of loss and sufficient supporting information must be received within 180 days after the end of the Plan Year. A Claim denied for late filing may be reconsidered if circumstances beyond the claimant's control caused the delay. Proof of loss must include your name, ID and group number; the Covered Person's name; the Provider's name and address; an itemized bill with applicable ICD, CPT, HCPCS, and NDC codes; and a statement of any other applicable coverage.

Right to Collect Information. You must cooperate with reasonable requests for information (medical records, other coverage, accurate/complete information) within 45 days of our request, or the Claim may be denied pending receipt of that information.
Payment of Benefits. Benefits are paid according to the Policy, the SBC, and any applicable reimbursement guide, coded per current CPT/ICD standards. The Plan Administrator retains final responsibility for Claims determinations. Payment made in good faith releases the Plan from further liability for that amount; benefits paid in error may be recovered or offset against future payments.

Timely Redemption of Payment. A Claims payment check or other payment method unredeemed after 12 months is deemed denied upon expiration of that period.

Rights of Administration. The Plan retains the right to determine eligibility for, and the amount of, any benefit payable.

Claims Involving Fraud or Misrepresentation. Claims involving fraud or misrepresentation by a Covered Person or representative will be denied in whole or in part; the Plan may recover benefits already paid, and coverage may be terminated or rescinded, with the Covered Person subject to civil and/or criminal penalties.

Timing of Benefit Determinations.

	Urgent Care Claims	**Pre-Service Claims**	**Post-Service Claims**
Initial determination deadline	72 hours	15 calendar days	30 calendar days
Extension available	No (see below for missing-information extensions)	One 15-day extension for matters beyond the Plan's control, with notice within the initial period	One 30-day extension for matters beyond the Plan's control, with notice within the initial period
If information is missing	Notice within 24 hours; you have at least 48 hours to respond	Notice specifies needed information; you have at least 45 days to respond; the clock pauses until response or deadline	Same as Pre-Service

Adverse Benefit Determination Notices will include the specific reason(s) for denial, the Policy provision(s) relied upon, the Plan's review procedures and time limits, and — where based on Medical Necessity or similar clinical judgment — an explanation of the scientific/clinical basis for the determination.

Concurrent Care Decisions. If the Plan intends to reduce or terminate benefits for an approved, ongoing course of treatment before the previously approved period ends, you have the right to appeal, and the Plan will provide advance notice (generally 30 days) sufficient to allow an appeal before the change takes effect.

APPEAL PROCEDURES

You have the right to a full and fair internal review of any Adverse Benefit Determination. The internal appeals process includes two levels of appeal.

Level 1 Internal Appeal. File a written request within 180 days of the Adverse Benefit Determination with ARM LTD, ATTN: Claims Department, 814 W. Northwest Hwy. Arlington Heights IL 60004. The appeal will be conducted by a named fiduciary who did not make, and is not subordinate to anyone who made, the original decision, and who will consider all submitted information without regard to whether it was part of the original determination. Where medical judgment is involved, a qualified healthcare professional will be consulted.

Level 2 Internal Appeal. If you disagree with the Level 1 outcome, you may request a Level 2 Internal Appeal in writing within 60 days of the Notice of Level 1 Resolution, following the same procedure.

Timing of Appeal Decisions.

	Urgent Care	**Pre-Service**	**Post-Service**
Deadline for decision	As soon as possible, no more than 72 hours	15 days	30 days

An additional 14 days may be requested if more information is needed, with written notice of the reason for delay.

External Review. After exhausting internal appeals (except where life or health is seriously jeopardized), you may request a Standard External Review by an Independent Review Organization (IRO) for Adverse Benefit Determinations involving medical judgment (Medical Necessity, experimental/investigational status, rescission, and similar determinations), within 4 months of the final internal decision. The Plan completes a preliminary eligibility review within 5 business days, assigns an accredited, unbiased IRO, and the IRO issues a written decision within 45 days that is binding on the Plan (subject to other remedies available under state or federal law). **Expedited External Review** is available in urgent situations, with a decision as expeditiously as the medical condition requires and no later than 72 hours after the IRO receives the request.

XI – RECOVERY PROVISIONS

Overpayment. If the Plan pays more than it should have, it may recover the excess from you, the Beneficiary, or the Provider, and may offset the overpayment against future benefit payments.

Subrogation Right. When the Plan pays benefits on your behalf, it is subrogated to your rights of recovery against any third party, liability coverage, or other insurance (including uninsured/underinsured motorist coverage), up to the amount the Plan paid. You must not prejudice this right, must cooperate with the Plan, and must provide notice and documentation of any related claim or lawsuit. The Plan may intervene in related proceedings and is not required to share attorney's fees or costs related to your recovery.

Right to Reimbursement. If the Plan is precluded from exercising subrogation, it may instead seek reimbursement from any amount you recover (by suit, settlement, judgment, or otherwise) from a third party or other insurance, up to the amount the Plan paid, subject to the same cooperation and notice obligations described above.

Workers' Compensation Not Affected. Coverage under this Plan does not replace or affect Workers' Compensation Insurance requirements.

XII – CONTINUATION

If you or a Covered Dependent lose eligibility, coverage may be continued as described below. The Plan will provide notice of continuation rights as required by law.

Federal Continuation Rights (COBRA). COBRA generally applies to employers (other than the federal government and religious organizations) that maintain a group health plan and employed 20+ full-time-equivalent employees on more than 50% of business days in the preceding year. A "Qualified Beneficiary" is a person covered under the Plan as an active Covered Employee, or as the spouse or Dependent of an active Covered Employee, as of the day before a qualifying event (including a child born to, or placed for adoption with, the Covered Employee during a continuation period).

Qualifying Event	**Continuation Period**
Termination of employment or reduction of hours (not gross misconduct)	Up to 18 months
Social Security disability determined within 60 days of the above	Additional 11 months (29 total)
Death of the Covered Employee	Up to 36 months

Divorce or legal separation	Up to 36 months
Loss of Dependent eligibility	Up to 36 months
Concurrent continuations (second qualifying event during 18/29-month period)	Extended to up to 36 months total
Covered Employee becomes entitled to Medicare before termination/reduction of hours	The longer of 18 (or 29) months from that event, or 36 months from Medicare entitlement

Notice and Election. You must notify the Employer in writing of a divorce, legal separation, or Dependent's loss of eligibility within 60 days. The Employer must notify the Qualified Beneficiary of continuation rights within 44 days of the qualifying event (or 14 days of receiving notice of a divorce/loss of eligibility). Election must be made within 60 days of the later of the loss of coverage or the date notice is provided. The first premium payment is due within 45 days of election (2% administrative surcharge generally applies); subsequent payments are due monthly, with a 31-day grace period.

Continuation Ends on the earliest of: the end of the applicable continuation period; the Employer ceasing to offer any group health plan; failure to make a required payment; the Qualified Beneficiary becoming covered under another group health plan without a pre-existing condition exclusion affecting them; or the Qualified Beneficiary becoming entitled to Medicare.

Right to Elect Individual Coverage. Other coverage options — including the Health Insurance Marketplace, Medicaid, or a spouse's plan through a Special Enrollment Period — may cost less than COBRA. See www.healthcare.gov.

USERRA Continuation for Active-Duty Military. An "Eligible Person" (a Covered Employee leaving for active duty, or their covered spouse/Dependent) may continue group health benefits for up to 24 months following the date the Covered Employee leaves employment for active duty, running concurrently with (and instead of) COBRA. The Eligible Person must elect coverage and pay the first month's payment within 31 days of the date coverage would otherwise end (or within 31 days of notice, if later). Monthly payments are 102% of the full Plan cost if active duty exceeds 30 days. Upon timely release from active duty and timely return to work, coverage is reinstated without a new Employment Waiting Period.

XIII – OTHER PROVISIONS

Plan Costs. The Employer pays the balance of premiums and administrative expenses from its general assets; Employee contributions, where applicable, are paid pre-tax through the Employer's cafeteria plan.

Conformity with Federal Statutes. If any Policy provision conflicts with applicable federal law, it is administered in accordance with the applicable law despite anything to the contrary in this Policy.

Enforcement of Plan Provisions. Our failure to enforce any provision at one time does not waive our right to enforce it at another time.

Required Data. You must furnish information the Plan reasonably requires, including Social Security numbers for enrolled Dependents as required for IRS reporting under the ACA.

Rescission. The Employer may rescind coverage retroactively for fraud or intentional material misrepresentation, or for other circumstances such as non-payment of premium or failure to report a Dependent's loss of eligibility. Where the ACA requires it, 30 days' advance written notice of rescission will be provided.

Assignment. Except for voluntary assignments to Healthcare Providers as permitted by law, your right to receive benefits may not be assigned to any other person.

Severability. If any provision of this Policy or the SBC is held invalid, the remaining provisions remain in effect.

Legal Action. No Claim, suit, or cause of action may be brought until administrative remedies (the Claims review process) have been exhausted, and no such action may be brought more than 18 months from the date of the alleged breach or denial, regardless of any longer statute of limitations. [Note for counsel review: confirm whether jury-trial waiver and mandatory mediation/arbitration language, as used in the source template, is appropriate for Atlantic Risk's plans and jurisdictions before inclusion.] Service of legal process may be made upon a plan trustee or the Plan Administrator.

XIV – NOTICE OF PRIVACY PRACTICES

This notice describes how Protected Health Information ("PHI") created or received by the Plan may be used and disclosed, and how a Covered Person can get access to it. A federal law called HIPAA requires health plans to protect the privacy of PHI. This Notice summarizes Covered Persons' rights under HIPAA's privacy provisions and the Plan's related obligations. "We"/"Us" means the Plan.

Effective Date. This Notice becomes effective on [Effective Date].

The Plan's Responsibilities. The Plan must maintain the privacy of PHI and provide this Notice describing its legal duties, your rights, its privacy practices, its obligation to abide by this Notice, and its obligation to notify you of a breach of unsecured PHI. Genetic information may not be used or disclosed for underwriting purposes. The Plan applies the HIPAA "minimum necessary" standard except where an exception applies (e.g., disclosures for treatment, to the individual, to HHS, or as required by law).

Information Collected may include your name, address, Social Security number, insurance history, health condition and history, prescription information, and information from consumer reporting agencies.

Permissible Uses and Disclosures.

- **Treatment, Payment, and Healthcare Operations** — e.g., coordinating care between Providers, paying Claims, subrogation, utilization review, quality assessment, fraud detection, underwriting and stop-loss activities, and audits.
- **Required Disclosures** — to HHS for compliance investigations; to Covered Persons or their personal representatives (subject to safe-harbor exceptions for suspected abuse or endangerment); to Business Associates (e.g., the third-party administrator, broker, network, and utilization review vendor) under a written agreement; to other covered entities for their treatment/payment activities; to the Plan Sponsor for plan administration or summary health information; and to authorized Plan Sponsor Personnel performing plan administration functions (who may not use PHI for employment purposes).
- **Other Permitted Uses** — as required by law; for public health, health oversight, abuse/neglect reporting, judicial/administrative proceedings, law enforcement, coroners/organ donation, research (with appropriate safeguards), to prevent a serious threat to health or safety, military/national security activities, inmate care, workers' compensation compliance, emergencies, and underwriting (excluding genetic information).
- **Authorization Required** — for uses/disclosures not described above, including any sale of PHI, most marketing, and psychotherapy notes. Authorizations may be revoked in writing prospectively.

Potential Impact of State Law. Stricter state or other federal privacy laws (e.g., for HIV/AIDS, mental health, substance use, genetic testing, or reproductive health information) will control over the HIPAA Privacy Rule where they provide greater protection.

A Covered Person's Rights include the right to: request a restriction on use/disclosure of PHI; request confidential communications; inspect and copy PHI in a designated record set; request

an amendment to PHI; receive an accounting of certain disclosures (up to 6 years); be notified of a breach of unsecured PHI; and receive a paper copy of this Notice on request. Requests should be directed to the Privacy Contact identified by [Atlantic Risk / TPA Name].

Complaints. You may file a complaint with the Privacy Contact or with the HHS Office for Civil Rights (200 Independence Avenue, S.W., Washington, D.C. 20201; (877) 696-6775; http://www.hhs.gov/ocr/privacy/index.html) within 180 days of when you became aware of the issue. The Plan will not retaliate against you for filing a complaint.

Changes to This Notice. The Plan may revise this Notice; material changes will be distributed to Covered Persons.

XV – OTHER NOTICES

Benefits During Family Medical Leave. Where the Employer is subject to the Family and Medical Leave Act of 1993 ("FMLA"), coverage may continue during an approved leave on the same terms as active employment, with employee contributions handled per the Employer's FMLA leave policy. State family leave laws may also apply.

Genetic Information Nondiscrimination Act (GINA). The Employer may not request or require genetic information from you or your family members except as specifically permitted by GINA. "Genetic information" includes family medical history, genetic test results, and related information.

Mental Health Parity and Addiction Equity Act (MHPAEA). Where the Plan provides mental health or substance use disorder benefits, MHPAEA generally prohibits less favorable treatment limitations on those benefits than on medical/surgical benefits. MHPAEA does not itself require a plan to offer mental health or substance use disorder benefits. [Note for counsel review: because this Plan's medical/surgical benefits are also highly limited (Network-only, deductible-based, largely excluding Hospital/Outpatient Surgery), MHPAEA parity analysis should specifically confirm that the Virtual Mental and Behavioral Health benefit is not more restrictive, in the aggregate, than the Plan's comparable medical/surgical benefits.]

Michelle's Law. A covered Dependent child enrolled full-time at a post-secondary institution who must take a Medically Necessary Leave of Absence due to a serious illness or injury may continue coverage for up to one year from the start of the leave, on the same terms as if enrollment had continued, upon the treating physician's written certification of medical necessity. COBRA continuation is available at the end of this period if coverage would otherwise end.

Newborns' and Mothers' Health Protection Act. [Note for counsel review: this federal notice traditionally applies to plans that offer maternity/newborn benefits. Because this Plan's SBC lists Pregnancy and Childbirth/Delivery services as generally excluded, confirm whether this notice remains applicable, and revise or remove as appropriate once the plan's final maternity benefit design is confirmed.]

No Surprises Act (NSA). The Consolidated Appropriations Act, 2021 ("No Surprises Act"), effective January 1, 2022, protects Covered Persons from most surprise/balance billing.

- **Emergency Services.** If you have an Emergency Medical Condition and receive Emergency Services from an Out-of-Network Provider or facility, you cannot be billed more than the Plan's in-Network cost-sharing amount, even though this Plan does not otherwise cover Emergency Room care — the NSA cost-sharing protection applies to the amount you may be billed regardless of the Plan's own coverage determination. [Note for counsel review: coordinate this section carefully with Section VI's "Emergency Room Care — Not Covered" provision to ensure NSA compliance, since the NSA governs permissible billing/cost-sharing even where the underlying plan design otherwise excludes the service.]
- **Certain Services at an In-Network Facility.** Because this Plan uses a Network (unlike a referenced-based-pricing or networkless plan), if you receive care at an in-Network facility from an Out-of-Network ancillary Provider (e.g., anesthesiology, radiology, pathology, emergency medicine, assistant surgeon), you generally cannot be balance billed more than the Plan's in-Network cost-sharing amount, unless you give informed, written consent to receive care from that Out-of-Network Provider under the NSA's notice-and-consent process.
- **Your Protections.** You are never required to give up your balance-billing protections, and you may always choose any Provider or facility. Where balance billing is not allowed, you are responsible only for your in-Network cost share, and the Plan pays any additional amount owed directly to the Provider or facility.
- **Complaints.** Contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.cms.gov/nosurprises/consumers.
- **Continuity of Care.** If a Network Provider or facility involved in your ongoing course of treatment (e.g., hospitalization, scheduled nonelective surgery, pregnancy, or treatment for a serious and complex condition) leaves the network, you may be eligible to continue receiving transitional care at the in-Network benefit level for up to 90 days, subject to the Claims Administrator's application process and timely notice of the network termination.

Notice of HIPAA Enrollment Rights (Special Enrollment). If you decline enrollment because of other coverage, you may enroll yourself and your Dependents later if that other coverage (or employer contribution toward it) ends, provided you request enrollment within 30 days. You may also enroll following marriage, birth, adoption, or placement for adoption within 30 days of that

event, and following loss of Medicaid/CHIP eligibility, or gaining Medicaid/CHIP premium-assistance eligibility, within 60 days.

Premium Assistance Under Medicaid & CHIP. If you or your Dependents are eligible for Medicaid or CHIP, your state may have a premium assistance program to help pay for this coverage. Contact your state Medicaid/CHIP office, call 1-877-KIDS-NOW, or visit www.insurekidsnow.gov.

Women's Health and Cancer Rights Act. If the Plan covers mastectomy, it must also cover reconstruction of the affected breast, surgery on the other breast for symmetry, prostheses, and treatment of physical complications (including lymphedema) at all stages of mastectomy, subject to the Plan's Deductible, Copayment, Coinsurance, and other applicable terms.

XVI – DEFINITIONS GLOSSARY

Certain capitalized terms used throughout this Policy have the specific meanings below. This glossary has been streamlined for this baseline draft to the terms most relevant to Atlantic Risk's plan design; a complete definitions glossary (including additional ERISA/ACA-standard terms) should be finalized with counsel before this document is used for plan administration.

Adverse Benefit Determination – Any denial, reduction, or termination of, or failure to pay for, a benefit, including determinations based on eligibility, utilization review, or a finding that a service is Experimental/Investigational or not Medically Necessary.

Balance Bill – The difference between a Provider's charge and the Plan's allowed amount for a covered service.

Claim(s) – A request for a benefit made in accordance with the Plan's Claims procedures.

Coinsurance – The percentage of charges for Covered Services that a Covered Person must pay under the Plan (not used as a primary cost-sharing mechanism under this Plan's current design, which instead uses copays and a Deductible).

Copayment (Copay) – The flat dollar amount you pay for a Covered Service, applied after the Deductible where applicable.

Covered Charge(s) – An expense the Plan determines is: incurred for treatment, services, or supplies from a Healthcare Practitioner, facility, or supplier; incurred by a Covered Person while coverage is in force; incurred for services or supplies listed in Sections VI or VII; and not in excess of the Maximum Allowable Amount.

Covered Dependent / Covered Person – A person who meets the Plan's Dependent or eligibility definition and for whom coverage is in effect.

Deductible – The amount of Covered Services expense you must incur before the Plan begins to pay, as shown in Section II.

Dependent – Your lawful spouse (or Domestic Partner, if applicable), or a child under age 26 who is your natural, adopted, step-, or legal-guardianship child, a child placed with you for adoption, or a child you are required to cover by a court or qualified medical support order.

Domestic Partner – A same- or opposite-sex partner meeting the Plan's domestic partnership requirements (age 18+, competent to contract, not related by blood to a degree prohibiting marriage, and not married or partnered with anyone else), evidenced by an affidavit on file with the Plan.

Effective Date – The date coverage under the Plan begins for a Covered Person, at 12:01 a.m. local time in the Covered Person's state of residence.

Emergency Medical Condition / Emergency – A condition with acute symptoms of sufficient severity that a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy to health, serious impairment of bodily function, or serious dysfunction of a bodily organ or part.

Experimental/Investigational Service – A treatment, procedure, drug, device, or supply not accepted as Standard Medical Treatment for the condition being treated, or lacking required governmental approval at the time services are provided, as determined by the Claims Administrator.

Formulary – The list of Prescription Drugs and Clinical Preventive Medications/Products eligible for benefit consideration under the Plan, organized into tiers, maintained by [Pharmacy Benefit Manager Name] and subject to change.

Health Savings Account (HSA) – A tax-advantaged savings account used with a High Deductible Health Plan (HDHP) to pay Qualified Medical Expenses not covered by the HDHP; owned and funded by the individual, with contributions permitted from the individual, the employer, or others up to IRS limits.

High Deductible Health Plan (HDHP) – A health plan meeting the minimum deductible and maximum out-of-pocket requirements of Internal Revenue Code Section 223(c)(2), as adjusted annually by the IRS, that qualifies an enrollee to contribute to an HSA.

Maximum Allowable Amount – The maximum amount of a billed charge the Plan will consider when determining Covered Charges. For Network Providers, this is the network-contracted rate.

Medical Necessity / Medically Necessary – Healthcare services or supplies needed to diagnose or treat a condition, provided within generally accepted medical standards, not solely for convenience, and not experimental, investigational, or cosmetic (except as expressly covered).

Network Provider – A Provider that has contracted with the Plan's provider network to accept the network's negotiated rate as payment for Covered Services.

Out-of-Network Provider – A Provider that has not contracted with the Plan's provider network.

Out-of-Pocket Limit – The most a Covered Person will pay in a Plan Year for Covered Services, as shown in Section II; does not include premiums, balance-billing amounts, or the cost of non-covered services.

Plan – The healthcare plan provided by Atlantic Risk, established by this Plan Document, and evidenced by the Policy.

Plan Year – The 12-month period during which the Plan is in force, as shown in Section I.

Prescription Drug – A medication FDA-approved for marketing in the United States that legally requires a Prescription Order.

Provider – A licensed or board-certified provider of medical or mental health services acting within the scope of their license and performing Medically Necessary services.

Qualified Beneficiary – A person entitled to elect COBRA continuation coverage, as described in Section XII.

Sickness – A disease or illness of a Covered Person, including Behavioral Health and Substance Use disorders, but not a family history of, or genetic predisposition toward, a future disease.

Specialist / Specialty Care Provider – A Healthcare Practitioner classified as a specialist by the American Boards of Medical Specialties; does not include a Primary Care Practitioner.

Urgent Condition – A condition requiring prompt medical attention that is not life-threatening.

We, Us, Our – Atlantic Risk (the Plan).

You, Your, Yours – The Covered Employee.

XVII – CONTACT INFORMATION

Member Services : (800)519-2969, Concierge@mympb.com

Prescriptions / Pharmacy Benefit Manager : RXvalet, (855)-798-2538, https://www.myrxvalet.com/en

Atlantic Risk : 561-247-3970