The Dun & Bradstreet Medical Plan
Summary Plan Description
for Active Employees

Table of Contents

HOW TO REACH YOUR MEDICAL PLAN SERVICE PROVIDER 7

ABOUT YOUR PARTICIPATION 8

Who Is Eligible 8

When Coverage Begins 11

Coverage Levels 12

Paying for Coverage 13

W2 Healthcare Cost Reporting Requirement 14

When Coverage Ends 14

Rescission of Coverage 15

MAKING CHANGES DURING THE YEAR 17

Qualified Changes in Family Status 17

Other Permissible Mid-Year Election Changes 18

Special Enrollment Rights 21

WHEN YOUR EMPLOYMENT ENDS 25

YOUR MEDICAL PLAN 27

How Your Medical Plan Works 27

Prior Approval for Medical Services (Precertification) 31

What Is Covered 35

What Is Not Covered 56

Filing a Claim 64

PRESCRIPTION DRUG BENEFITS 65

ADDITIONAL RULES THAT APPLY TO THE MEDICAL PLAN 74

Continuity of Care 74

Maternity Admissions 75

Qualified Medical Child Support Order (QMCSO) 75

Compliance with the Affordable Care Act 75

Protections Against Surprise Medical Bills 76

Subrogation and Right of Recovery Provision 77

Coordination of Benefits If Covered by More than One Medical Plan 81

Other Coverage Definition 81

Here's how COB works 81

Determining who pays 82

How are benefits paid? 83

Coordination with Medicare 84

PLAN ADMINISTRATION 86

CONTINUATION OF COVERAGE 90

COBRA Continuation 90

Continuation of Coverage for Employees in the Uniformed Services 102

Continuation of Coverage While on a Family and Medical Leave 103

Continuation of Coverage While on an Employer-Approved Leave of Absence 104

INTERNAL CLAIMS AND APPEALS PROCESS 105

Time Frame for Initial Claim Determination 106

If You Receive an Adverse Benefit Determination....109

Procedures for Appealing an Adverse Benefit Determination....110

Foreign Language Assistance....113

Exhaustion of Administrative Remedies and Limitations on Actions....113

YOUR RIGHT TO AN EXTERNAL REVIEW.... 115

Types of Eligible Determinations....115

External Review Request....115

Procedures After your Request is Approved....117

Expedited External Review Requests....118

YOUR RIGHTS UNDER ERISA.... 120

Receive Information About Your Plan and Benefits....120

Continue Group Health Coverage....120

Prudent Actions by Plan Fiduciaries....120

Enforce Your Rights....121

Assistance with Your Questions....121

HIPAA PRIVACY RIGHTS AND PROTECTED HEALTH INFORMATION.... 122

NO GUARANTEE OF EMPLOYMENT.... 122

GLOSSARY OF OTHER IMPORTANT TERMS.... 123

The Dun & Bradstreet Corporation Welfare Benefit Plan provides health care, life, accident, disability, employee assistance and flexible spending account benefits to eligible active employees of Dun & Bradstreet and its related companies who participate in the plan, and their dependents. The Dun & Bradstreet Medical Plan for active employees (the "Medical Plan" or "Plan") is part of The Dun & Bradstreet Corporation Welfare Benefit Plan and provides medical benefits to active employees. This document summarizes the Dun & Bradstreet Medical Plan, as in effect on January 1, 2026, unless otherwise noted, for eligible active employees and their eligible dependents. It describes the benefits as they apply to eligible participants and serves as the summary plan description (SPD) for these benefits.

Dun & Bradstreet encourages you to read this SPD carefully and share it with your eligible dependents covered under the Medical Plan. If you have any questions about your benefits, please contact the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

The legal plan document provides additional information about the administration of the Medical Plan. If there is any difference between the information in this SPD and in the legal plan document, or if there are details not covered in this SPD, the legal plan document will determine how to resolve these issues.

Important Information

The Dun & Bradstreet Corporation ("Dun & Bradstreet" or the "Company") is the Plan Sponsor of the Medical Plan.

The medical coverage provided under the Medical Plan is self-insured by Dun & Bradstreet, and Dun & Bradstreet has contracted with an insurance company (the "Claims Administrator") to perform certain medical claims services. Dun & Bradstreet has contracted with a Prescription Drug Provider to administer the prescription drug coverage benefit under the Medical Plan.

Day-to-day operations of the Medical Plan have been delegated to the Benefits Center for The Dun & Bradstreet Corporation (the "Dun & Bradstreet Benefits Center"). You can contact the Claims Administrator, the Prescription Drug Provider or the Dun & Bradstreet Benefits Center if you have questions or need more information. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

Information About the Health Insurance Marketplaces

You have the ability to purchase health coverage for yourself and your family members through the Health Insurance Marketplace (otherwise known as an Exchange). You are allowed to enroll in this coverage only during certain months of the year unless you experience a special event that allows you to enroll at midyear. If you purchase coverage through the Marketplace, you may be eligible for a premium tax credit to help pay for that coverage, but in most cases the tax credit is only available if your employer does not offer you coverage under a health plan that is "affordable" and provides "minimum value." The Company believes that the coverage provided by this Plan is affordable and does provide minimum value. You will be given a notice at certain times which explains the coverage offered through Marketplace and any tax credit that may be available to you. You should review that notice carefully. You may request a copy of this notice from the Plan Administrator at any time, and one will be provided free of charge.

HOW TO REACH YOUR MEDICAL PLAN SERVICE PROVIDER

Here is how you can reach your Dun & Bradstreet Medical Plan providers:

Provider	Contact Information
Administrative Services: Dun & Bradstreet's Benefits Center at Fidelity	1-877-362-8953 (or 1-888-343-0860 for the hearing impaired) http://netbenefits.fidelity.com
Medical Claims Administrator: Aetna	1-800-422-1749 www.aetna.com
Retail Prescription Drug Provider: CVS Caremark	1-877-321-2649 www.caremark.com
Mail Order Prescription Drug Provider: CVS Caremark	1-800-875-0867

ABOUT YOUR PARTICIPATION

This section contains important information about your participation in the Medical Plan, including eligibility information, when coverage begins, coverage levels, paying for coverage, reducing coverage and when coverage ends.

Who Is Eligible

You are eligible for coverage under the Medical Plan if you meet all of the following conditions:

- You are an active full-time or part-time employee employed by Dun & Bradstreet or a related company that participates in the Medical Plan with Dun & Bradstreet's approval, and
- You are regularly scheduled to work 20 or more hours per week.

If you are classified by a Dun & Bradstreet company as a temporary employee, intern, leased employee, or an independent contractor, you are not eligible to participate in the Medical Plan.

In addition, if you are not classified as an eligible employee by a Dun & Bradstreet company but are later reclassified as such either by action of the Plan Administrator or by a governmental or judicial authority, you will be deemed to have become an employee eligible to participate in the Medical Plan only prospectively and not retroactively to the date on which you are found to have first become an employee, assuming all other eligibility requirements are met.

Eligibility of Rehired Retirees

If you are participating in the Retiree Health Reimbursement Arrangement and you are hired or rehired by Dun & Bradstreet or a related employer, your coverage under the Retiree Health Reimbursement Arrangement will terminate and you will be eligible to participate in the Medical Plan for active employees only if you satisfy the applicable eligibility requirements. When you later terminate employment, you will not be allowed to re-enroll in the Retiree Health Reimbursement Arrangement.

Dependent Eligibility

Your eligible dependents are also eligible for coverage under the Medical Plan if you enroll for coverage.

Eligible dependents include:

- Your legal spouse (not including your divorced spouse) or your same-sex or opposite-sex domestic partner,
- Your or your spouse's/domestic partner's eligible dependent children until December 31 of the year in which they turn 26, and
- Your or your spouse's/domestic partner's unmarried eligible dependent child, regardless of age, who is mentally or physically disabled and incapable of earning his or her own living.

Eligible children may include:

- Biological children,
- Adopted children (eligible as of the date of birth if legally adopted before birth; otherwise, eligible as of the date they are placed in your home),
- Stepchildren,
- Foster children, and
- Children placed in your care by court order/legal guardianship.

You may not cover a dependent if he or she is also covered as a Dun & Bradstreet employee.

Children Who Are Incapacitated

Unmarried, disabled children age 26 and older, who cannot support themselves, are eligible for continued coverage if the following criteria are met:

1. he or she was covered under the Dun & Bradstreet Medical Plan before age 26, and
2. the proof of disability was approved by the Claims Administrator at least 15 days before the end of the year in which your dependent reached age 26.

For your child's coverage to continue, you must provide the Claims Administrator proof of your child's qualifying disability 90 days prior to the dependent turning 26 and any additional information required by the Claims Administrator. If the Claims Administrator does not certify your child's disability, his or her coverage will terminate as of the last day of the year in which he or she turns age 26 subject to his or her right to elect COBRA continuation coverage (discussed later in this SPD). As

a condition of this extended coverage, the Plan Administrator may require that a physician chosen by the Plan Administrator examine your child at no cost to you. You may also be required to provide periodic proof that your child continues to meet these conditions of incapacity and dependency. Failure to provide such proof within the required period will result in termination of your child's coverage. The Claims Administrator will review and re-certify eligibility for continued coverage at its discretion from time to time. If you are unable to meet these requirements for reasons beyond your control, please contact the Dun & Bradstreet Benefits Center.

Domestic Partner Eligibility

Your domestic partner may be eligible for coverage under the Medical Plan. In order for you to cover your domestic partner, you and your partner must either:

- Have registered properly your domestic partnership with an approved governmental domestic partnership registry.

or

- Be at least 18 years old,
- Share a committed and exclusive relationship for at least six months,
- Not be married to another person,
- Not be related by marriage or blood, which would otherwise prohibit legal marriage in the state of residence, and
- Live together in the same household.

or

- Enter into a civil union in accordance with the laws of a state which permits couples to enter into civil unions.

If any of the above eligibility requirements are no longer being met, domestic partner coverage ends. You must notify the Dun & Bradstreet Benefits Center immediately. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information. The domestic partner

who no longer has coverage may be eligible for continuation coverage as if he or she were an eligible spouse under COBRA.

Dependent Eligibility Verification Documentation

The Plan reserves the right to conduct audits and reviews of all dependent eligibility to ensure that individuals covered by the Plan meet the eligibility requirements. Currently, these verifications are administered by a third-party administrator, Gainwell, but the administrator may change from time to time.

When you first enroll a dependent in the Plan, you will be asked to provide documentation which provides proof that your dependent satisfies the applicable eligibility requirements. This includes any dependent that you enroll in the Plan when you first become eligible after your date of hire, as well as any dependent that you enroll following a qualifying life event (i.e., marriage, birth) or during the annual Open Enrollment (OE) period in the fall. As part of the audit process, Gainwell will send you a letter requesting certain documents intended to prove that your dependent is eligible under the terms of the Plan. Required documentation may include a government-issued marriage certificate, government-issued birth certificate, and a Federal tax return. If a dependent that you enrolled is ineligible or you fail to verify the dependent's eligibility, he or she will be dropped from coverage under the Plan and COBRA continuation coverage will not be offered.

When Coverage Begins

You must enroll for medical coverage within 31 days of your date of hire or the date you first become eligible. If you enroll within the 31 days, your coverage is effective the day you began employment with a Dun & Bradstreet company or the date you became eligible for medical coverage under the Medical Plan. Coverage for your covered dependent(s) starts the same day your coverage begins, if you have enrolled for dependent coverage.

If you do not choose to participate in the Medical Plan when you first become eligible, you must wait until the next annual enrollment, unless you have an eligible family status change or another qualifying mid-year event in accordance with IRS rules. See the section, "Making Changes During the Year" in this SPD for information on changing coverage during the year.

Coverage Levels

The Medical Plan offers the following levels of coverage:

You only,

You and one dependent, or

You and two or more dependents.

Spousal Surcharge

If you enroll your spouse or domestic partner in the Medical Plan, you will pay a spousal surcharge each time you pay the premium for coverage under this Medical Plan unless you can certify during new hire or at annual enrollment that one of the following conditions applies:

- Your spouse/domestic partner is not employed or is self-employed;
- Your spouse/domestic partner works at Dun & Bradstreet;
- Your spouse/domestic partner is employed but not eligible for medical coverage through his/her employer;
- Your spouse's/domestic partner's employer charges 100% of the cost of coverage; or
- Your spouse/domestic partner is covered by COBRA, Medicare or Medicaid.

If it is determined that the spousal surcharge applies, it will apply for the entire year (or the remainder of the year if enrollment occurs mid-year). However, if your spouse or domestic partner satisfies one of the conditions listed above during the middle of the year (e.g., your spouse terminates employment), the spousal surcharge will be removed if you report the event to the Dun & Bradstreet Benefits Center within 31 days of the loss. If the spousal surcharge does not apply and your spouse or domestic partner ceases to satisfy one of the conditions listed above (e.g., your spouse gains employment with other medical coverage), you must report your spouse's or your domestic partner's access to such coverage and the spousal surcharge will apply. The working spouse surcharge will be removed the first of the month following timely notification of removal. You will not receive any retroactive reimbursement for amounts already collected. Alternatively, you may terminate his or her coverage under the Medical Plan.

The spousal surcharge is subject to audit. It may be applied retroactively if it is determined (upon audit or otherwise) that the surcharge should be applied to you.

Paying for Coverage

At this time, you and Dun & Bradstreet share the cost of medical coverage. You pay your share of the cost for coverage through before-tax payroll deductions, except if you cover a domestic partner (or a domestic partner's dependent) you are required to pay for coverage on an after-tax basis as described below. Additional information is provided below.

Before-Tax Contributions

Before-tax contributions are deducted from your pay before federal income and Social Security (FICA) taxes, and in most cases, before state and local taxes, are withheld. This lowers your taxable income and, as a result, reduces the taxes you pay. However, because of IRS rules, you can only change your before-tax choices during annual enrollment, except when certain events occur, including a "qualified family status change." If you experience a change in family status, any change you make to your medical coverage must be as the result of and consistent with your family status change. See the section "Making Changes During the Year" in this SPD for information on qualified family status changes and other events that may allow you to change your elections mid-year. Also, since before-tax contributions reduce your taxable income, there may be a small impact on the Social Security benefits you earn, although in most cases your tax savings outweigh any minor reduction.

Cost of Coverage for Domestic Partners and their Child(ren)

Dun & Bradstreet pays the same amount for a domestic partner as it does for a spouse. However, when you enroll your domestic partner or your partner's child(ren) in coverage, the IRS considers the Company's contribution toward the cost of coverage provided to your domestic partner or your partner's child(ren) as a taxable benefit (unless they qualify as your tax dependent), which means it is reported as imputed income on your paycheck and is subject to ordinary federal, state, local and FICA taxes. This also means that the premium that you pay to cover your domestic partner and/or your partner's child(ren) is deducted post-tax.

If your domestic partner and his/her child(ren) qualifies as your tax dependent under Section 105(b) of the Internal Revenue Code, please request to complete the Certification of Domestic Partner Tax Dependents form. This form must be submitted during annual enrollment (for coverage effective January 1) or within

30 days of either enrolling your dependent when you are a new hire, or the tax status of your dependent has changed for health care purposes.

For additional information about covering your domestic partner and your domestic partner's child(ren), you may contact the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information."

W2 Healthcare Cost Reporting Requirement

The Patient Protection and Affordable Care Act (PPACA), also known as Health Care Reform, requires employers to report the aggregate cost of applicable employer-sponsored health coverage on employees' Form W-2s. This reporting is intended to help employees better understand the benefit they receive through their employers, and at the same time gain awareness of the true cost to obtain health coverage. The amount reported is the total cost of medical coverage which includes both Dun & Bradstreet's cost and any premiums paid by the employee. This amount will appear on your W-2 in Box 12 using code DD. This amount is for informational purposes only and is non-taxable.

When Coverage Ends

Coverage under the Medical Plan will end for you when any one of the following occurs:

- You cancel coverage,
- You terminate employment for any reason,
- Dun & Bradstreet terminates this plan,
- You are no longer eligible for benefits,
- You fail to make the required contributions on a timely basis, or
- You die.

Your dependent's coverage will end for the following reasons:

- Dun & Bradstreet terminates all dependent coverage under this plan,
- Dun & Bradstreet terminates this plan,
- Your dependent becomes covered as a Dun & Bradstreet employee,

- Your dependent is no longer eligible for benefits,
- You fail to make the required contributions on a timely basis,
- Your coverage terminates, or
- You or your dependent dies.

In general, coverage will end at the end of the month in which the event occurs, *except* if Dun & Bradstreet terminates the Medical Plan, coverage will end on the date of the Medical Plan termination. You or your eligible dependents may be able to continue Dun & Bradstreet medical coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA). In special situations described below, you may be able to continue your coverage beyond your termination of employment without electing COBRA. See the section "When Your Employment Ends" later in this SPD.

Your coverage (or your dependent's coverage) will also terminate on the date you revoke your election for such coverage (which generally must be prospectively) provided the revocation is otherwise permitted under the terms of the Medical Plan.

If the Plan Administrator determines that you or your dependent have engaged in fraud or have intentionally misrepresented a material fact in connection with the Medical Plan, including enrollment and participation, your coverage and/or your dependent's coverage will be terminated on the date specified by the Plan Administrator.

Rescission of Coverage

The Plan Administrator will not rescind your coverage or your dependent's coverage under the Medical Plan unless you or your dependent performs an act, practice, or omission that constitutes fraud (as defined by the Medical Plan) or unless you or your dependent makes an intentional misrepresentation of a material fact with respect to the Medical Plan. The Plan Administrator shall provide you or your dependent with at least 30 days advance written notice of any rescission. All rescissions are subject to the claims and appeals procedures applicable to the Medical Plan.

For this purpose, a rescission of medical coverage is a cancellation or discontinuance of such coverage that has retroactive effect. However, there are some situations where a cancellation or discontinuance of coverage is not a rescission, including any of the following situations:

- You voluntarily request a cancellation or discontinuance of medical coverage with a retroactive effective date;
- The cancellation or discontinuance of medical coverage is only effective prospectively;
- The cancellation or discontinuance of medical coverage is attributable to a failure to timely pay required premiums or contributions;
- The cancellation or discontinuance of medical coverage results from a participant's termination of employment; or
- The cancellation or discontinuance of medical coverage of a spouse results from a failure to timely report a spouse's failure to satisfy the applicable eligibility requirements.

MAKING CHANGES DURING THE YEAR

Qualified Changes in Family Status

You are not permitted to change your election for coverage once the plan year has begun except in certain circumstances.

You may be able to change your election during the middle of the year if you experience an approved qualified family status change. Approved qualified family status changes under the Medical Plan include:

- A change in your legal marital status (such as marriage, divorce, death of spouse and annulment) or domestic partner status (i.e. your domestic partner meets or fails to meet the domestic partner criteria),
- A change in the number of your dependents (such as through birth, death, adoption and placement for adoption),
- Your dependent's meeting (or failing to meet) the Medical Plan's dependent eligibility rules,
- A change in residence for you, your spouse/domestic partner or your dependent (the change must affect your eligibility for coverage).

Any change you make as a result of a qualified change in family status must be permitted by law and consistent with the qualifying event. Benefit changes are consistent with the event only if they:

- Result in your, your spouse's/domestic partner's or your dependent's gaining or losing eligibility to participate in the Medical Plan or the plan of your spouse's/domestic partner's or your dependent's employer, and
- Are on account of and correspond with the gain or loss of coverage. For example, generally, if you have or adopt a child, you can add the child to the Medical Plan, but you would not be able to drop medical coverage unless it is to enroll in your spouse's or domestic partner's plan.

You will have **31 days** from the date of your change in your family status to change your Medical Plan elections. Otherwise, you must wait until the next annual enrollment. To make the change, contact the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

Other Permissible Mid-Year Election Changes

Other events which may allow you to make a mid-year election change include:

- Changes consistent with the special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA).
- Changes due to the Children's Health Insurance Program Reauthorization Act (CHIPRA).
- Changes required by a judgment, decree or order, including a qualified medical child support order (QMCSO), resulting from a divorce, legal separation, annulment or change in legal custody. If the order directs you to cover the child, you may enroll the child (and yourself) in the Medical Plan. If the order directs someone other than you to cover the child, you may drop coverage for the child.
- Changes due to entitlement (or loss of entitlement) to Medicare or Medicaid. If you, your spouse/domestic partner or a covered dependent becomes entitled to Medicare or Medicaid (becomes enrolled), you may drop or reduce coverage for that individual. If you, your spouse/domestic partner or a dependent loses entitlement to Medicare or Medicaid, you may enroll or increase coverage for that individual (and yourself) in the Medical Plan.
- Cost Changes
  - Automatic changes. If the cost of your Medical Plan increases (or decreases) during a period of coverage and, under the terms of the Medical Plan, you are required to make a corresponding change in your payments, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in your elective contributions for the Medical Plan.
  - Significant cost changes. If the cost charged to you for a benefit package option (e.g., the PPO or the CDHP option) significantly increases or decreases during a period of coverage, you may make a corresponding change in election under the Medical Plan. For example, you can commence participation in the option with a decrease in cost. In the case of an increase in cost, you can revoke an election for that coverage and receive coverage under another benefit option providing similar coverage or drop coverage if no other benefit option providing similar coverage is available.
- Coverage Changes

— Significant curtailment without loss of coverage. If you or your spouse/domestic partner or dependent has a significant curtailment of coverage under the Medical Plan that is not a loss of coverage, you may revoke your election for that coverage and elect to receive coverage under another benefit package option providing similar coverage. A significant curtailment without a loss of coverage includes a significant increase in the deductible, the copayment or the out-of-pocket limit.

— Significant curtailment with loss of coverage. If you or your spouse/domestic partner or dependent has a significant curtailment that is a loss of coverage under the Medical Plan, you may revoke your election under the Medical Plan and elect either to receive coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available. A loss of coverage means a complete loss of coverage under the benefit package option or other coverage option — such as the elimination of a benefit package option, or an individual's losing all coverage under the option by reason of an overall lifetime or annual limitation. In addition, the Plan Administrator, in its discretion, may treat the following as a loss of coverage:

  – A substantial decrease in the medical care providers available under the benefit package option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in a preferred network);

  – A reduction in benefits for a specific type of medical condition or treatment with respect to which you, your spouse/domestic partner or your dependent is currently in a course of treatment; or

  – Any other similar fundamental loss of coverage.

— Addition or improvement of a benefit package option. If a new benefit package option or other coverage option is added, or if coverage under an existing benefit coverage option is significantly improved during a period of coverage, you may revoke your election under the Medical Plan and make an election for coverage under the new or improved benefit option. This provision applies whether or not you have previously made an election under the Medical Plan or have previously elected the benefit option.

— Change in coverage under another employer plan. You may make a prospective election change that is on account of and corresponds with a change made under another employer plan if either:

  - The other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or
  - This Medical Plan permits you to make an election for a plan year which is different from the plan year under the other cafeteria plan or qualified benefits plan (i.e., different open enrollment period).

- Changes consistent with taking leave under the Family and Medical Leave Act (FMLA). If you take leave under the FMLA, you may revoke your election under this Medical Plan and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

To make an election change on account of one of the events described above, in most cases, you must make the election change within 31 days of the event. For additional information, contact the Dun & Bradstreet Benefits Center.

Special Enrollment Rights

If you or your dependents declined coverage under the Medical Plan because you or they have medical coverage elsewhere, and one of the following events occurs, you have 31 days from the date of the event to enroll yourself and/or your dependents in the Medical Plan:

- You and/or your dependents lose the other medical coverage because eligibility was lost for reasons including divorce, death, termination of employment or reduced work hours, change in residence, change in eligibility or satisfaction of the other coverage's lifetime maximum limit (but not due to failure to pay premiums on a timely basis, voluntary termination of coverage or termination of coverage for cause),
- The employer contributions to the other coverage have stopped, or
- The other coverage was COBRA and the maximum COBRA coverage period ends.

As an employee, you may enroll your new spouse within 31 days of your marriage and a new child within 31 days of his or her birth, adoption or placement for adoption. In addition, if you are not enrolled in the Medical Plan as an employee, you also must enroll in the Medical Plan when you enroll any of these dependents. And, if your spouse /domestic partner is not enrolled in the Medical Plan, you may enroll him or her in the Medical Plan when you enroll a child due to birth, adoption or placement for adoption.

In the case of birth, adoption or placement for adoption, marriage or the establishment of eligible domestic partner relationship coverage is retroactive to the date of the event.

In addition, you may be able to enroll yourself and your dependents in the Medical Plan (1) if your or your eligible dependent’s coverage under a Medicaid plan or a State Children’s Health Insurance Program (“CHIP”) plan terminates due to loss of eligibility for such coverage, or (2) if you or your eligible dependents become eligible for premium assistance with respect to the Medical Plan under a Medicaid plan or a CHIP plan. However, you must request enrollment within 60 days after the date of termination of such coverage or the date you or your dependent is determined to be eligible for such assistance, whichever is applicable.

To request special enrollment or obtain more information, call the Dun & Bradstreet Benefits Center. If you are already enrolled in medical coverage for yourself, you may change your own medical coverage election in connection with enrolling a dependent child or spouse under the above special rules.

Examples of Situations Where You Can Make Changes to Your Medical Coverage During the Year

The following table provides some examples of the types of changes you may be able to make to your Medical Plan coverage if you experience a qualified change in your family status. Whenever you experience a change in family status you should notify the Dun & Bradstreet Benefits Center to determine the kinds of changes you can make to your Medical Plan benefits. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information. In all cases the election change must be permitted under applicable tax laws.

Dun & Bradstreet's contributions towards the cost of providing coverage for your domestic partner and other dependents may be considered imputed income in certain situations. See the section "Cost of Coverage for Domestic Partners and Child(ren) of Your Domestic Partner" in this SPD for more information.

Status Change	Allowable Changes to Your Coverage	Allowable Changes to Your Dependent Coverage (You must be enrolled in coverage to enroll your dependents)
Marriage or establishment of an eligible domestic partner relationship	▪ You can waive out of your current medical coverage to enroll under your spouse's or domestic partner's plan. ▪ You can enroll in medical coverage for the first time along with your spouse/domestic partner.	▪ You may add your new spouse/domestic partner and/or your and your spouse's/domestic partner's dependent child(ren) as dependents under your Medical Plan.
Divorce or end of an eligible domestic partner relationship	▪ If you are not enrolled in the Medical Plan because you were enrolled in your spouse's/domestic partner's plan, you can enroll for the first time.	▪ If your spouse or domestic partner is covered under the Medical Plan, you must terminate coverage for the divorced spouse or domestic partner (he or she may be eligible for coverage under COBRA). ▪ You can enroll your dependents who were previously enrolled in your spouse's/domestic partner's plan in the Dun & Bradstreet Medical Plan.
Birth, adoption or change in custody of a dependent child	▪ You can waive out of your current coverage to enroll in your spouse's or domestic partner's plan. ▪ If you are not enrolled in the Medical Plan, you can enroll	▪ You may add your new child(ren) and/or, your spouse/domestic partner not previously enrolled to your Medical Plan.

Status Change	Allowable Changes to Your Coverage	Allowable Changes to Your Dependent Coverage (You must be enrolled in coverage to enroll your dependents)
	for the first time along with your new child(ren). ▪ If you are enrolled in the Medical Plan, you may elect to receive coverage under another benefit package option while enrolling your new spouse/domestic partner and/or new child(ren).	
Death of a spouse/domestic partner or dependent	▪ If you are not enrolled in the Medical Plan because you were enrolled in your spouse's/domestic partner's medical plan, you can enroll for the first time.	▪ Coverage for your spouse/domestic partner or dependent will end. ▪ You can enroll your dependents who were previously enrolled in your spouse's/domestic partner's medical plan.
Loss of your spouse's/domestic partner's health coverage because his or her employment ends or changes	▪ If you are not enrolled in the Medical Plan, you can enroll for the first time.	▪ You may add your spouse/domestic partner along with your or your spouse's/domestic partner's dependent child(ren) covered under your spouse's/domestic partner's former plan, to your current Medical Plan.
Your spouse/domestic partner obtains coverage because his or her employment begins or changes	▪ You may waive out of your current medical coverage to enroll under your spouse's or domestic partner's plan	▪ You may terminate coverage under the Medical Pan for your spouse/domestic partner and your covered dependents, so they can enroll in the spouse's/domestic partner's medical plan.

Status Change	Allowable Changes to Your Coverage	Allowable Changes to Your Dependent Coverage (You must be enrolled in coverage to enroll your dependents)
The issuance of a Qualified Medical Child Support Order (QMCSO) for a dependent child	▪ If you are not enrolled in the Medical Plan, you must enroll in order to cover your dependent child(ren).	▪ You may add coverage for your dependent child(ren), as required by the QMCSO.
Termination of coverage under another employer's COBRA coverage, through no fault of your own	▪ If you are not enrolled in the Medical Plan, you can enroll for the first time.	▪ You may add your spouse/domestic partner along with any of your or your spouse's/ domestic partner's dependent children covered under your spouse's/domestic partner's former plan to your current Medical Plan.

WHEN YOUR EMPLOYMENT ENDS

In most cases, your coverage will terminate at the end of the month in which your employment ends. In special circumstances, your coverage may continue beyond that date. The following chart describes some of the special circumstances in which your coverage under the Medical Plan may continue. If these special circumstances do not apply to you, you will be given an opportunity to continue coverage for yourself and your dependents by electing and paying for COBRA coverage (unless your employment was terminated for gross misconduct). See the section "COBRA Continuation" in this SPD for more information.

If You….	What Happens to Your Medical Plan Coverage
Are approved for an LTD leave prior to January 1, 2021, and you terminate employment at a time when you: ▪ Are totally and permanently disabled (as determined by the Dun & Bradstreet LTD Plan claims administrator); and ▪ Have completed 10 years of Eligibility Service (as defined below) after age 22.	You may continue Medical Plan coverage for you and your eligible dependents. In order to continue medical coverage: ▪ The Dun & Bradstreet LTD Plan claims administrator must certify, in its complete discretion, your ongoing long-term disability; *and* ▪ You must make the necessary contributions on a timely basis to pay the cost of continued medical coverage. Once you become eligible for Medicare, your Dun & Bradstreet medical coverage will be secondary, and you will need to submit your medical claims to Medicare before filing a claim with the Dun & Bradstreet Medical Plan. See the section "Coordination with Medicare" in this SPD for more information. If your benefits under the Dun & Bradstreet LTD Plan terminate for any reason, your continued participation in the Medical Plan will terminate at the end of the month in which your long-term disability benefits terminate.
Are approved for LTD leave on or after January 1, 2021, and terminate employment at a time when you: ▪ Are totally and permanently disabled (as determined by the Dun & Bradstreet LTD Plan claims administrator).	You may continue Medical Plan coverage for you and your eligible dependents for a period of 6 months. In order to continue medical coverage: ▪ The Dun & Bradstreet LTD Plan claims administrator must certify, in its complete discretion, your ongoing long-term disability; *and* ▪ You must make the necessary contributions on a timely basis to pay the cost of continued medical coverage. At the end of the 6 month period, your coverage will terminate and you will be offered an opportunity to continue coverage for yourself and your dependents by electing and paying for COBRA coverage. See the section "COBRA Continuation" in this SPD for more information. If your benefits under the Dun & Bradstreet LTD Plan terminate for any reason, your continued participation in the Medical Plan will terminate at the end of the month in which your long-term disability benefits terminate.

If You….	What Happens to Your Medical Plan Coverage
Die	Dun & Bradstreet will continue to cover your eligible dependents, at no cost, for six months beyond the end of the month in which you died, provided your covered dependents continue to meet the eligibility criteria of the Medical Plan. This six-month period is counted as part of any period of COBRA coverage to which your covered dependent may be entitled. See the section "COBRA Continuation" in this SPD for more information.

Eligibility Service

For employees employed full-time or part-time with 20 or more hours per week, years of Eligibility Service is defined as the number of years between the date you start working at Dun & Bradstreet and the date you leave the Company. Each month or partial month counts as one-twelfth of a year.

Leave of Absence. If you take an authorized, approved leave of absence (including military leave), this period will count towards Eligibility Service if you resume your employment at the end of such leave of absence or within the period prescribed by law for the exercise of employment rights.

YOUR MEDICAL PLAN

You may choose between two Preferred Provider Organizations (PPOs) plans for your medical coverage:

- Consumer Directed Health Plan (CDHP), or
- PPO Select.

How Your Medical Plan Works

Preferred Provider Organization (PPO)

Both the CDHP and PPO Select plans are PPO plans. With a PPO, each time you need care, you can choose to receive care from an in-network provider who is part of the managed care network or an out-of-network provider. You will receive a higher level of benefits if you visit an in-network provider. You don't need a Primary Care Physician (PCP) or a referral to visit an in-network provider.

When you receive care from an in-network provider, your out-of-pocket costs are less than they would be if you received care from an out-of-network provider because you are paying negotiated rates. Network providers obtain all necessary pre-certifications and file all claims on your behalf.

When you receive care from an out-of-network provider, your out-of-pocket costs are higher because the Medical Plan does not have a negotiated rate with the out-of-network provider and benefits are based on the Recognized Charge (discussed below). If the charge by your out-of-network provider for a covered service or supply is more than the Recognized Charge, you pay the amount that exceeds that amount, in addition to any applicable deductible and coinsurance amounts.

Recognized charge

The Recognized Charge is the amount of an out-of-network provider's charge that is eligible for coverage. Recognized Charge will apply to most covered health services and supplies received from an out-of-network provider. If your out-of-network provider charges more than the Recognized Charge, you are responsible for all amounts above the Recognized Charge. The Recognized Charge depends, in part, on the geographic area where you receive the service or supply. Recognized Charge does not apply to involuntary services. (See the Definitions section of this SPD for more information about the Recognized Charge.)

Finding a medical network provider

Use the online directory. To locate a provider in the CDHP or PPO Select plan network, visit https://www.aetna.com/docfind. Enter the name of your doctor or facility or enter the type of health care professional you need, then enter your zip code and select "Open Access Choice POS II".

National Advantage Program (NAP). NAP providers are out-of-network providers and third-party vendors that have contracts with Aetna but are not network providers. The Medical Plan allows access to NAP providers. If your ID card displays NAP logo, your cost of care may be lower when you get care from a NAP provider for whom we access NAP rates instead of another out-of-network provider that is not a NAP provider. Claims for services received from a NAP **provider** and paid at the NAP contracted rate are not subject to the federal surprise bill law. Through NAP, the **recognized charge** is determined as follows:

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

- If your service was not received from a NAP **provider,** a claim specific rate or discount may be negotiated by Aetna or a third-party vendor.

Except for involuntary services, when you get care from a NAP provider your out-of-network cost sharing applies. Before you receive services from an out-of-network provider, you should contact the Claims Administrator to confirm whether the provider you are going to see is a NAP provider. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

Your Benefits

The following page provides a plan comparison chart of the commonly used services and **your out-of-pocket cost** when utilizing the plan. See the "What Is Covered" section for more details on covered services and limits.

Contact the Claims Administrator for a complete list of covered services. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

Medical Plan Comparison Chart				
	CDHP		PPO Select	
Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Plan Provider Network	Aetna Choice POS II (Open Access)		Aetna Choice POS II (Open Access)	
Annual Deductible	$2,500 – Single $5,000 – Family[1]	$4,500 – Single $9,000 - Family	$2,000 – Single $4,000 - Family	$3,650 – Single $7,300 - Family
Annual Out-of-Pocket Maximum	$5,500 – Single $11,000 – Family $10,600 – Individual in Family[2]	$11,000 – Single $22,000 – Family $21,200 – Individual in Family	$5,500 – Single $11,000 – Family $5,500 – Individual in Family	$10,500 – Single $21,000 – Family $11,000 – Individual in Family
Lifetime Maximum	None		None	
Primary Care Visit	20% after deductible	50% after deductible	$35 copay	50% after deductible
Teladoc	20% after deductible	Not applicable	$35 copay	Not applicable
Specialist Visit	20% after deductible	50% after deductible	$60 copay	50% after deductible
Preventive Care	No cost	50% after deductible	No Cost	50% after deductible
X-Ray, Imaging and Lab tests	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient Hospital	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Services	20% after deductible and 50% after deductible for non emergency use	20% after deductible and 50% after deductible for non emergency use	$250 copay and 50% after deductible for non emergency use	$250 copay and 50% after deductible for non emergency use
Ambulance Services	20% after deductible	20% after deductible	$250 copay; no deductible	$250 copay; no deductible
Urgent Care	20% after deductible	50% after deductible	$60 copay/visit	50% after deductible
Childbirth/delivery professional services	20% after deductible	50% after deductible	$35 copay / visit	50% after deductible
Childbirth/delivery facility services	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Home Health Care – 120 visits limit	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Rehabilitation services	20% after deductible	50% after deductible	$60 copay/office visit in office setting and 20% after deductible in facility	50% after deductible
Habilitation services	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Acupuncture	20% after deductible	50% after deductible	$60 copay/visit	50% after deductible
Hearing Aids	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Orthotics	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Spinal Manipulation	20% after deductible	50% after deductible	$60 copay/visit	50% after deductible
TMJ	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled nursing care-Limited to 120 days per calendar year	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Private Duty Nursing	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Durable medical equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Bariatric surgery	20% after deductible	Not covered	20% after deductible	Not covered
Hospice services	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Autism	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Applied Behavior Analysis	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Mental Disorders and Substance Abuse				
Outpatient	20% after deductible	50% after deductible	Office: $60 copayment Facility: 20% after deductible	50% after deductible
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible

Other Mental Health / Substance Abuse services	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Prescriptions (administered by CVS/caremark)				
Retail (30 day supply)				
Generic	20% after deductible[3]	No coverage	*$5 copay*[5]	No coverage
Preferred	20% after deductible[3]	No coverage	*20% co-insurance ($25 min; $70 max)*	No coverage
Non-Prefered	20% after deductible[3]	No coverage	*35% coinsurance ($40 min; $90 max)*	No coverage
Specialty	20% after deductible[3]	No coverage	*30% coinsurance*	No coverage
Mail (90 day supply)				
Generic	20% after deductible[3]	No coverage	*$10 copay*	No coverage
Preferred	20% after deductible[3]	No coverage	*20% co-insurance ($50 min; $140 max)*	No coverage
Non-Prefered	20% after deductible[3]	No coverage	35% coinsurance ($80 min; $180 max)	No coverage
Specialty	20% after deductible[3]	No coverage	*30% coinsurance no deductible $0 through PrudentRx program*[4]	No coverage

[1] When more than one person is covered, the entire family deductible must be met before co-insurance applies for all covered participants.
[2] When covering more than one person, the individual in-network out of pocket maximum is capped at $10,600 before the Plan pays eligible claims at 100% for the individual who reaches this cap. Once the entire family out-of-pocket maximum is met by the remaining members, the plan begins to pay 100% of the allowed amount for covered services for all other members.
[3] Deductible does not apply to medications on the CVS Caremark Preventive Drug Therapy List (as applicable).
[4] Specialty medications on the Plan's formulary and exclusively dispensed by CVS Specialty will be subject to a 30% co-insurance. However, members enrolled in the PrudentRx Co-pay program (if applicable) will have a $0 out-of-pocket co-pay for eligible specialty medications.
[5] The PPO Select plan does not have a deductible for the pharmacy benefits, and covered pharmacy expenses apply only to OOP max only.

Prior Approval for Medical Services (Precertification)

For certain services, you or your physician must obtain approval before services are rendered to ensure that they meet the plan guidelines for payment. During the approval process, Aetna verifies that your plan benefits cover the service and that it follows generally accepted medical practice. This review and approval process is called "precertification." Precertification is required for certain medical treatments, procedures, places of treatment, and devices**. Failure to pre-certify will result in a co-insurance penalty (you will pay 50% after the deductible, instead of 40%) provided the services or supplies are otherwise determined to be covered under the Medical Plan**.

Services and Supplies Which Require Precertification

- Stays in a hospital;
- Stays in a skilled nursing facility;
- Stays in a rehabilitation facility;
- Stays in a hospice facility;
- Outpatient hospice care;
- Stays in a Residential Treatment Facility;
- Partial hospitalization programs;
- Home health care;
- Private duty nursing care;
- Intensive outpatient programs;
- Applied Behavioral Analysis;
- Neuropsychological testing;
- Outpatient detoxification;
- Psychiatric home care services;
- Psychological testing;
- Nusinersen.

Process for Obtaining Precertification

You do not need to pre-certify services provided by an in-network provider. In-network providers are responsible for obtaining necessary precertification for you. When you go to an out-of-network provider, it is your responsibility to obtain precertification from Aetna. If you fail to do so, the benefit may not be covered in which case you will be responsible for full payment of services.

Precertification should be secured within the timeframes specified below. Precertification is not required for Emergency Services but you should notify Aetna within the timeframes listed below. To obtain precertification, call Aetna at the telephone number listed on your ID card. This call must be made within the following timeframes:

For non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
For an emergency outpatient medical condition:	You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
For an emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury.
For outpatient non-emergency medical services requiring precertification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your physician (and the facility, if applicable) of the precertification decision. If your expenses are precertified, the approval is good for 60 days unless the precertification relates to an inpatient admission. If the precertification relates to an inpatient admission, the approval becomes invalid if:

- You enter a facility other than the one specified as part of the precertification process;
- You change attending practitioners;
- More than 30 days elapse between the time you obtain authorization and the time you enter the hospital or other facility except in the case of a maternity admission;
- There is an alteration in your condition or treatment plan.

When you have an inpatient admission to a facility, Aetna will notify you, your physician and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days will need to be certified. You, your physician or the facility will need to call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If precertification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how Aetna's decision can be appealed.

How Failure to Precertify Affects Your Benefits

You are responsible for obtaining the necessary precertification from Aetna prior to receiving services from an out-of-network provider. In many cases, your provider may precertify your treatment for you; however, you should verify with Aetna prior to the procedure, that the provider has obtained precertification from Aetna. **If your treatment is not precertified by you or your provider, the benefit may not be covered, which means you will be responsible for full payment of services, or it will be subject to reduced coinsurance (you will pay 50% of the covered expense after the deductible instead of 40%).**

The Medical Plan does not pay any charges that are not authorized in accordance with the process outlined above.

Special Situations

The following special situations can affect your benefits:

- **Illness While You Are Traveling.** If you are traveling within the United States and have an illness that requires immediate medical attention such as an ordinary sprain, ear infection, headache or flu, call the Claims Administrator for the names and addresses of the nearest participating network providers.
- When you have a true medical emergency, seek care immediately.
- **Hospitalization or Treatment When Coverage Begins.** If you are hospitalized when your coverage begins, your benefits for the duration of your hospital stay will be paid by the medical plan that was in effect at the beginning of your hospitalization.
- **Medical Services and Supplies Received Outside of the United States.** If you receive medical services or supplies while you are outside of the United States, the services will be treated as any other service or supply that is received out-of-network. This means that you must satisfy the deductible and pay the same coinsurance that applies to other out-of-network services and supplies. If you need emergency care, your services will be paid like other out-of-network emergency care.

See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

Medical Necessity

The Medical Plan only covers care that is medically necessary. To be covered under the Medical Plan, your medical expenses must be:

- Determined by the Claims Administrator to be medically necessary,
- Incurred on a date of service while you (or your eligible dependents) are covered,
- A non-occupational injury or illness, and
- Provided by a licensed health care professional acting within the scope of his or her license.

The Medical Plan pays benefits based on covered services that are considered to be medically necessary subject to the Recognized Charge limit for services and supplies received from an out-of-network provider.

In order for an expense to be covered, it must be determined by the Claims Administrator to be medically necessary. A service or supply furnished by a provider is deemed medically necessary if the Claims Administrator determines that it is appropriate for the diagnosis, the care or treatment of the illness or the injury involved. To be considered appropriate, the service or supply must be:

- Care or treatment that is as likely to produce a significant positive outcome as it is likely (and not more) to produce a negative outcome than any alternative care or treatment, both as to the illness or injury involved and the person's overall health condition, or
- A diagnostic procedure (indicated by the person's health status) as likely to result in information that could affect the course of treatment as it is likely (and not more) to produce a negative outcome than any alternative diagnostic procedure, both as to the illness or injury involved and the person's overall health condition.

In addition, the service or supply must cost less than any alternative service or supply to meet the above tests. This takes into account all health expenses incurred (the date services are performed or supplies are provided) in connection with the service or supply.

The Claims Administrator will take into consideration:

- Information provided on the affected person's health status,
- Reports in peer-reviewed medical literature,
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data,
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment,
- The opinion of health professionals in the generally recognized health specialty involved, and
- Any other relevant information brought to the Claims Administrator's attention.

In no event will the Claims Administrator consider the following services or supplies as medically necessary:

- Those that do not require the technical skills of a medical, mental health or dental professional,
- Those furnished mainly for the personal comfort or convenience of the patient, any person who cares for the patient, any person who is part of the patient's family, or any health care provider or health care facility,
- Those furnished solely because the person is an in-patient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined, or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's office or other less costly setting.

What Is Covered

The Plan covers certain Medically Necessary medical services and supplies, subject to applicable deductibles, co-insurance and/or copayment amounts. See the summary chart at the beginning of this section, "Your Benefits," for an overview of deductibles, co-insurance and copayment amounts, and contact the Claims Administrator for more detailed information.

Acupuncture	Coverage is limited to when it is used in lieu of other anesthesia for a surgical or dental procedure covered under the medical plan, and the health care provider administering it is a legally qualified physician practicing within the scope of his/her license. Coverage also extends to acupuncture for medically necessary indications, but only when administered by a health care provider who is a legally qualified physician practicing within the scope of his/her license. Needle acupuncture (manual or electro acupuncture) is covered if medically necessary for any of the following indications: Chronic low back pain. (Maintenance treatment, where the patient's symptoms are neither regressing or improving, is considered not medically necessary); Migraine headache; Nausea of pregnancy; Pain from osteoarthritis of the knee or hip (adjunctive therapy); Postoperative and chemotherapy-induced nausea and vomiting; Postoperative dental pain; or Temporomandibular disorders (TMD)
Allergy Testing and Treatment	The Medical Plan covers allergy testing and treatment, including routine allergy injections
Ambulatory Surgery	The Medical Plan covers charges for ambulatory surgery performed in a hospital outpatient department or out-of-hospital, a practitioner's office or an ambulatory surgical center in connection with covered surgery.
Anesthesia	The Medical Plan covers anesthetics and their administration.
Audiology Services	The Medical Plan covers audiology services rendered by a physician or a licensed audiologist, where such services are determined to be Medically Necessary and appropriate and when performed within the scope of practice.
Autism Spectrum Disorder	The Medical Plan covers services and supplies provided by a physician or Behavioral Health Provider for the diagnosis and treatment of Autism Spectrum Disorder for covered children. Covered expenses include routine behavioral health services such as office visits or therapy and Applied Behavior Analysis when ordered by a physician or a Behavioral Health Provider as part of a treatment plan for a covered child who is diagnosed with Autism Spectrum Disorder. Includes Applied Behavior analysis for a diagnosis of autism spectrum disorder. Applied behavior analysis is a process of applying interventions that: • Systematically change behavior

	• Are responsible for observable improvements in behavior. Applied Behavior Analysis requires precertification.
Bariatric Surgery	The Medical Plan has a maximum of $15,000 per lifetime for the treatment of this condition. Covered medical expenses include charges made by an Aetna IOQ facility for the surgical treatment of morbid obesity of a covered person. Coverage includes the following expenses as long as they are incurred within a two-year period: One morbid obesity surgical procedure including complications directly related to the surgery; Pre-surgical visits; Related outpatient services; and One follow-up visit. This two-year period begins with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned. **REQUIRED: Aetna Institutes of Quality® Bariatric Surgery Facilities** Surgery will only be covered when performed at an Aetna Institutes of Quality® (IOQ) Bariatric Surgery facilities. Aetna's IOQs are a national network of health care facilities that are designated based on measures of clinical performance, access and efficiency for bariatric surgery. Visit www.aetna.com and log in to your secure member website. Click the link to "Find a Doctor, Dentist or Facility." Then, look for facilities listed as Institutes of Quality facilities and specialists who have privileges at these hospitals.
Birthing Centers	Services including pre-natal and post-natal care and delivery will be covered. After your child is born, eligible services include (i) 48 hours of care in a birthing center after a vaginal delivery and (ii) 96 hours of care in a birthing center after a cesarean delivery. A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

Coverage for Clinical Trial Therapies (experimental and investigational)	Services include experimental or investigational drugs, devices, treatments or procedures from a provider under an "approved clinical trial" only when you have cancer or terminal illnesses and all of the following conditions are met: Standard therapies have not been effective or are not appropriate. We determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment. An "approved clinical trial" is a clinical trial that meets all of these criteria: The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval. The clinical trial has been approved by an Institutional Review Board that will oversee the investigation. The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization. The trial conforms to standards of the NCI or other, applicable federal organization. The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution. You are treated in accordance with the protocols of that study.
Clinical Trials (routine patient costs)	Services include "routine patient costs" incurred by you from a provider in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709. Routine patient costs do not include any of the following: The investigational items, devices or services themselves; Items and services that are provided solely to satisfy clinical trial data collection and analysis needs and that are not used in the direct clinical management of the patient; and Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. As it applies to in-network coverage, coverage is limited to benefits for routine patient services provided within the network as long as the network provider will accept you as a patient. If the approved clinical trial is only offered outside the patient's state of residence, the Plan will cover routine patient costs of services and items which are provided by out-of-network providers.
Dental Care and Treatment	The Medical Plan covers: The diagnosis and treatment of oral tumors and cysts, The surgical removal of bony impacted teeth, and

	Tempro-mandibular joint dysfunction syndrome (TMJ): The Plan will consider medical treatment for TMJ. Treatment includes FDA approved devices as well as medically appropriate short-term rehabilitation. The plan will also provide coverage for medically appropriate surgical correction that is not determined to be dental in nature. The plan will provide no coverage for dental implants. In addition, no coverage will be provided for corrective procedures and/or devices considered investigational in nature for the treatment or this condition. The plan has a combined maximum of $10,000 per lifetime for the treatment of this condition. Medical Plan does not cover any charges for orthodontia, crowns or bridgework. Treatment of an accidental injury to natural teeth or the jaw is covered, but only if: The accidental injury was not caused, directly or indirectly, by biting or chewing. Treatment includes replacing natural teeth lost due to such accidental injury; in no event does it include orthodontic treatment. **Jaw joint disorder treatment**: Covered services include the diagnosis and surgical treatment of jaw joint disorder by a provider, including: The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD) **Oral and maxillofacial treatment (mouth, jaws and teeth):** Covered services include the following when provided by a **physician**, a dentist and **hospital**: • Cutting out: - Teeth partly or completely impacted in the bone of the jaw - Teeth that will not erupt through the gum - Other teeth that cannot be removed without cutting into bone - The roots of a tooth without removing the entire tooth - Cysts, tumors, or other diseased tissues. • Cutting into gums and tissues of the mouth – Only when not associated with the removal, replacement or repair of teeth
Diabetes Benefits	Benefits are provided for expenses incurred for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or nurse practitioner/clinical nurse specialist: a. blood glucose monitors and blood glucose monitors for the legally blind b. test strips for glucose monitors and visual reading and urine testing strips; c. insulin; d. injection aids; e. cartridges for the legally blind; f. syringes; g. insulin pumps and appurtenances thereto; h. insulin infusion devices; and i. oral agents for controlling blood sugar.

	This program provides benefits for expenses incurred for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of his or her condition, including information on proper diet.
Diagnostic Complex Imaging Service	The Medical Plan covers charges for complex imaging services by a provider, including Computed tomography (CT) scans; Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA); Nuclear medicine imaging, including Positron emission tomography (PET) scans; and Other outpatient diagnostic imaging service where the billed charge exceeds $500. Complex imaging for preoperative testing is covered under this benefit.
Diagnostic Lab Work and Radiological Services	The Medical Plan covers charges for diagnostic radiological services (other than diagnostic complex imaging), lab services (including COVID-19 testing) and pathology and other tests, but only when you receive them from a licensed radiological facility or lab.
Dialysis Center Charges	The Medical Plan covers dialysis center charges.
Domestic Violence	Coverage shall not be denied for those covered services and supplies incurred in the treatment of an injury or injuries sustained as the result of domestic violence.
Emergency Services	When you experience an Emergency Medical Condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help. Your coverage for Emergency Services will continue until your condition is stabilized and: • Your attending physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care; • You are in a condition to be able to receive from the out-of-network provider delivering services the notice and consent criteria with respect to the services; and • Your out-of-network provider delivering the services meets the notice and consent criteria with respect to the services If your physician decides you need to stay in the hospital (emergency admission) or receive follow-up care, these are not Emergency Services. Different benefits and requirements apply and are described elsewhere in this SPD. Use of emergency room for non-Emergency Medical Conditions will be covered at the out-of-network benefit level. **Important Note:**

	In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from a network provider. The cost share will be based on the median contracted rate, determined in accordance with applicable law. Contact Aetna immediately if you receive such a bill. For additional information, you should refer to the notice provided later in this SPD regarding the No Surprises Act.
Facility Charges	The Medical Plan covers charges for hospital semi-private room and board and routine nursing care when it is provided to you by a hospital on an inpatient basis. If a covered person incurs charges as an inpatient in a special care unit, the Medical Plan covers the charges the same way it covers charges for any illness. The Medical Plan will also cover outpatient hospital services including services provided by a hospital outpatient clinic. The Medical Plan covers emergency room treatment. If a covered person is an inpatient in a facility at the time your group's program ends, the Medical Plan will continue to cover that facility stay in accordance with all other terms of your group's program.
Fertility Services	The Medical Plan covers charges for artificial and surgical procedures designed to enhance fertility, including, but not limited to, artificial insemination, in-vitro fertilization, in-vivo fertilization, gamete-intra-fallopian-transfer (GIFT), Zygote Intra-fallopian-transfer (ZIFT), sperm, egg, and/or inseminated eggs procurement and processing and freezing, and storage and thawing of sperm and/or embryos. Storage is limited to six months. **Basic fertility**: covered services include seeing a provider: • To diagnose and evaluate the underlying medical cause of infertility. • To do surgery to treat the underlying medical cause of infertility. Examples are endometriosis surgery or, for men, varicocele surgery. **Limited infertility services**: Covered services include the following infertility services provided by an infertility specialist: • Ovulation induction cycle(s) using medication to stimulate the ovaries. This may include the use of ultrasound and lab tests. • Artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination. All fertility medical services **are limited to a $20,000 lifetime maximum***. Prescription oral and injectables are limited to a **separate $15,000 lifetime maximum*** under the prescription drug plan. * *Infertility services lifetime maximums do not apply towards satisfying the plan maximum out-of-pocket limit*.
Gender Reassignment Surgery	Surgery to change the sex of a person diagnosed with gender identity disorder in accordance with guidelines administered by the World Professional Association for Transgender Health (WPATH) medical necessity guidelines as long as you or a covered dependent have obtained precertification from the Claims Administrator.

	Related cosmetic procedures and surgeries, and prosthetic devices are excluded from coverage. Please contact Claim Administrator for further details and requirements.
Habilitation therapy services	Habilitation therapy services are services needed to keep, learn or improve your skills and functioning for daily living (e.g., therapy for a child who isn't walking or talking at the expected age). The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a: • Licensed or certified physical, occupational or speech therapist • **Hospital, skilled nursing facility** or hospice facility • **Home health care agency** • **Physician**
Home Health Agency Care	Subject to 120 visits maximum per calendar year. Home health agency care services and supplies are covered only if all of the following requirements are met: You are homebound. Your physician orders them. The services take the place of your needing to stay in a hospital or a skilled nursing facility or needing to receive the same services outside your home. The services are skilled nursing services, home health aide services or medical social services, or are short-term rehabilitation. Services are furnished by providers on a part-time or intermittent basis. If you are discharged from a hospital or skilled nursing facility after a stay, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. Home health aide services are provided under the supervision of a registered nurse. Medical social services are provided by or supervised by a physician or social worker. The home health care plan must be established in writing by the covered person's practitioner within 14 days after home health care starts and it must be reviewed by the covered person's practitioner at least once every 60 days. No prior inpatient admission is required. Each visit by a home health aide, nurse, or other provider whose services are authorized under the home health care plan can last up to four hours. Short-term rehabilitation provided in the home are subject to the conditions and limitations imposed on therapy provided outside the home. Your Medical Plan does not cover: Services furnished to family members, other than the patient; Custodial care; or Services and supplies not included in the home health care plan.
Hospital care	**Covered services** include inpatient and outpatient **hospital** care. This includes: - Semi-private **room and board** (your plan will cover the extra expense of a private room when appropriate because of your medical condition). - Services and supplies provided by the outpatient department of a **hospital**, including the facility charge. - Services of **physicians** employed by the **hospital.** - Administration of blood and blood products.

	The following are not **covered services**: All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps
Hospice Care	Hospice care benefits will be provided for: Part-time professional nursing services of an R.N., L.P.N., or L.V.N., Home health aide services provided under the supervision of an R.N., Medical care rendered by a hospice care program practitioner, Therapy services, Diagnostic services, Medical and surgical supplies and durable medical equipment if pre-approved, Prescription drugs, Oxygen and its administration, Medical social services, Psychological support services to the terminally ill or injured patient, Family counseling related to the patient's terminal condition, Dietitian services, and Inpatient room, board and general nursing services. No hospice care will be provided for: Medical care rendered by the patient's private practitioner, Volunteer services or services provided by others without charge, Pastoral services, Homemaker services, Food or home-delivered meals, Private-duty nursing services, Dialysis treatment, Treatment not included in the hospice care plan, Service and supplies provided by volunteers or others who do not regularly charge for their services, Funeral services and arrangements, and Legal or financial counseling or services. "Terminally ill or injured" means that the covered person's practitioner has certified in writing that the covered person's life expectancy is 12 months or less. Hospice care must be furnished according to a written "Hospice Care Program."
Inpatient Physician Services	Services provided to a covered person who is in a registered inpatient in a facility.
Mastectomy Benefits	The program covers a hospital stay of at least 72 hours following a modified radical mastectomy and a hospital stay of at least 48 hours following a simple mastectomy,

	unless the patient in consultation with his physician determines that a shorter length of stay is medically appropriate. While there is no requirement that the patient's provider obtain pre-approval from the Claims Administrator for prescribing 72 or 48 hours, as appropriate, of inpatient care, any notification requirements under your group's policy remain in force.
Maternity/Obstetrical Care	Medical care related to pregnancy, childbirth, abortion, or miscarriage, includes the hospital delivery and hospital stay for at least 48 hours after a vaginal delivery or 96 hours after a cesarean section if the attending practitioner determines that inpatient care is medically necessary and appropriate or if requested by the eligible mother notwithstanding medical necessity and appropriateness. Services and supplies provided by a hospital to a newborn child during the initial covered hospital stay of the mother and child are covered as part of the obstetrical care benefits. However, if the child's care is given by a different physician from the one who provided the mother's obstetrical care, the child's care will be covered separately, provided the child is enrolled properly for coverage. The Medical Plan also covers birthing center charges made by a practitioner for pre-natal care, delivery, and post-partum coverage to a child of a child dependent. Abortion includes services provided and supplies used in connection with an abortion
Maternity/Obstetrical Care for Child Dependents	The Medical Plan covers obstetrical benefits for a child dependent. A female child dependent is covered under the Medical Plan for any services incident to or resulting from her pregnancy. However, the Medical Plan does not provide coverage to a child of a child dependent**.**
Medical Emergency	The Medical Plan covers charges relating to an Emergency Medical Condition, including diagnostic x-ray and laboratory charges as outlined in the Schedule of Covered Services and Supplies. Some examples of medical emergencies include, but are not limited to, heart attack or suspected heart attack, poisoning, uncontrolled or severe bleeding, severe burns, severe shortness of breath, suspected overdose of medications, high fever, and sudden loss of consciousness. The determination of whether an actual emergency exists is made by the Claims Administrator. Minor burns, sprains, earaches, colds or minor injuries are not true medical emergencies. In these situations, call your Physician or Member Services for further guidance.
Mental Disorders	The Medical Plan covers charges for services and supplies related to the treatment of Mental Disorders provided by a hospital, psychiatric hospital, Residential Treatment Facility, physician, or Behavioral Health Provider as follows: • Inpatient room and board at the semi-private room rate, and other services and supplies related to your condition that are provided during your stay in a hospital, psychiatric hospital, or Residential Treatment Facility. • Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital or Residential Treatment Facility, including: - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician. - Intensive outpatient program provided in a facility or program for mental

	health treatment provided under the direction of a physician.
	- Office visits to a physician or Behavioral Health Provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor.
	- Other outpatient treatment for Mental Disorders such as:
	  - Electro-convulsive therapy (ECT)
	  - Mental health injectables
	  - Transcranial magnetic stimulation (TMS)
	
	The Medical Plan also covers skilled behavioral health services provided in the home, but only when all of the following criteria are met:
	• You are homebound.
	• Your physician orders them.
	• The services take the place of a stay in a hospital or a Residential Treatment Facility or needing to receive the same services outside your home.
	• The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications.
	
	Medical plan limits may apply.
	
	Notwithstanding, the Medical Plan does not provide coverage for the following:
	• Mental health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases (ICD)):
	  - Dementias and amnesias without behavioral disturbances
	  - Sexual deviations and disorders except for gender identity disorders
	  - Tobacco use disorders except as required under the Affordable Care Act's rules regarding coverage for preventive care
	  - Specific disorders of sleep
	  - Antisocial or dissocial personality disorder
	  - Pathological gambling, kleptomania, pyromania
	  - Specific delays in development (learning disorders, academic underachievement)
	  - Intellectual disability
	  - School and/or education service.

Physician services	Include services by your physician to treat an illness or injury. You can get

	services: • At the physician's office • In your home • In a hospital • From any other inpatient or outpatient facility • By way of telemedicine Other services and supplies that your **physician** may provide: • Allergy testing and allergy injections • Radiological supplies, services, and tests • Immunizations that are not covered as preventive care **Important note:** For behavioral health services, all in-person, **covered services** with a **behavioral health provider** are also **covered services** if you use **telemedicine** instead. **Telemedicine** may have a different cost share from other **physician** services. See your schedule of benefits.
Nutritional Counseling	The Medical Plan covers nutritional counseling when medically necessary for chronic diseases in which dietary adjustments has a therapeutic role (e.g., Diabetes, eating disorders and other conditions) and prescribed by a physician and delivered by a provider recognized under the plan (e.g. registered dietician, licensed nutritionist, etc). Nutritional counseling may also be covered as a preventive care service (see below).
Short Term Rehabilitation	The Medical Plan covers inpatient short term rehabilitation treatment in a rehabilitation center. Short term rehabilitation includes physical and occupational therapy and short-term cardiac and pulmonary rehabilitation services. Inpatient treatment will include the same services and supplies available to a facility inpatient. The services and supplies must be available in the rehabilitation center. **Cardiac rehabilitation** Covered services include cardiac rehabilitation services you receive at a hospital, skilled nursing facility or physician's office, but only if those services are part of a treatment plan determined by your risk level and ordered by your physician. **Pulmonary rehabilitation** Covered services include pulmonary rehabilitation services as part of your inpatient hospital stay if they are part of a treatment plan ordered by your physician. A course of outpatient pulmonary rehabilitation may also be covered if it is performed at a hospital, skilled nursing facility, or physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your physician.
Practitioner's Charges for Non-Surgical Care and Treatment	The Medical Plan covers practitioner's charges for the medically necessary and appropriate non-surgical care and treatment of an illness, accidental injury, Mental Disorder or Substance Abuse subject to the limits described in this SPD.

Practitioner's Charges for Surgery	The Medical Plan covers practitioner's charges for surgery. The Medical Plan does not cover cosmetic surgery. Surgical procedures shall include, but are not limited to, those following a mastectomy on one breast or both breasts, reconstructive breast surgery and surgery to achieve symmetry between the two breasts. If primary surgeon is in-network then associate radiologist, anesthesiologist and pathologist services performed in conjunction with network surgery will be paid at in-network level of benefits up to billed charges.
Pre-admission Testing	The Medical Plan covers pre-admission diagnostic x-ray and laboratory tests needed for a planned hospital admission or surgery. The Medical Plan only covers these tests if the tests are done on an outpatient or out-of-hospital basis within seven days of the planned admission or surgery. However, the Medical Plan does not cover tests that are repeated after admission or before surgery, unless the admission or surgery is deferred solely due to a change in the covered person's health.
Preventive Care	The Medical Plan provides benefits for certain covered services and supplies relating to preventive care including related x-rays and laboratory tests with no cost sharing. Coverage is limited each benefit period as described in the schedule of covered services and supplies. Preventive care includes screenings and other services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Any charges that are diagnostic in nature and outside of the Medical Plan's frequency and age limitations will be covered according to the Plan's deductible and coinsurance and subject to medical necessity. The covered preventive care benefits include, but are not limited to, the following: **Colorectal cancer screening:** Starting at age 45 and frequency for coverage under the preventive benefit depends on the specific service. a. Colonoscopy every 10 years b. Computed Tomographic Colonography / Virtual Colonoscopy every 5 years c. Double contrast barium enema every 5 years d. Sigmoidoscopy every 5 years e. Stool DNA testing every 3 years f. A follow-up colonoscopy after an abnormal or positive non-invasive stool-based screening test or direct visualization test (e.g., sigmoidoscopy, CT colonography) **Contraceptive Methods and Counseling:** FDA approved contraceptive methods, sterilization procedures, and provider, for all adolescent and adult women. Contraceptive counseling – first 2 visits covered without cost share. See Prescription Drug section for coverage of prescription drugs. **Gynecological Care and Examinations:** The Medical Plan covers one routine gynecological care and examinations including one pap smear per calendar year. **Hearing Exam (Routine):**

The Medical Plan covers one routine hearing exam per calendar year. Covered services include hearing exams for evaluation and treatment of illness, injury or hearing loss when performed by a hearing specialist.

Mammography:

The Medical Plan covers charges made for mammograms provided to a female covered person according to the schedule below. Coverage will be provided, subject to all the terms of the Medical Plan, and the following limitations. The Medical Plan will cover charges for:

– One baseline mammogram from ages 35-39,

– Annual mammograms for women over 40.

Maternity Care:

Well-woman visits including preconception counseling and routine, low-risk prenatal care

Gestational diabetes screening

Breast-feeding support, supplies, and counseling, including costs for renting or purchasing specified breast-feeding equipment from a network provider or national durable medical equipment supplier.

Lactation Counseling – first 6 visits covered without cost share when provided by a certified lactation support provider.

Routine Physicals and Immunizations:

The Medical Plan covers routine physical examination(s) and immunizations for you, your spouse/domestic partner, and dependent children including travel immunizations and flu shots.

A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury.

Covered services include:

• Office visit to a physician

• Hearing screening

• Vision screening

• Radiological services, lab and other tests

• For covered newborns, an initial hospital checkup

Please contact the Claims Administrator for more details.

Well-Child Immunizations:

Well-child immunizations are covered in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control.

Prostate Cancer:

Prostate-specific antigen (PSA): annually for men age 40 and older.

	Well-Woman Preventive Care Services: In addition to the other services described in this section, the Medical Plan provides expanded coverage for certain preventive care services for women. This includes, for example, screenings (and in some cases counseling) for domestic abuse, HPV, sexually transmitted infections and HIV. It also provides coverage for genetic counseling and evaluation for BRCA testing for women whose family or personal history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes and, if appropriate, the BRCA testing itself. **Other Preventive Care Services:** The Medical Plan covers all federally-required preventive services under the Preventive Care Services benefit (to the extent not described above). These services are described in the United States Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and Health Resources and Services Administration (HRSA) Guidelines. Additional information may be found at https://www.healthcare.gov/preventive-care-benefits/. For those recommendations that apply specifically to high risk groups, the individual's attending physician will determine whether the individual is in the high-risk group. If a specific preventive care item or service does not specify a limitation on the frequency, method, treatment or setting, the Medical Plan may apply reasonable limitations. Also, the applicable office visit or facility copayment may apply if (a) the preventive service is billed separately from the office visit, or (b) the primary purpose of the office visit is other than the delivery of preventive service and the preventive service is not billed separately from the office visit.
Second Opinion Charges	The Medical Plan covers practitioner's charges for a second opinion and charges for related diagnostic x-rays and laboratory tests in accordance with the Utilization Review Section of your Medical Plan. The Medical Plan covers such charges if the practitioner who gives the opinion: Is board certified and qualified, by reason of his specialty, to give an opinion on the proposed surgery or hospital admission; Is not a business associate of the practitioner who recommended the surgery; and Does not perform or assist in the surgery if it is needed.
Skilled Nursing Facility Charges	The Medical Plan covers bed and board, including diets, drugs, medicines and dressings, and general nursing service in a skilled nursing facility. Benefits are limited to 120 days per calendar year.
Spinal Disorder / Manipulation	Covered expenses include charges made by a physician, licensed chiropractor, or therapist on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

	Benefits are subject to a 30-visit maximum per calendar year. Additional visits as medically necessary. This maximum does not apply to expenses incurred: During your hospital stay; or For surgery. This includes pre- and post-surgical care provided or ordered by the operating physician.
Substance Abuse	The Medical Plan covers charges for services and supplies related to the treatment of Substance Abuse provided by a hospital, psychiatric hospital, Residential Treatment Facility, physician or Behavioral Health Provider as follows: • Inpatient room and board at the semi-private room rate, and other services and supplies related to your condition that are provided during your stay in a hospital, psychiatric hospital or Residential Treatment Facility. Treatment of substance abuse in a general medical hospital is only covered if you are admitted to the hospital's separate substance abuse section or unit unless you are admitted for the treatment of medical complications of substance abuse, such as detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium and hepatitis. • Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital or Residential Treatment Facility, including: - Partial hospitalization treatment provided in a facility or program for the treatment of substance abuse provided under the direction of a physician. - Intensive outpatient program provided in a facility or program for substance above provided under the direction of a physician. - Ambulatory detoxifications which are outpatient services that monitor withdrawal from alcohol or other Substance Abuse, including administration of medications. - Office visits to a physician or Behavioral Health Provider. - Other outpatient mental health treatment such as outpatient monitoring of injectable therapy. Medical plan limits may apply.
Surgical Services	The Medical Plan covers surgical procedures subject to the following: The Medical Plan will not make separate payment for pre- and post-operative services. If more than one surgical procedure is performed during the same operation through only one route of access, the Medical Plan will cover the primary procedure only. There will be no payment for any other procedures performed at the same time. If more than one surgical procedure is performed during the same operation through more than one route of access, the Medical Plan will cover the primary procedure, plus 50% of what the Medical Plan would have paid for each of the other procedures had those procedures been performed alone. Surgical procedures shall include reconstructive breast surgery, following a mastectomy on one or both breasts, as follows: surgery to restore and achieve symmetry between the two breasts, cost of breast prosthesis, outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer. These benefits will be provided to the same extent as for any other sickness under the Medical Plan.

	Under the Women's Health and Cancer Rights Act of 1998, if you are receiving benefits in connection with a mastectomy and elect to have breast reconstruction along with that mastectomy, your Medical Plan must provide, in a manner determined in consultation with the attending physician and you, coverage for the following: – Reconstruction of the breast on which the mastectomy was performed; – Surgery and reconstruction of the other breast to produce a symmetrical appearance; – Prostheses and physical complications at all stages of the mastectomy, including lymphodemas. These benefits will be provided to the same extent as for any other illness under your coverage. The Medical Plan also covers a hospital stay for at least 72 hours following a modified radical mastectomy and a hospital stay for at least 48 hours following a simple mastectomy, unless the covered person, in consultation with the covered person's physician, determines that a shorter length of stay is medically appropriate. While there is no requirement that the covered person's provider obtain pre-approval from the Medical Plan for prescribing 72 or 48 hours, as appropriate, of inpatient care as set forth in this subsection, any notification requirements remain in full force and effect.
Telemedicine	The Medical Plan offers the option to receive health care consultations virtually via Teladoc. Teladoc provides 24/7 access to U.S. board-certified doctors and nurses by phone or online video. Teladoc can diagnose, recommend treatments and prescribe medication for conditions including sinus problems, allergies, pediatric care, etc., for non-emergency medical issues. Call 1-800-835-2362 or go to Teladoc.com/Aetna for more information.
Therapeutic Manipulations	The Medical Plan covers charges for therapeutic manipulations.
Therapy Services	The Medical Plan covers charges for all therapy services as indicated below: Chelation Therapy Chemotherapy Cognitive Rehabilitation Therapy: Maximum of 30 visits. Additional visits as medically necessary. Dialysis Treatment Infusion Therapy Occupational Therapy: if it is expected to develop any impaired function Maximum of 30 visits. Additional visits as medically necessary. Physical Therapy: if it is expected to develop any impaired function. Maximum of 30 visits. Additional visits as medically necessary. Radiation Therapy Respiration Therapy Speech Therapy - if it is expected to develop speech function that resulted from delayed development (Speech function is the ability to express thoughts, speak words and form sentences.). Maximum of 30 visits. Additional visits as medically necessary

Transplant Benefits	The Medical Plan covers pre-approved services and supplies incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your covered dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue. Heart; Lung; Heart/Lung; Simultaneous Pancreas Kidney (SPK); Pancreas; Kidney; Liver; Intestine; Bone Marrow/Stem Cell; Multiple organs replaced during one transplant surgery; Tandem transplants (Stem Cell); Sequential transplants; Re-transplant of same organ type within 180 days of the first transplant; Any other single organ transplant, unless otherwise excluded under the plan. The following will be considered to be more than one Transplant Occurrence: Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant); Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant); Re-transplant after 180 days of the first transplant; Pancreas transplant following a kidney transplant; A transplant necessitated by an additional organ failure during the original transplant surgery/process; More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant). The network level of benefits is paid only for a treatment received at a facility designated by the plan as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants. Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services. The plan covers: Charges made by a physician or transplant team. Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program. Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services. Charges for activating the donor search process with national registries.

	Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children. Inpatient and outpatient expenses directly related to a transplant. Limitations: Unless specified above, not covered under this benefit are charges incurred for: Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence; Services that are covered under any other part of this plan; Services and supplies furnished to a donor when the recipient is not covered under this plan; Home infusion therapy after the transplant occurrence; Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness; Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness; Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.
Urgent Care Facility	Provides coverage at an Urgent Care facility. Use of facility for non-urgent care covered as an out-of-network benefit. Covered services include services and supplies to treat an urgent conditios at an urgent care center. An urgent condition is an illness or injury that requires prompt medical attention but is not a life-threatening emergency medical condition. An urgent care center is a facility licensed as a freestanding medical facility to treat urgent conditions. If you need care for an urgent condition, you should first seek care through your physician, PCP. If your physician is not reasonably available, you may access urgent care from an urgent care center
Walk-In Clinic	Provides coverage at network facilities for non-emergency illnesses or injuries and certain immunizations.

Eligible Supplemental Services and Supplies The Plan also covers certain supplemental medical services and supplies:

Covered Supplemental Services and Supplies	
Ambulance Services	The Medical Plan covers medically necessary charges for emergency transport of a covered person when his or her condition is unstable and requires medical supervision and rapid transport. These emergency ambulance services are limited to transportation by a licensed ambulance: - To the first hospital to provide emergency services - From one facility to another if the first facility can't provide the emergency services that are needed by the covered person The Medical Plan covers rotary wing (helicopter) air ambulance transport when: – Ground ambulance transportation is not medically appropriate because of the distance involved or because the member has an unstable condition requiring medical supervision and rapid transport – Transport is needed to a hospital or one hospital to another because the first hospital doesn't have the required services and/or facilities that are needed. Prior approval is needed for elective air ambulance transport by fixed wing aircraft (plane), including facility-to-facility transfers. Potential use of a fixed wing (plane) elective air ambulance includes transport: – In a state other than your home state – From facility to facility (does not include rotary wing (helicopter) transport service) – To other than nearest facility Transportation by fixed wing aircraft (plane) for member convenience or for non-clinical reasons is not covered. Non-emergency Ground Ambulance **Covered services** also include non-emergency transportation when an ambulance is the only safe way to transport you. These non-emergency ambulance services are limited to transportation by a licensed ambulance: - To the nearest facility able to treat your condition - From a facility to your home by ground ambulance The following are not **covered services**: - Ambulance services for non-emergency transportation except as expressly provided in this SPD - Ambulance services for routine transportation to receive outpatient or inpatient services **Charges for the use of an ambulance for a non-emergency will not be covered except as expressly provided in this SPD**.

Covered Supplemental Services and Supplies	
Blood	The Medical Plan does not pay for blood which has been donated or replaced on behalf of the covered person. Blood transfusions including the cost of blood, blood plasma and blood plasma expanders are covered from the first pint and only to the extent that the first pint and any additional pints to follow are not donated or replaced without charge through a blood bank or otherwise. The Medical Plan covers expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia for expenses incurred in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia when the home treatment program is under the supervision of a State approved hemophilia treatment center. Participation in a home treatment program shall not preclude further or additional treatment or care at any eligible facility if the number of home treatments, in accordance with a ratio of home treatments to benefit days established by regulation by the Commissioner of Insurance, does not exceed the total number of benefit days provided for any other illness under the Medical Plan. As used in the paragraph, "blood product" includes but is not limited to Factor VIII, Factor IX and cryopreciptate; and "blood infusion equipment" includes but is not limited to syringes and needles.
Contraceptive Devices, Implants & Injectables	The Medical Plan covers charges for office visits at no cost for injectables (Depo-Provera and Lunell), diaphragm fitting, and cervical cap and IUD devices for women.
Durable Medical Equipment	Your Medical Plan covers charges for the rental of durable medical equipment (DME) needed for therapeutic use. The Medical Plan may determine to cover the purchase of such items when it determines that doing so is more cost efficient. The Medical Plan will not cover the purchase of any item unless it is needed for long-term use. Coverage includes (i) one item of DME for the same or similar purpose; (ii) repairing DME due to normal wear and tear (repairs needed because of misuse or abuse are not covered); and (iii) a new DME item needed because your physical condition has changed or to replace one that is damaged due to normal wear and tear (as long as purchasing would be cheaper than repairing it or renting a similar item). The Medical Plan does not cover the rental or purchase of any items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not fully meet the definition of durable medical equipment.
Foot Orthotics	The Medical Plan covers foot orthotics, orthopedic shoes, and supportive devices.
Hearing Aids	Hearing Aids are covered for all children up to $3,000 per 36 months provided the Hearing Aid meets the specifications prescribed for correction of hearing loss.

Covered Supplemental Services and Supplies	
Home Infusion Therapy	Home infusion therapy is a method of administering intravenous (IV) medications or nutrients via pump or gravity in the home. These services and supplies are eligible when rendered or used in connection with home infusion therapy: Solutions and pharmaceutical additives, Pharmacy compounding and dispensing services, Ancillary medical supplies, and Nursing services associated with patient and/or alternative caregiver training, visits necessary to monitor intravenous therapy regimen and medical emergency care, but not for administration of home infusion therapy. Home infusion therapy includes chemotherapy, intravenous antibiotic therapy, total parenteral nutrition, enteral nutrition (when sole source of nutrition) hydration therapy, intravenous pain management, gammaglobulin infusion therapy (IVIG), and prolastin therapy. Note: Home infusion therapy must be authorized by the Medical Plan.
Oxygen and Administration	The Medical Plan covers oxygen and its administration.
Private Duty Nursing	The Medical Plan covers charges by a nurse for private duty nursing care by a nurse when ordered by a physician. Coverage is limited to 70-shift benefit (one shift = up to eight hours). Inpatient services are available to a covered person who is an inpatient if the Medical Plan determines that the services provided are of such a nature or degree of complexity or quantity that they could not be or are not usually provided by the regular nursing staff of the facility. Services are available to a covered person in the covered person's home if the services provided require the skills of a nurse. No benefits will be provided for the services of a nurse who ordinarily resides in the covered person's home or is a member of the covered person immediate family.
Prosthetic Devices	The Medical Plan limits coverage for prosthetic devices. The Medical Plan covers the fitting and purchase of artificial limbs and eyes, and other prosthetic devices. To be covered, such devices must take the place of a natural part of a covered person's body or be needed due to a functional birth defect in a covered child dependent, or as needed for reconstructive breast surgery. The Medical Plan does not cover dental prosthetics or devices. Coverage includes: Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed; Replacements required by ordinary wear and tear or damage; and Instruction and other services (such as attachment or insertion) so you can properly use the device.

What Is Not Covered

The Plan does not cover certain services, some of which are listed below. Please contact the Claims Administrator to confirm whether or not your service will be covered. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

Non-Covered Services and Supplies

- Administration of oxygen, except as otherwise stated in the plan.
- Ambulance, in the case of a non-medical emergency (except as otherwise stated in the plan).
- Anesthesia and consultation services when they are given in connection with non-covered charges.
- An inpatient admission or any part of an inpatient admission primarily for:
  - Short term rehabilitation, except as otherwise specified in the Medical Plan, and/or
  - Rehabilitation therapy, except as otherwise specified in the Medical Plan.
- Any charge to the extent it exceeds the allowance.
- Any therapy not included in the definition of therapy services.
- Balances for services and supplies after payment has been made under the Medical Plan.
- Blood or blood plasma or other blood derivatives or components, which are replaced by a covered person.
- Blood, blood plasma, synthetic blood, blood derivatives or substitutes: Blood, blood products, and related services which are supplied to your provider free of charge
- Broken appointments.
- Charges incurred during a person's temporary absence from an eligible provider's grounds before discharge.
- Charges in excess of the Recognized Charge.
- Clinical trial therapies (experimental or investigational) except as expressly specified in the Medical Plan.
- Clinical trial therapies (routine patient costs)
  - Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs).
  - Services and supplies provided by the trial sponsor without charge to you
  - The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with the Plan's claim policies.
- Completion of claim forms.
- Conditions classified as V-codes (conditions not arising from a mental disorder recognized in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association).
- Conditions related to behavior problems or learning disabilities.
- Conditions, which the Medical Plan determines, are due to developmental disorders including, but not limited to, academic skills disorders, or motor skills disorders except as may be necessary to provide newly born dependents with coverage for accidental injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, unless otherwise noted in the SPD.
- Conditions, which the Medical Plan determines, lack a recognizable III-R classification in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric

Non-Covered Services and Supplies

Association. This includes, but is not limited to, treatment for adult children of alcoholic families or co-dependency.

- Contraceptives which are not approved by the FDA or which are not prescribed by a doctor.
- Contraceptives obtained from non-network pharmacies.
- Copayments, deductibles, and the individual's part of any coinsurance; expenses incurred after any payment maximum is or would be reached.
- Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:
  - Rehabilitation therapy, except as otherwise specified in the Medical Plan.
  - Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
  - Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
  - Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
  - Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when medically necessary;
  - Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy);
  - Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
  - Surgery to correct Gynecomastia;
  - Breast augmentation; and
  - Otoplasty.
- Any cost for a service when any **out-of-network provider** waives all or part of your **copayment**, **payment percentage**, **deductible**, or any other amount
- Court ordered treatment which is not medically necessary.
- Custodial care or domiciliary care, including respite care except as specifically covered under your Medical Plan.
- Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:
  - services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
  - dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
  - non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

  This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.

Non-Covered Services and Supplies

- Non-surgical medical and dental services, and therapeutic services related to jaw joint disorder
- Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.
- Diversional/recreational therapy or activity.
- Drugs, medications and supplies (except as otherwise stated in the plan):
  - Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
  - Any services related to the dispensing, injection or application of a drug;
  - Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
  - Immunizations related to work;
  - Needles, syringes and other injectable aids, except as covered for diabetic supplies;
  - Drugs related to the treatment of non-covered expenses;
  - Performance enhancing steroids;
  - Injectable drugs if an alternative oral drug is available;
  - Outpatient prescription drugs;
  - Any prescription drugs, injectables, or medications or supplies provided by the customer or through a third party vendor contract with the customer; and
  - Drugs dispensed to a covered person while a patient in a facility.
- Drugs, obtained from a state or local public health agency, for the treatment of venereal disease or mental disease.
- Drugs dispensed by other than a pharmacist or a pharmacy or for services rendered by a pharmacist which are beyond the scope of his license. Benefits are not provided for drugs given by a physician or other practitioner.
- Educational services:
  - Any services or supplies related to education, training or retraining services or testing, including special education, remedial education, job training and job hardening programs;
  - Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, training or cognitive rehabilitation, regardless of the underlying cause; and
  - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.
- Education or training while a covered person is confined in an institution that is primarily an institution for learning or training.
- Egg Donors:
- Medical costs of a live donor used in egg retrieval after the donor has been released by the reproductive endocrinologist.
- Non-medical costs of an egg or sperm donor.
- Employment/career counseling.

Non-Covered Services and Supplies

- Experimental or investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs).
- Any health or dental examinations are needed:
  - Because a third party requires the exam. Examples include examinations to get or keep a job, and
  - examinations required under a labor agreement or other contract.
  - To buy coverage or to get or keep a license.
  - To travel.
  - To go to a school, camp, sporting event, or to join in a sport or other recreational activity.
- Eye examinations, eyeglasses, contact lenses, and all fittings, except as specified in this document; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.
- Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a provider that is not an eligible facility.
- Food items: Any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.
- Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:
  - treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
  - ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury.
- Growth/Height: Any treatment, device, service or supply (including surgical procedures and devices to stimulate growth), solely to increase or decrease height or alter the rate of growth.
- Health examinations:
  - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
  - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
  - any special medical reports not directly related to treatment except when provided as part of a covered service.
- Hearing aid if it is a replacement of a hearing aid that is lost, stolen or broken or a hearing aid that was installed within the prior 24-month period.
- Hearing aid replacement parts, repairs, batteries or cords.
- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as
- part of the overall **hospital stay**
- Herbal medicine.
- Home health care visits for care of mental, psychoneurotic or personality disorders, or in connection with administration of dialysis.

- Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:
  - Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds. and swimming pools;
  - Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
  - Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
  - Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
  - Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
  - Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury;
  - Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness; and
  - Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.
- Housekeeping services except as an incidental part of the eligible services of a home health care agency.
- Hypnotism.
- Illness or accidental injury which occurred on the job or which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.
- Illnesses, mental or nervous condition or substance abuse, including conditions which are the result of disease or bodily infirmity, which are covered or could have been covered for benefits provided under workers' compensation, employer's liability or similar law; or illnesses or injuries occurring while the individual is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit or intended for wage or profit.
- Immunizations, except as otherwise specified in the Medical Plan.
- Local anesthesia charges billed separately by a practitioner for surgery he performed on an Outpatient basis.
- Maintenance therapy for:
  - Physical therapy,
  - Manipulative therapy,
  - Occupational therapy, and
  - Speech therapy.
- Outpatient physical, occupational, and speech therapies: the following are not covered services:
  - Services provided in an educational or training setting or to teach sign language
  - Vocational rehabilitation or employment counseling
- Marriage, career or financial counseling; sex therapy.
- Medical emergency services, or supplies, when not rendered by a practitioner.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Methadone maintenance.

Non-Covered Services and Supplies

- Medical supplies – outpatient disposable: Any outpatient disposable supply or device. Examples of these include: Sheaths, Bags, Elastic garments, Support hose, Bandages, Bedpans, Home test kits not related to diabetic testing, Splints, Neck braces, Compresses and Other devices not intended for reuse by another patient
- **Missed appointments:** Any cost resulting from a canceled or missed appointment
- Non-medical equipment which may be used primarily for personal hygiene or for comfort or convenience of a covered person rather than for a medical purpose, including air conditioners, dehumidifiers, purifiers, saunas, hot tubs, televisions, telephones, first aid kits, exercise equipment, heating pads and similar supplies which are useful to a person in the absence of illness or injury.
- Non-prescription drugs or supplies, except as may be medically necessary and appropriate for the treatment of certain illness or injury, except as otherwise stated in this Medical Plan.
- **Nutritional support:** Any food item, including: Infant formulas, Nutritional supplements, Vitamins, **Prescription** vitamins, Medical foods, Other nutritional items
- Over-the-counter COVID-19 tests.
- Pastoral counseling.
- Personal comfort and convenience items. Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.
- Psychoanalysis to complete the requirements of an educational degree or residency program.
- Psychological testing for educational purposes.
- Removal of abnormal skin outgrowths and other growths including, but not limited to, paring or chemical treatments to remove corns, calluses, warts, cornified nails and all other growths, unless it involves cutting through all layers of the skin.
- Rest or convalescent cures.
- Room and board charges for any period of time during which the covered person was not physically present in the room.
- Routine examinations or health wellness, including related diagnostic x-rays and laboratory tests, except as otherwise stated in this document; pre-marital or similar examinations or tests not required to diagnose or treat illness, accidental injury, mental illness or substance abuse; screening, research studies, education or experimentation, mandatory consultations required by hospital regulations, routine pre-operative consultations.
- Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.
- Services for injuries resulting from a motor vehicle accident if such services are eligible for payment under the personal injury protection or compulsory medical payments provisions of a motor vehicle insurance contract required by any federal or state no-fault motor vehicle insurance law. This exclusion applies whether or not a proper and timely claim for payment for these services is made under the motor vehicle insurance contract and regardless of whether any such policy is designated as secondary to health coverage.
- Services involving equipment or facilities used when the purchase, rental or construction has not been approved in compliance with applicable state laws or regulations.
- Services performed by any of the following:

Non-Covered Services and Supplies

- — A hospital resident, intern or other practitioner who is paid by a facility or other source, who is not permitted to charge for services covered under the Medical Plan, whether or not the practitioner is in training. However, hospital-employed physician specialists may bill separately for their services.
- — Anyone who does not qualify as a physician.

- Services provided during a stay at a facility, which in whole or in part was for diagnostic studies. This exclusion applies when the services were provided for any of the following reasons: diagnosis, evaluation, confirmation (or to rule out), or to check the current status of a condition which was treated in the past.
- Services required by the group as a condition of employment or rendered through a medical department, clinic, or other similar service provided or maintained by the group.
- Services or supplies:
  - — Eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the covered person asserts his rights to obtain this coverage or payment for these services,
  - — For which a charge is not usually made, such as a practitioner treating a professional or business associate, or services at a public health fair,
  - — For which the provider has not received a certificate of need or such other approvals as are required by law,
  - — For which the covered person would not have been charged if he did not have health care coverage,
  - — Furnished by one of the following members of the covered person's family, unless otherwise stated in this document: spouse, child, parent, in-law, brother or sister,
  - — In connection with any procedure or examination not necessary for the diagnosis or treatment of injury or sickness for which a bona fide diagnosis has been made because of existing symptoms,
  - — Needed because the covered person engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony,
  - — Not specifically covered under your Medical Plan,
  - — Provided by a practitioner if the practitioner bills the covered person directly for the services or supplies, regardless of the existence of any financial or contractual arrangement between the practitioner and the provider,
  - — Provided by or in a government hospital unless the services are for treatment:
    - Of a non-service medical emergency,
    - By a Veterans' Administration hospital of a non-service related illness or accidental injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law,

    NOTE: The above limitations do not apply to military retirees, their dependents, and the dependents of active duty military personnel who have both military health coverage and coverage under your Medical Plan and receive care in facilities run by the Department of Defense or Veterans' Administration.
  - — Provided by a licensed pastoral counselor in the course of his normal duties as a pastor or minister,
  - — Provided by a social worker, except as otherwise stated in this document,
  - — Provided during any part of a stay at a facility, or during home health care chiefly for bed rest, rest cure, convalescence, custodial or sanatorium care, diet therapy or occupational therapy,

Non-Covered Services and Supplies

  - Received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection,
  - Rendered prior to the covered person's effective date or after his termination date of coverage under the program, unless specified otherwise,
  - Which are specifically limited or excluded elsewhere in this document,
  - Which are not medically necessary and appropriate, or
  - Which a covered person is not legally obligated to pay for.
- **Sexual dysfunction and enhancement:** Except where described in the *Coverage and exclusions* section, any treatment, **prescription** drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Special medical reports not directly related to treatment of the covered person (e.g., employment physicals, reports prepared in connection with litigation).
- Stand-by services required by a practitioner; services performed by surgical assistants not employed by a facility.
- Sterilization reversal.
- Sunglasses even if by prescription.
- Surrogate motherhood.
- Telephone consultations, except as the Medical Plan may request.
- TMJ syndrome treatment, except as otherwise stated in this document.
- **Tobacco cessation:** any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  - Counseling, except as specifically provided in the Coverage and exclusions section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the Coverage and exclusions section
  - Nicotine patches
  - Gum
- Transplants, except as otherwise stated in this document.
- Transportation; travel.
- Vision therapy, vision or visual acuity training, orthoptics and pleoptics.
- Vitamins and dietary supplements.
- Weight reduction or control, unless there is a diagnosis of morbid obesity or the services, treatment or supplies must be covered as preventive care under the Affordable Care Act; special foods, food supplements, liquid diets, diet plans or any related products, except as specifically covered under the Medical Plan.
- Wigs, toupees, hair transplants, hair weaving, or any drug used to eliminate baldness unless deemed medically necessary and appropriate.
- Wilderness Treatment Program or any such related or similar program.

Filing a Claim

If you use a participating provider for care, the provider should file the claim for you. For out-of-network benefits, you must file claims for reimbursement. You must attach proper documentation of your claim including the provider's name, the date services are received and any bills or receipts. By providing a complete claim, you will avoid unnecessary delays in processing.

Medical claim forms are available from the Dun & Bradstreet Benefits Center via the Internet. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information. Medical benefits are generally payable to you. However, the Medical Plan has the right to pay the provider directly.

Claims Filing Deadline

You must file all claims for health care expenses within 12 months of when you incurred the expense. If you do not file claims on a timely basis, your claims will not be eligible for reimbursement and the Claims Administrator will deny the claim. Expenses are generally considered "incurred" on the date of service, not the date of the invoice. If you have questions about claims, you can call the Claims Administrator.

If You Do Not Present Claims Reimbursement Checks for Payment

If you do not present claims reimbursement checks for payment within 25 months after the date reimbursement was issued, the reimbursement will be cancelled.

PRESCRIPTION DRUG BENEFITS

If you are enrolled in the CDHP or PPO Select medical plan, you automatically receive prescription drug coverage through your Prescription Drug Provider. You do not need to enroll separately for it.

The Medical Plan covers both generic and brand-name prescription drugs. You can fill a prescription at a retail pharmacy that is part of the network of participating pharmacies or through the mail order service. If you use a non-participating pharmacy, you are responsible for paying the entire cost of the prescription and will not be eligible for reimbursement under the Medical Plan. To get a list of participating pharmacies, contact the Prescription Drug Provider.

Prescription Drug Classifications

- **Generic Drugs**
  Generic drugs must meet the same rigid FDA-approved standards as brand-name drugs and be identical or the "bioequivalent" to the brand-name drugs. Bioequivalent means the drug enters your bloodstream at the same rate and to the same extent, contains the same amount of active ingredients, has the same dosage, and is labeled in a similar manner as the brand-name. Generic drugs usually cost 30 percent to 60 percent less than brand-name drugs.
- **Preferred Brand-Name Drugs**
  A preferred drug is any brand-name medication designated by the Prescription Drug Provider to be the most clinically appropriate and cost-effective agents in a therapeutic class. A committee of independent doctors and pharmacists evaluates the clinical efficacy and safety of a drug and then votes on whether it should be on the formulary list. These prescriptions usually cost less than similar medicines not on the preferred list.
- **Non-Preferred Brand-Name Drugs**
  A non-preferred drug is a brand-name medicine not on the Prescription Drug Provider's preferred brand list. Using a non-preferred brand-name drug will cost you more money. In most cases, your doctor should be able to prescribe an equally effective, less expensive medicine either as a generic or from the list of preferred brand-name drugs.
- **Specialty Drugs**
  High-cost prescription medications used to treat complex, chronic conditions.

The amount you are required to pay depends on whether the drug is a generic, preferred-brand, non-preferred brand-name or specialty drug medication. The Plan has a list of covered drugs called a formulary. A formulary is a list of FDA-approved, generic, preferred brand-name, non-preferred brand-name and specialty prescription drugs that are covered by a health plan. Formularies are updated from time to time, so you may want to review it periodically to see if certain drugs have been added or dropped from the Medical Plan's formulary. You may request a copy of the formulary or preferred drug list used by the Medical Plan, free of charge, by contacting the Prescription Drug Provider.

When you have your prescription filled at one of the retail pharmacies that participate in the network, you can receive up to a 30-day supply after you pay your copayment or co-insurance, whichever is applicable.

For prescription medicines associated with a chronic condition or for maintenance prescriptions such as those used to control high blood pressure, you can also use the mail order service. When you order your prescription drugs through the mail, you can receive a 90-day supply after you pay your copayment or co-

insurance, whichever is applicable. To fill a prescription through the mail order program, complete a mail order drug form and return it along with your prescription to the address shown on the form. A separate copayment or co-insurance applies to each 90-day prescription order and you can refill your mail order prescriptions online.

See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

Preventive Care Medications under the Affordable Care Act (ACA) Certain prescriptions intended to prevent illness and disease, as well as contraceptives, are covered at 100% under all medical plans. This applies to generic and certain single-source brand drugs as well as some over-the-counter (OTC) drugs (prescription required). For a list of the preventive care drugs covered by this provision, contact CVS Caremark.

Preventive Therapy Drugs Under the CDHP

Your CDHP plan requires you to pay the full negotiated cost for your care until you reach your deductible for most health care expenses, including most prescription medications. After you meet the deductible, you pay only the coinsurance and your plan pays the rest.

If you are enrolled in a CDHP, using medications on the preventive therapy drug list will reduce your cost for select prescriptions that help prevent chronic health conditions when taken regularly. If you take medications on the preventive therapy drug list, you will pay only the coinsurance for these medications even if you have not yet met your annual plan deductible. For a list of the preventive therapy drugs covered by this provision, contact CVS Caremark.

Generic Drug Substitute

The PPO Select plan requires the use of generic drugs, when available. If a generic drug is not available you will receive the brand-name drug and pay the appropriate brand-name co-insurance. However, if you choose to receive the brand-name drug when a generic is available, you will pay the brand-name co-insurance plus the full cost difference between the brand-name and its generic equivalent. If the brand-name co-insurance plus the difference equals more than the full cost of the brand-name drug, you will pay the full cost of the brand-name drug.

This provision does not apply to brand-name contraceptives which are covered under the Medical Plan if the brand-name is medically necessary as determined by your physician. To begin the exceptions process,

you must contact the Claims Administrator. See the section "How To Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

For the CDHP Plan, all eligible prescriptions filled at a participating pharmacy will be covered at 80% after the deductible has been met.

Maintenance Choice® Program

This program applies to drugs taken regularly (i.e. three months or more) for chronic conditions or long-term therapy when dosage adjustments are either no longer required or made infrequently. A few examples include drugs for birth control, or for managing high blood pressure, asthma, diabetes, or high cholesterol.

You may obtain up to three 30-day supply prescription fills of a maintenance medication at a network retail pharmacy. After your third fill, you'll be required to receive future refills of your maintenance medication in one of two ways, unless you opt-out: (1) Through the CVS Caremark mail order pharmacy, or (2) Though the Maintenance Choice® option.

Maintenance Choice gives you the option of picking up your 90-day maintenance prescriptions at a CVS retail pharmacy rather than receiving them through the mail. You will pay the same coinsurance at a CVS retail pharmacy as you would through CVS Caremark mail order.

There are several ways to start obtaining your 90-day maintenance medication:

Sign up for mail service:

1. Use the FastStart® tool on www.caremark.com;
2. Call FastStart® at 1-800-875-0867; or
3. Have your doctor call FastStart at 1-800-378-5697.

Register at your local CVS pharmacy:

1. Log on to www.caremark.com to register and select a CVS pharmacy location for pick-up; or download the CVS Caremark mobile app
2. Visit your local CVS pharmacy and speak with a pharmacist.

While it is optional to participate, Dun & Bradstreet encourages members to use this program for savings and convenience. To opt-out of this program and continue receiving 30-day supplies of a maintenance medication at a non-CVS network retail pharmacy, you will need to call CVS Caremark at the number on the back of your prescription ID card. Opt-out is required for each individual maintenance medication. If

you do not contact CVS Caremark to opt-out and you choose to continue to fill your maintenance prescription at a non-CVS retail pharmacy, that prescription will not be covered under the Dun & Bradstreet prescription drug plan, and you will be responsible for the full retail cost of the drug. You are also required to opt-out on an annual basis in order to continue filling 30-day supplies of your long-term maintenance medications at retail.

PrudentRx Copay Program for Specialty Medications

The PrudentRx Copay Program assists members in the PPO Select Plan in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications in particular, specialty medications thereby reducing out-of-pocket expenses.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible members will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call 1-800-578-4403 to opt-out. If you do not opt out, you will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx program.

Medications on the Plan's specialty drug list and exclusively dispensed by CVS Specialty are included in the program and will be subject to a 30% co-insurance. However, enrolled members who get copay card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

As certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's out-of-pocket maximum.

Standard Covered Drugs

The Medical Plan covers certain standard drugs. These are listed below:

Standard Covered Drugs
▪ Federal legend drugs (any drug that requires a prescription to be filled) ▪ Compounded medications in which at least one ingredient is a legend drug ▪ CNS drugs for treatment of ADD/ADHD or narcolepsy — e.g., Dexedrine, Adderall, Desoxyn, Ritalin — with no age limits

- Topical Acne Agents for participants under age 35 (Retin-A, Avita, Differin and Ziana)
- Oral, topical and injectable contraceptives, plus contraceptive devices,
    - Generic drugs and single-source brands that don't have a generic equivalent will have no cost–sharing (100% coverage) at an in network pharmacy.
    - Multi-source brand drugs that have a generic equivalent will be paid under the existing benefits with patient cost-sharing unless your doctor determines that the brand name contraceptive is medically necessary for you. If you or your doctor believe that a brand name contraceptive is medically necessary for you, you or your doctor should contact the claims administrator to begin the exceptions process. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.
- Biologicals, immunization agents and vaccines
- Insulin and pre-filled insulin syringes
- Diabetic supplies — insulin syringes and needles, glucose monitors, blood and urine glucose test strips, lancets and lancet devices, glucose tabs and alcohol swabs — covered with no copayment. Deductible and coinsurance apply under CDHP
- Non-insulin syringes and needles
- Erectile dysfunction medications subject to quantity limits of 6 per 25- day supply for retail and 18 per 75-day supply for mail order service
- Legend vitamins
- Growth hormones
- Fertility agents — oral and injectable (limited to a $15,000 lifetime maximum)
- Glucagon
- Anaphylaxis kits (Ana-Kit)
- Betaseron
- Epinephrine
- All injectables, except IV injectables are covered, unless specifically identified as an exclusion
- B-Complex with C and Folic Acid vitamins (GPI 7813300000****) regardless of whether over-the-counter equivalents exist
- Smoking cessation products – limit of 168 day supply in one year of treatment with generic Zyban, Chantix, or Nicotine replacement products (Nicotine patch, gum and lozenges) - covered with no copayment

Excluded Standard Drugs

The Medical Plan excludes certain standard drugs. These are listed below:

Excluded Standard Drugs
▪ Therapeutic devices or support garments and other non-medical substances ▪ Over-the-counter (OTC) medications, unless indicated otherwise ▪ Cosmetic alteration agents ▪ Legend drugs with OTC equivalents ▪ IV injectable medications

Managed Drug Limitations

Drug Limitations (MDL) limit coverage of drugs over a defined time period to a specific amount or quantity. MDL's are based on manufacturers' maximum-recommended dosing and FDA approval.

The MDL drug classes are listed below.

- Migraine Agents (e.g., Imitrex, Maxalt),
- Erectile Dysfunction Agents (e.g., Viagra, Cialis),
- Potent Anti-Nausea Drugs (e.g., Zofran, Kytril),
- Influenza Treatment & Prevention (e.g., Tamiflu)
- Select Pain Medicines (e.g., Stadol NS, Toradol)

Prior Authorization Drugs

The Medical Plan requires that you receive prior authorization for certain medications because they either have the potential to generate high costs or may be prescribed for uses that do not meet the criteria established by the Food and Drug Administration (FDA) based on the Manufacturer's Published Scientific Studies. The criteria the FDA establishes for approved drugs include conditions for use, proper dosage and length of time a person can use a particular medication.

If you need to fill a prescription for a prior authorization drug, your doctor must contact the Prescription Drug Provider's prior authorization department to determine if the dispensing criteria have been met. Once approved, the authorization is usually valid for a period of one year from the original prescription's date.

The Prescription Drug Provider may require a re-evaluation with your doctor in order to renew the prescription after the authorization period ends. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

The prior authorization drug classes are listed below:

Prior Authorization Drugs
▪ Anti-obesity/Weight Loss drugs (e.g., Xenical, Meridia, Adipex, Didrel, Fastin and Ionamin, Saxenda) ▪ Anemia drugs (Aranesp, Procrit & Epogen) ▪ Anabolic steroids (Winstrol, Anadrol-50, and Oxandrin) ▪ Drug classes used for Transgender Care: o Gonadotropin-releasing hormone (GnRH) agonists (i.e., Lupron products, Supprelin® LA, Zoladex®) o Testosterones o Depo-Provera® (medroxyprogesterone) ▪ Multi-Ingredient Compounds (all compound drugs exceeding $300 will require a prior authorization) o Topical Acne Agents for participants age 35 and over (Retin-A, Avita, Differin and Ziana) Transmucosal Immediate Release Fentanyl (TIRF) products

Prior Authorization also ***may*** come into play if you attempt to receive certain products in quantities that exceed the existing Managed Drug Limitations (MDL) on those products. See below for examples.

- **Potent Anti-Nausea Drugs** - (e.g., Kytril, Zofran, Marinol, Aloxi & Anzemet ... individual MDL's vary between drugs)
- **Influenza Drugs -** (e.g., Tamiflu and Relenza ... MDL = #1 fill per every 180 days)
- **Migraine Agents** - (e.g., Imitrex, Maxalt, Zomig, Migranal, etc... individual MDL's vary between drugs)

Please note: the drugs listed above are for exemplary purposes only and do not represent a complete list of the drugs affected by MDL and Prior Authorization. For additional information, contact the Prescription Drug Provider. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

Specialty Guideline Management Program

The specialty pharmacy program is for specialty pharmacy medications which are designated as "self-administered." These are medications which are administered outside of the physician's office – and may either be injectable/or oral medications. There are also several infused medications – (usually in the hemophilia class) and oral cancer medications. The specialty medications are typically used to treat ongoing conditions such as rheumatoid arthritis, multiple sclerosis, cancer, HIV, and transplants.

Prescriptions for specialty pharmacy medications must be filled through CVS Caremark Specialty Pharmacy. If you are starting a specialty drug for the first time or have questions whether your prescription is a specialty medication, contact the CVS Specialty Pharmacy at 1-800-237-2767. All specialty medications must be approved by the CVS Caremark Specialty Pharmacy Program. CVS Caremark will work with your doctor to review your medicine and treatment plan and decide whether they meet drug-specific guidelines.

CVS Weight Management Program

If you are on weight-loss medication, the CVS Weight Management provides the customized support you need for lasting results. This program is offered through your benefit plan at no cost to you.

This enhanced program requires enrollment to access anti-obesity medication benefits. It offers convenient access to a dedicated Care Team – including Registered Dietitians and Providers – through one-on-one coaching and a digital platform (Health Optimizer App). The program is designed to support weight loss and reduce obesity-related comorbidities through personalized coaching, connected devices, and medication optimization. The program can help you reach your health goals through:

- **One-on-one support** from a team of clinicians, including providers and registered dietitians
- **A nutrition plan** personalized just for you
- **Health Optimizer™ app** with helpful guides, recipes, goal setting and much more
- **Connected body weight scale** and other devices, as applicable, to support and track your progress

Enrollment is mandatory for members to receive the plan-designated cost share for anti-obesity medications. To enroll, you must download the Health Optimizer App and complete the registration

process. For assistance with app navigation or troubleshooting, please call at 1-800-207-2208 or visit https://cvsweightmanagement.com.

If you have an approved Prior Authorization (PA), enroll in and stay active in the Weight Management Program, you will only pay the plan's cost share for anti-obesity medication. However, if you have an approved PA but do not enroll in the program, you will be required to pay the full cost despite the approved PA. If the PA is denied, you will pay the full pharmacy rate and will need to contact the retail pharmacy for pricing.

ADDITIONAL RULES THAT APPLY TO THE MEDICAL PLAN

The following rules apply to the Medical Plan.

Continuity of Care

If you are participating in the Medical Plan and your health care provider stops being part of the Medical Plan's network, you may have to find a new provider if you want to continue to receive in-network benefits. However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. If this situation applies to you, contact Aetna for details. If the Medical Plan approves your request to keep going to your current provider, you will be told how long you can continue to see your provider. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery.

Breast Reconstruction Benefits

The Medical Plan provides benefits related to breast reconstruction in compliance with the requirements of The Women's Health and Cancer Rights Act of 1998.

Under this federal law, group health plans and health insurance issuers that provide medical and surgical benefits for mastectomy must provide certain additional benefits related to breast reconstruction.

If you (or a covered dependent) are receiving mastectomy benefits and elect breast reconstruction in connection with the mastectomy, the Medical Plan will provide coverage for:

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

Covered services will be provided in a manner determined in consultation between the attending physician and the patient. You will be required to pay any applicable amounts.

Maternity Admissions

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and health care issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Order (QMCSO)

The Medical Plan will comply with all the terms of a qualified medical child support order (QMCSO). A QMCSO is an order or judgment from a court or administrative body that directs the plan to cover a child of a participant under the health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Medical Plan's procedure for determining if the order is valid. Coverage under the Medical Plan pursuant to a medical child support order will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

Compliance with the Affordable Care Act

It is the Company's policy and intent to comply with all applicable provisions of the Affordable Care Act and its related regulations and other governmental guidance. The Company will investigate fully any complaint that the Company or the Plan has not complied with such laws and regulations and will take steps to remedy any violations should they occur. If you believe that the Company or the Plan has violated a provision of the Affordable Care Act, you are encouraged to share your complaint with the Company by contacting the Dun & Bradstreet Benefits Center. Please provide as much information as you can regarding your complaint to help the Company with its investigation. The Company will not retaliate or

otherwise discriminate against you if you assert a complaint or take any other action which is protected under the Affordable Care Act.

Protections Against Surprise Medical Bills

Beginning January 1, 2022, participants in the Medical Plan are protected from certain surprise medical bills through a federal law known as the "No Surprises Act." In general, these protections apply in the following situations:

- The participant receives Emergency Services from a non-network provider.
- The participant receives certain ancillary services (such as anesthesiology, radiology, laboratory, neonatology, assistance surgeon, hospitalist services) from a non-network provider in a network hospital or ambulatory surgical center.
- The participant receives non-ancillary services from a non-network provider in a network hospital or ambulatory surgical center and does not waive the surprise medical bill protections in accordance with the requirements of the law. The protections may only be waived in limited situations.
- The participant receives air ambulance services from an out-of-network provider.

In each of these situations, the participant pays the in-network cost sharing (even though services are received out-of-network), and the amount used to determine the participant's cost-sharing will be calculated in accordance with the requirements of the No Surprises Act. In addition, amounts paid by the participant will count towards the in-network deductible and in-network out-of-pocket maximum.

In each situation where the surprise medical bill protections apply, the participant may not be balance billed by the non-network provider or non-network facility for amounts that exceed the amount paid by the Medical Plan. The amount paid by the Medical Plan to the provider or facility will be determined in accordance with the requirements of the No Surprises Act.

If you believe that you have been wrongly billed by a provider or facility for items or services which are protected under the No Surprises Act, you should contact Aetna immediately. For additional information regarding surprise medical bill protections, refer to the No Surprises Act notice which can be found under Legal Documents.

Subrogation and Right of Recovery Provision

The provisions of this section apply to all current or former plan participants and also 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 right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan's rights of subrogation and reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

The Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the Plan, the plan shall be subrogated to (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 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.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) 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. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, 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 representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, 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, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights 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 payments, 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 damages sustained. The Plan rejects the "common-fund doctrine" and any other similar rule which would require the Plan to share in the recovery costs. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion

of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's right of subrogation and right of recovery shall apply without regard to any equitable defenses that you assert or may be entitled to assert, including without limitation any defense of unjust enrichment. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to 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 and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. 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. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

You acknowledge that 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 his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that 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 its subrogation and reimbursement rights.

Interpretation

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

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

Recovery of Excess Payments and Overpayments

The Plan has the right to recover excess payments from any individual (including you, your dependents and a provider), insurance company or other entity or organization to whom the excess payments were made—or to withhold payment, if necessary, on current and future benefits or offset current and future benefits to the extent of the excess payment until the excess payment is recovered. The Company may also withhold the excess payment from any other source of funds paid by the Plan or the Company. Whenever payments have been made based on inaccurate, misleading or fraudulent information provided by you or your dependent, the Plan will exercise all available legal rights to recover the excess payment, including its right to withhold payment on future benefits or offset future benefits to the extent of the excess payment until the excess payment is recovered.

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. One of the ways Aetna recovers overpayments to in-network providers is by reducing future payments to the in-network provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by Aetna. Aetna would then credit the recovered amount to the plan that overpaid the in-network provider. Payments to in-network providers under this Plan may be subject to this same process when Aetna recovers overpayments for other plans administered by Aetna. This right does not affect any other right of recovery the Plan may have with respect to overpayments.

An "excess payment" includes – (1) any payment of plan benefits received by or on behalf of yourself or a dependent, which you or a dependent is not entitled to under the terms of the Plan, (2) any payment of

benefits under the Plan received by or on behalf of yourself or a dependent, which are in excess of the amount necessary to satisfy the requirements of this Plan, and (3) any additional payment of Plan benefits to or on behalf of a healthcare provider, where the Plan has previously paid Plan benefits to or on behalf of yourself or dependent and you or the dependent has failed to remit all or a portion of the previous payment(s) to the provider. Excess payments also include any legal costs, attorneys' fees and court costs incurred as a result of or relating to the excess payment.

Coordination of Benefits If Covered by More than One Medical Plan

In situations where you have other healthcare coverage, the Plan will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Other Coverage Definition

A "plan" through which you may have other coverage for health care expenses refers to:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here's how COB works

When this Plan is the primary plan, this Plan will pay your medical claims first as if the other plan does not exist.

When this Plan is the secondary plan, this Plan will pay benefits after the primary plan and will reduce the benefits to the lesser of:

- What this Plan would have paid if it had been primary
- What this Plan would have paid less the primary plan's payment.

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan. In addition, this plan always pays secondary to:

- Any medical payment, PIP or No-Fault coverage under any automobile policy available to you.
- Any plan or program which is required by law.

You should review your automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or Dependent	The plan covering you as an employee or retired employee.	The plan covering you as a dependent.
Exception to the rule above when you are eligible for Medicare	If you or your spouse have Medicare coverage, the rule above may be reversed. If you have any questions about this, you can contact Aetna: • **Online**: Log on to your Aetna Navigator® at www.aetna.com. Select Find a Form, then select Your Other Health Plans. • **By phone**: Call the Member Services number on your ID card.	
COB rules for dependent children		
Child of: **Parents who are married or living together**	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary
Child of: • **Parents separated or divorced or not living together** • **With court-order**	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse's plan.	The plan of the other parent. But if that parent has no coverage, then his/her spouse's plan is primary.
Child of: **Parents separated or divorced or not living together – court-order states both parents are**	Primary and secondary coverage is based on the birthday rule.	

responsible for coverage or have joint custody		
Child of: **Parents separated or divorced or not living together and there is no court-order**	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist and we compare that benefit to the primary plan's benefit. If the primary plan's benefit is equal to or more than our benefit, we don't pay a benefit. If the primary plan's benefit is less than our benefit, we pay the difference between the primary plan's benefit and our benefit.

Coordination with Medicare

This section explains how the benefits under this Plan interact with benefits available under Medicare.

Medicare, when used in this Plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you are covered under it by reason of:

- Age, disability, or
- End stage renal disease

You are also eligible for Medicare even if you are not covered if you:

- Refused it
- Dropped it, or
- Did not make a proper request for it

When you are eligible for Medicare, the Plan coordinates the benefits it pays with the benefits that Medicare pays. In the case of someone who is eligible but not covered, this Plan may pay as if you are covered by Medicare and coordinates benefits with the benefits Medicare would have paid had you enrolled in Medicare. Sometimes, this Plan is the primary plan, which means that the Plan pays benefits before Medicare pays benefits. Sometimes, this Plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered.

Who pays first:

If you are eligible due to age and have group health plan coverage based on your or your legal spouse's current employment and:	**Primary plan**	**Secondary plan**
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan
If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30-month period.	Medicare Your plan
A disability other than ESRD and the employer has more than 100 employees and you have coverage due to current employment status	Your plan	Medicare

Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD,

Medicare will remain your primary plan and this Plan will be secondary.

This Plan is secondary to Medicare in all other circumstances.

How are benefits paid?

If D&B is primary	We pay your claims as if there is no Medicare coverage.
If Medicare is primary	We calculate the amount we would pay if there were no Medicare coverage. If the Medicare payment is equal to or more than what we would pay, we make no payment. If Medicare paid less than what we would pay, we pay the difference between our payment and the Medicare payment.

When You Remain an Active Employee After You Attain Age 65

In general, while you are actively employed, your Dun & Bradstreet Medical Plan coverage will be your primary coverage and Medicare is secondary. However, you have the choice to elect Medicare coverage alone as your primary plan and stop coverage under the Medical Plan after you attain age 65 and are still actively working. If you are actively employed and enrolled in a group health plan, you can enroll in Medicare Part A and delay enrollment in Medicare Part B without incurring the penalty for late enrollment.

Benefits for Disabled Individuals

If you stop working at Dun & Bradstreet because of a disability and subsequently become disabled as defined by the Social Security Administration, you must apply for Medicare Parts A and B. Medicare is the primary plan payer for most disabled persons.

PLAN ADMINISTRATION

This information about the administration of the Medical Plan is provided in compliance with the Employee Retirement Income Security Act (ERISA) of 1974, as amended. While you should not need these details on a regular basis, the information may be useful if you have specific questions about your Medical Plan.

Plan Name

The name of the plan is The Dun & Bradstreet Corporation Welfare Benefit Plan. The Medical Pan is one part of this plan.

Plan Sponsor

The Dun & Bradstreet Corporation is the Plan Sponsor of The Dun & Bradstreet Corporation Welfare Benefit Plan, of which the Medical Plan is a part. The name, address and telephone number of the Plan Sponsor are:

The Dun & Bradstreet Corporation
5335 Gate Parkway
Jacksonville, FL 32256
1-800-234-3867

This plan is a group health plan providing medical benefit.

Participating Employers

As of January 1, 2026, the participating employers are:

The Dun & Bradstreet Corporation
Dun & Bradstreet Credibility Corporation
Dun & Bradstreet, Inc.
MDM Technology USCo, LLC (prior to July 1, 2026)

For a complete list, please contact the Plan Administrator.

Plan Administrator

The name, address and telephone number of the Plan Administrator are:

The Plan Administration Committee
The Dun & Bradstreet Corporation
5335 Gate Parkway
Jacksonville, FL 32256
1-800-234-3867

The administration of the Medical Plan will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator (or its delegee Claims Administrator) will have the exclusive right to determine all matters relating to eligibility, coverage determination, interpretation and operation of the Medical Plan.

Claims Administrator

The medical coverage provided under the Medical Plan is self-insured by Dun & Bradstreet, and Dun & Bradstreet has contracted with third party administrators (the "Claims Administrator") to perform claims administration and other administrative services.

The name, address, and telephone number of the Claims Administrators are:

Medical Claims
Aetna
PO Box 981106
El Paso, TX 9998-1106
1-800-422-1749

Prescription Drug Claims
Caremark
P.O. Box 830070
Birmingham, AL 35283
1-877-321-2649

The Plan Administrator has delegated to the Claims Administrators full discretion to determine all matters relating to medical claims, up to and including final appeals. Any determination by the Plan Administrator, or any authorized delegate, shall be final and binding.

Agent for Service of Legal Process

The name, address and telephone number of the agent for service of legal process are:

The Plan Administration Committee
The Dun & Bradstreet Corporation
5335 Gate Parkway
Jacksonville, FL 32256
1-800-234-3867

Identification Numbers

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to Dun & Bradstreet is 22-3725387. The plan number for The Dun & Bradstreet Corporation Welfare Benefit Plan is 501.

Plan Year

The plan year for the Medical Plan is January 1 through December 31.

Organizations Providing Administrative Services

Day-to-day operations of the Medical Plan have been delegated to the Dun & Bradstreet Benefits Center. The name, address and telephone number of the Dun & Bradstreet Benefits Center are:

Dun & Bradstreet's Benefits Center at Fidelity
P.O. Box 770003
Cincinnati, OH 45277
1-877-362-8953

http://netbenefits.fidelity.com

Plan Funding

The Medical Plan is a self-insured plan. Benefits from this plan are paid from participant contributions, as applicable, and from the general assets of Dun & Bradstreet, as needed. Dun & Bradstreet has contracted with third party administrators to administer this plan.

Plan Document

This SPD is intended to help you understand the main features of the Medical Plan. The legal plan document provides additional information about the administration of the Medical Plan. If there is any difference between the information in this SPD and in the legal plan document, or if there are details not covered in this SPD, the legal plan document will determine how to resolve these issues.

Future of the Plan

Dun & Bradstreet reserves the right to amend, modify, suspend or terminate the plan, in whole or in part, by action of the Compensation Committee of the Company's Board of Directors (or any delegate from time to time). Plan amendment, modification, suspension or termination may be made for any reason, and at any time.

Limited Authorization of Payments

To the extent allowed by the Claims Administrator, you may authorize the Claims Administrator to make payments directly to a health care provider for covered services. Further, even without such an authorization, the Claims Administrator may make direct payments to a health care provider for covered services pursuant to the Claims Administrator's rules and procedures as of the applicable time.

Authorizations of payments to a health care provider or direct payments to a health care provider are not assignments of benefits. Even though you may authorize a health care provider to receive a payment or reimbursement of covered services and even though the Claims Administrator may pay a health care provider directly for payments or reimbursements of covered services, in no event will any such authorizations, payments or reimbursements to or on behalf of a health care provider cause the provider to become a Plan participant or Plan beneficiary (or assignee of a participant or beneficiary) under ERISA.

No Assignment of Rights and Benefits

Your rights and benefits under the Plan cannot be assigned, sold or transferred to any person, including your health care provider. For this purpose, your Plan rights and benefits, include, without limitation, the right to file an administrative appeal (internal and external), the right to sue following a denied administrative appeal, and any other Plan rights and benefits, whether actual or potential. Any purported assignment of rights and/or benefits under the Plan shall be void and shall not apply to the Plan. Further, a payment or reimbursement of covered services by the Claims Administrator to a health care provider (whether pursuant to an authorization or otherwise) will not waive the application of this provision. The application of this provision does not affect your right to appoint an authorized representative. See the Authorized Representative provisions in the Plan Administration Section for additional information.

Health Care Provider Agreements not Binding on the Plan

Sometimes your health care provider requests that you sign various agreements and other documentation as a condition of receiving health care services from the provider. Any agreement, assignment or other document executed by you and a health care provider (or executed by parties that include you and a health care provider, but that do not include the Plan Administrator) are not binding on and will have no legal effect whatsoever on the Plan or the Claims Administrator. Further, a payment or reimbursement of covered services by the Claims Administrator to a health care provider (whether pursuant to an authorization or otherwise) will not waive the application of this provision.

CONTINUATION OF COVERAGE

COBRA Continuation

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical Plan. **This section generally explains COBRA continuation coverage, when it may become available to you and your covered spouse and dependent children, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you when you would otherwise lose coverage under the Medical Plan. It may also become available to your spouse and dependent children who are covered under the Medical Plan when they would otherwise lose such coverage.

In addition to COBRA continuation coverage, you may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Additional information is provided below.

What is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of plan coverage when you would otherwise lose such coverage because of a life event known as a "qualifying event."

Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if covered under the Medical Plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Additionally, a child who is born to or adopted or placed for adoption with you (the covered employee) during the COBRA continuation coverage period is also considered a qualified beneficiary, provided that you elected COBRA continuation coverage for yourself. Under the Medical Plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described later in this notice.

COBRA Qualifying Events

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

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to (i.e., enrolled in) Medicare benefits as a retiree (under Part A, Part B, or both); or
- You become divorced from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to (i.e., enrolled in) Medicare benefits as a retiree (Part A, Part B, or both);
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "dependent child."

For this purpose, "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event. For example, any increase in the premium or contribution that must be paid by you (or your covered spouse or dependent children) for coverage under the Medical Plan that results from the occurrence of a qualifying event is a loss of coverage.

Giving Notice that a COBRA Qualifying Event (or Second Qualifying Event) Has Occurred

The Medical Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Dun & Bradstreet Benefits Center (on behalf of the Plan Administrator) has been timely notified that a qualifying event has occurred. In other words, to notify the Plan Administrator, call the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information. When the qualifying event is the employee's termination of employment (other than for gross misconduct) or reduction of work hours, or death of the employee, or the employee's becoming entitled to Medicare benefits as a retiree (under Part A, Part B, or both), the employer will notify the Plan Administrator of the qualifying event by contacting the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

Important Note: For the other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or your spouse must notify the Plan Administrator by contacting the Dun & Bradstreet Benefits Center within 60 days after the later of:

The date of qualifying event (or second qualifying event); or

The date the qualified beneficiary loses (or would lose) coverage under the Medical Plan as a result of the qualifying event (or second qualifying event). You must notify the Plan Administrator by calling the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

Failure to provide timely notice will result in ineligibility for COBRA.

How is COBRA Continuation Coverage Provided

Once the Dun & Bradstreet Benefits Center (on behalf of the Plan Administrator) receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a "COBRA Continuation Coverage Election Notice") to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

If coverage under the Medical Plan is changed for active employees, the same changes will be provided to individuals receiving COBRA continuation coverage. Qualified beneficiaries also may be able to change their

coverage elections during the annual enrollment periods, if a change in status occurs, or at other times under the Medical Plan to the same extent that similarly situated non-COBRA employees or retirees may do so.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of health coverage. When the qualifying event is the employee's termination of employment (other than for gross misconduct) or reduction of work hours, COBRA continuation coverage for the employee and the employee's covered spouse and dependent children generally lasts for only up to a total of **18 months**.

When the qualifying event is the death of the employee, the employee becoming entitled to (i.e., enrolled in) Medicare benefits as a retiree (under Part A, Part B, or both), or your divorce, COBRA continuation coverage for the employee's spouse and/or dependent children (but not the employee) lasts for up to a total of **36 months**. Also, the employee's dependent children are entitled to COBRA continuation coverage for up to **36 months** after losing eligibility as a dependent child under the terms of the Medical Plan.

There are three ways in which the 18-month period of COBRA continuation coverage due to the employee's termination of employment or reduction of work hours can be extended.

Employee's Medicare Entitlement Occurs Prior to a Qualifying Event That is Employee's Termination of Employment or Reduction of Work Hours — When the qualifying event is the employee's termination of employment (other than for gross misconduct) or reduction of work hours, and the employee became entitled to (i.e., enrolled in) Medicare benefits less than 18 months before the qualifying event (even if Medicare entitlement was not a qualifying event for the employee's spouse or dependent children because their coverage was not lost), COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the employee's Medicare entitlement. For example, if the employee becomes entitled to Medicare eight months before the date on which employment terminates, COBRA continuation coverage for the employee's covered spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Disability Extension — If either you, your spouse or any of your dependent children covered under the Medical Plan is determined by the Social Security Administration (SSA) to be disabled on the date of the employee's termination of employment or reduction of work hours, or at any time during the first 60 days of COBRA continuation coverage due to such qualifying event, each qualified beneficiary (whether or not disabled) may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of **29**

months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To qualify for this disability extension, you must notify the Plan Administrator (by calling the Dun & Bradstreet Benefits Center) of the person's disability status BOTH:

- Within 60 days after the latest of:
  - The date of the disability determination by the SSA,
  - The date on which the qualifying event occurs,
  - The date on which you lose (or would lose) coverage under the plan, or
  - The date on which you are informed of both the responsibility to provide this notice and the Medical Plan's procedures for providing such notice to the Plan Administrator, AND

Before the original 18-month COBRA continuation coverage period ends. You must provide a copy of the Social Security Disability Determination. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify the Plan Administrator by calling the Dun & Bradstreet Benefits Center within 30 days after this determination. **If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required period, you will not receive a disability extension of COBRA continuation coverage.** See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

Second Qualifying Event Extension — If the employee's spouse and/or dependents experience a second qualifying event while receiving the initial 18 months of COBRA continuation coverage, the employee's spouse and dependent children (but not the employee) can get up to 18 additional months of COBRA continuation coverage, for a maximum of **36 months**, if timely notice of the second qualifying event (by calling the Dun & Bradstreet Benefits Center) is given to the Medical Plan. See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

This extension may be available to the employee's spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to (i.e., enrolled in) Medicare benefits as a retiree (under Part A, Part B, or both), or gets divorced, or if the dependent child stops being eligible under the Medical Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Medical Plan had the first qualifying event not occurred. If a second qualifying event occurs at any time during the 29-month disability continuation period (as described above), then each qualified beneficiary who is the employee's spouse or dependent child (whether or not disabled) may further extend COBRA continuation coverage for seven more months, for a total of up to 36 months from the

employee's termination of employment or reduction of work hours. (See the section "Giving Notice that a COBRA Qualifying Event (or Second Qualifying Event) has Occurred" in this SPD for important details on the proper procedures and timeframes for giving this notice to the Plan Administrator). **If these procedures are not followed or if the notice is not provided in writing to the Dun & Bradstreet Benefits Center (on behalf of the Plan Administrator) within the required 60-day period, you will not receive an extension of COBRA continuation coverage due to a second qualifying event.**

The table below provides a summary of the COBRA provisions outlined in this section.

Qualifying Events That Result in Loss of Medical Coverage	Maximum Continuation Period		
	Employee	**Spouse**	**Child**
Employee's reduction of work hours (e.g., full-time to part-time)	18 months	18 months	18 months
Employee termination of employment for any reason (other than gross misconduct)	18 months	18 months	18 months
Employee or Employee's covered spouse or dependent child is disabled (as determined by the Social Security Administration) at the time of the qualifying event or becomes disabled within the first 60 days of COBRA continuation that begins as a result of termination or reduction in work hours, and provides proper notice	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and spouse divorce and provide proper notice	N/A	36 months	36 months
Employee becomes entitled to Medicare within 18 months prior to termination of employment or reduction in work hours (even if such Medicare entitlement was not the qualifying event for the covered spouse or dependent child because their coverage was not lost)	N/A	36 months*	36 months*
Child no longer qualifies as a dependent under the terms of the Medical Plan, and you provide proper notice	N/A	N/A	36 months

*36-month period is counted from the date the employee becomes entitled to Medicare.

Electing COBRA Continuation Coverage

You and/or your covered spouse and dependent children must choose to continue coverage within 60 days after the later of the following dates:

The date you and/or your covered spouse and dependent children would lose coverage under the Medical Plan as a result of the qualifying event; or

The date Dun & Bradstreet notifies you and/or your covered spouse and dependent children (through a "COBRA Continuation Coverage Election Notice") of your right to choose to continue coverage as a result of the qualifying event.

Other Health Coverage Options.

When making the decision of whether to elect COBRA continuation coverage, you should keep in mind that you may have other options. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Medicare or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov or by calling 1-800-318-2596.

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

Additional information is provided below.

Paying for COBRA Continuation Coverage

Cost: Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. With regards to the 11-month disability extension of COBRA continuation coverage, the cost of coverage for the 19th through 29th months of coverage is:

150% of the cost of group health plan coverage for all family members participating in the same coverage option as the disabled individual, and

102% for any family members participating in a different coverage option than the disabled individual, except as provided in the next sentence. If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the qualified beneficiary is disabled. However, if a second qualifying event

occurs during the otherwise applicable disability extension period (that is, during the 19th through 29th month), then the cost of coverage for the 19th through 36th months of coverage is

- The 150% rate for all family members participating in the same coverage option as the disabled qualified beneficiary, and
- The 102% rate for any family members in a different coverage option than the disabled qualified beneficiary.

Special COBRA rights may apply if you lose coverage because of termination of employment or a reduction in hours of employment and you qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 2002. Generally, in this situation, you may be entitled to a second opportunity to elect COBRA continuation coverage for yourself and certain family members (if you did not already elect COBRA continuation coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after your initial loss of coverage. In addition, eligible individuals can take a tax credit equal to 72.5% of the premiums paid for qualified health insurance, including COBRA coverage. Eligible individuals who elect to claim this tax credit will not be eligible for a premium subsidy through the Marketplace.

If you qualify or may qualify for assistance under the Trade Act, please contact the Plan Administrator for additional information. You must contact the Benefits Center promptly after qualifying for assistance under the Trade Act or you will lose these special COBRA rights. More information can be found by visiting www.doleta.gov/tradeact/ or www.irs.gov/HCTC.

Premium Due Dates: If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all premiums due but not paid) not later than 45 days after the date of your election. (This is the date the COBRA Election Notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Medical Plan. **Payment is considered made on the date it is sent to the Dun & Bradstreet Benefits Center (on behalf of the Medical Plan).**

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The premium due date and exact amount due for each coverage period for each qualified beneficiary will be shown in COBRA Election Notice you receive. Although periodic payments are due on the dates shown in the COBRA Election Notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will

be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you elect COBRA continuation coverage, but then fail to make an initial or periodic payment before the end of the 45 or 30 day grace period, respectively, for that coverage period, you will lose all rights to COBRA continuation coverage under the Medical Plan, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any person will end when the first of the following occurs:

The applicable 18, 29 or 36-month COBRA continuation coverage period ends;

Any required premium is not paid on time;

After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as an employee or otherwise) under another group health plan (not offered by Dun & Bradstreet);

After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes entitled to (i.e., enrolled in) Medicare benefits (under Part A, Part B, or both). This does not apply to other qualified beneficiaries who are not entitled to Medicare.

In the case of extended COBRA continuation coverage due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA continuation coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months;

For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation coverage, the date your COBRA continuation coverage period ends unless a second or qualifying event has occurred; or

Dun & Bradstreet ceases to provide any group health plan for its employees (and retirees).

COBRA continuation coverage may also be terminated for any reason the Medical Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

Health Insurance Marketplace

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

Time Limits on Enrolling in Marketplace Coverage: You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end, and you may not be able to enroll until annual enrollment, so you should take action right away if you think that you may want Marketplace coverage. In addition, you may also enroll in Marketplace coverage annually during what is called an "open enrollment" period. The open enrollment period is the time during which anyone can purchase coverage through the Marketplace.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

Enrolling in COBRA Coverage May Temporarily Limit Your Options: If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." If, however, you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if you enroll outside of the Marketplace open enrollment.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage once your election period ends.

Enrolling in Another Group Health Plan

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

Enrolling in Medicare instead of COBRA Continuation Coverage

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of (1) the month after your employment ends; or (2) the month after group health plan coverage based on current employment ends. (The rules are different for people with End Stage Renal Disease.)

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Factors to Consider when Choosing Coverage Options

When considering your options for health coverage, you may want to think about:

Premiums: You can be charged up to 102% of total plan premiums for COBRA coverage (more if you qualify for an extension of coverage on account of a disability). Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.

Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If You Have Questions

Questions concerning your Medical Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your rights, as well as the rights of your spouse and dependent children, you should keep the Dun & Bradstreet Benefits Center informed of any changes in the addresses of your spouse and/or dependent children. You should also keep a copy, for your records, of any notices you send to the Dun & Bradstreet Benefits Center.

See the section "How to Reach Your Medical Plan Service Provider" at the beginning of this SPD for contact information.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees with regards to military service. If you go on a qualifying military leave of absence, you are generally entitled to participate in any rights under benefits not based on seniority that are available to employees on comparable non-military leaves. Upon reinstatement to active employment with your employer, you are generally entitled to the seniority, and all seniority-based rights and benefits associated with the position that you held at the time your employment was interrupted, plus the additional seniority; and seniority-based rights and benefits that you would have attained with reasonable certainty if your employment had not been interrupted.

If you take a qualifying military leave of absence, you may continue your medical coverage by paying the same amount charged to active employees for the same coverage.

The maximum period of continuation coverage available to you and your eligible dependents is the lesser of the 24-month period beginning on the date your leave begins, or the length of the period of your military service (plus the time allowed to apply for reemployment). Your coverage will end sooner than that if you fail to pay the required premium when it is due.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If you choose not to continue your medical coverage while on military leave, you are generally entitled to reinstate your health coverage with no waiting periods or exclusions (however, an exception applies to service-related injuries or illnesses) when you return to active employment with your employer.

To be eligible for the reemployment rights guaranteed by USERRA, you must meet certain requirements. One of these requirements is that you generally must return to active employment with your employer (or reapply for employment with your employer, as applicable) within the following time frames:

Return to work no later than the beginning of the first full, regularly scheduled work day following military service, including an 8-hour rest period after you return home from your military service, if you are on a military leave of less than 31 days,

Return to or reapply for employment within 14 days of completion of such period of duty, if your period of military service is more than 30 days and less than 180 days, or

Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

See your Human Resources representative for more information on applicable military leaves of absence.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave (26 weeks in the case of a military caregiver leave) for certain family and medical situations and continue their elected medical coverage benefits during this time.

If you are eligible, you can take up to 12 weeks of unpaid leave (26 weeks in the case of a military caregiver leave) in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care,
- For the care of a spouse, child, or parent who has a serious health condition,
- For your own serious health condition,
- For a qualifying exigency relating to the active duty, or call to active duty, of a family member who is a member of the US Armed Forces or of the reserves and who is deployed to a foreign country, or
- To care for a family member who is a member of the US Armed Forces or a veteran and who is being treated for or recovering from a serious injury or illness incurred or aggravated by service in the course of active duty (known as a "military caregiver leave").

Depending on the state you live in, the number of weeks of leave available to you for family and medical reasons may vary based on state law requirements.

Your participation in the Medical Plan will continue while you are on an approved FMLA leave (paid or unpaid) as long as you pay the required premium for coverage in a timely manner. If your leave is unpaid, you will be billed for the cost of coverage under the Medical Plan. If you do not pay the required premium in a timely manner, your coverage will terminate.

If you are on an unpaid FMLA leave of absence, you also have the right to terminate your coverage during your leave of absence and reinstate your coverage if you return to work at the end of the FMLA leave. If you do not return to work at the end of the FMLA leave and your leave of absence is not extended, your coverage under the Medical Plan will terminate unless you qualify for extended coverage. See the section "When Your Employment Ends" earlier in this SPD for more information. If your coverage terminates, you may be able to continue coverage for yourself and your dependents by electing and paying for COBRA coverage (unless your employment was terminated for gross misconduct). See the section "COBRA Continuation" in this SPD for more information.

Continuation of Coverage While on an Employer-Approved Leave of Absence

If you take an approved leave of absence (whether paid or unpaid), your coverage under the Medical Plan will continue at active rates during your approved leave of absence subject to timely payment of the required premium, with the exception of an FMLA or USERRA leave where you may choose to decline your benefit continuation.

If your leave of absence is paid, the cost of your coverage will be deducted from your pay. If your leave of absence is unpaid, you will be responsible for submitting payments for the required premium on a timely basis to continue coverage, otherwise your coverage will be terminated. The Dun & Bradstreet Benefits Center at Fidelity will bill you on a monthly basis for the cost of coverage starting the first of the month following the start of your approved unpaid leave. Payroll deductions will resume the first of the month following your return from the approved unpaid leave.

Your coverage may terminate before the end of your approved leave of absence if any of the other termination events described in the section "When Coverage Ends" occur, including your failure to pay the required contributions for coverage on a timely basis.

INTERNAL CLAIMS AND APPEALS PROCESS

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. All claims must be submitted in writing except for urgent care claims which may be initiated by phone. Any reference to "you" in this Claims, Appeals and External Review section includes you and your Authorized Representative. Additional information regarding appointment of an Authorized Representative is provided below.

If your claim is denied in whole or in part, you will receive a written notice of the denial from the Claims Administrator. The notice will explain the reason for the denial and the appeal procedures available under the Plan.

The Claims Administrator is responsible for determining all claims for medical and prescription drug benefits. The Plan Administrator will determine all eligibility claims and other similar non-benefit claims. The Plan Administrator will respond to all such claims within the time frames and in the manner that claims for benefits are decided (except that there will be only one level of appeal and the time periods for responding will be adjusted accordingly), but you must submit the claim to the Plan Administrator, not to the Claims Administrator. All appeals of such claims must also be filed with the Plan Administrator within 180 days of the denial. The Plan Administrator will respond to all such appeals within the time frames and in the manner described below.

Authorized Representative

You may appoint an authorized representative to act on your behalf for purposes of the Plan.

If you need to appoint an authorized representative for purposes of an internal claim or appeal for health and welfare benefits or for purposes of an external appeal for medical benefit claims, you must follow the rules and procedures of the Claims Administrator for such claim or appeal. If your claim is decided by the Plan Administrator, you must follow the rules and procedures of the Plan Administrator. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

To the extent the Claims Administrator has no rules or procedures or the claim is decided by the Plan Administrator, your appointment of an authorized representative must:

Be in writing and dated;

Clearly indicate the authorized representative, the scope of the appointment and any limitations on the authorized representative;

Be signed by you and notarized by a notary public;

Satisfy any other legal requirement applicable to appointments under state or federal law; and

Be approved by the Plan Administrator (or its delegate) in writing.

The Plan will also recognize a court order appointing a person as your authorized representative. The Plan Administrator may also provide different rules and procedures for an appointment of an authorized representative in emergency situations or for attorneys.

Appointing an individual or entity as your authorized representative is not an assignment of rights or benefits under the Plan and any such appointment (whether pursuant to the rules of a Claims Administrator or the Plan Administrator) does not waive the Plan's anti-assignment provisions.

Time Frame for Initial Claim Determination

Pre-Service Claims

For pre-service claims (claims that require approval of the benefit before receiving medical care) the Claims Administrator will notify you of its benefit determination (whether adverse or not) within 15 days after receipt of a pre-service claim.

Post-Service Claims

For post-service claims (claims that are submitted for payment after you receive medical care), the Claims Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For **pre- and post-service claims**, the benefit determination period may be extended by 15 days, provided that the Claims Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Claims Administrator must notify you before the end of the first 15- or 30-day period of the reasons(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must *also* specifically describe the required information. You

then have 45 days from the receipt of the notice to provide the information needed to process your claim. You will be notified of the Claim Administrator's decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

If an extension is necessary for **pre- and post-service claims** due to your failure to submit necessary information, the Medical Plan's time frame for making a benefit determination is stopped from the date the Claims Administrator sends you an extension notification until the date you respond to the request for additional information. If the Claims Administrator does not receive the requested information from you within 45 days of the date the Claims Administrator sends you the request, your claim will be considered without such additional information and the resulting claim determination by the Claims Administrator will be final.

In addition, if you or your authorized representative fails to follow the Medical Plan's procedures for filing a **pre-service claim**, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving **urgent care**) following the failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that:

Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters.

Is a communication that names you, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

Urgent Care Claims

Urgent Care Claims

An "Urgent care claim" is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations that:

- Could seriously jeopardize the patient's life, health or ability to regain maximum function
- In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

For urgent care claims, the Claims Administrator will notify you of its benefit determination (whether adverse or not) as soon as possible, taking into account the severity of the medical condition, but not later

than 72 hours after receipt of a claim initiated for urgent care. The decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification.

If you fail to provide the Claims Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Medical Plan, the Claims Administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of the:

Claims Administrator's receipt of the requested information.

End of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

If your request is denied, the course of treatment shall continue while your internal appeal is pending. Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a plan amendment or plan termination.

If You Receive an Adverse Benefit Determination

The Claims Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

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

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

References to the specific Medical Plan provisions on which the benefit determination is based, including plan limitations or exclusions.

A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary.

A description of the Medical Plan's internal appeal procedures (including an explanation of how to initiate an appeal) and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination.

Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.

If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Medical Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the adverse benefit determination concerns a claim involving **urgent care**, a description of the expedited review process applicable to the claim.

A description of available external review processes, including information regarding how to initiate any appeal.

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

Procedures for Appealing an Adverse Benefit Determination

You may file an appeal in writing with the Claims Administrator at the address provided in this booklet, or, if your appeal is of urgent nature, you may call the Claim Administrator's. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

A representative from the Claims Administrator may call your or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

Submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:

- Was relied upon in making the benefit determination.
- Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination.
- Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.

— Constitutes a statement of policy or guidance with respect to the Medical Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.

A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.

A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate.

A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental).

The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

Receive, free of charge and in advance of a final internal appeal determination, any new or additional evidence or rationale relied upon or considered in making the determination and be given an opportunity to respond prior to the Claims Administrator making the internal appeal determination.

If your claim involves urgent care, you may submit a request (orally or in writing) to file an expedited appeal by telephone, you should call the phone number included in your denial.

— All necessary information, including the Medical Plan's benefit determination on review, will be transmitted between the Medical Plan and you by telephone, facsimile or other available similarly prompt method.

Ordinarily, a decision regarding your appeal will be reached within:

Thirty-six hours after receipt of your request for review of an **urgent care claim.**

Fifteen days after receipt of your request for review of a **pre-service claim.**

Thirty days after receipt of your request for review of a **post-service claim**.

The Claims Administrator's notice of an adverse benefit determination on appeal will contain all of the following information:

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

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

References to the specific Medical Plan provisions on which the benefit determination is based.

A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

A statement describing any voluntary appeal procedures offered by the Medical Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.

A description of available external review processes, including information regarding how to initiate any appeal.

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

Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination or a statement that a copy of this information will be provided free of charge to you upon request.

If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Medical Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

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

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with the Claims Administrator within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. If your second-level appeal is denied, the notice will include the same information as the notice denying your first-level appeal.

Foreign Language Assistance

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

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

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

Exhaustion of Administrative Remedies and Limitations on Actions

If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable. You must use and fully exhaust all of your actual or potential rights under this Medical Plan's administrative claims and appeals procedures by filing an initial claim and then seeking a timely appeal of any denial before bringing suit. This relates to claims for benefits, eligibility and to any other issue, matter or dispute (including any plan interpretation or amendment issue). Any such suit or other legal action must be filed within the earliest of the following - (1) two years after receiving an adverse benefit determination on review or (2) two years of the date the claim arose. If the

Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying reimbursement request or benefit request is the final decision date. If the suit or other legal action does not relate to a claim for benefits, it must be brought within two years of the date you have actual or constructive knowledge of the claim. In addition, any such suit must only be brought or filed in a federal court in the Middle District of Florida. Failure to follow this Medical Plan's administrative claims and appeals procedures in a timely manner will cause you to lose your right to sue regarding an adverse benefit determination. This means that any claim, action or suit filed in court or in another tribunal will generally be dismissed.

In any action or consideration of a claim in court or in another tribunal following exhaustion of the Plan's claims procedures, the subsequent action or consideration shall be limited to the maximum extent permissible to the record that was before the Plan Administrator or Claims Administrator in the claims procedure process. Upon review by any court or other tribunal, the exhaustion requirement is intended to be interpreted to require exhaustion in as many circumstances as possible.

Discretionary Authority

The Plan Administrator and the Claim Administrator (with respect to any matters delegated to the Claims Administrator) have the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and their decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect. Benefits under the Plan will be paid only if the Plan Administrator or the Claims Administrator, as applicable, decides in its discretion that a participant is entitled to them.

YOUR RIGHT TO AN EXTERNAL REVIEW

Federal law gives you the right, in certain circumstances, to have an adverse benefit determination reviewed by an external independent review organization after you exhaust your rights under the internal claims and appeals procedure. The following is a general description of the external review process. However, you should review your notice of adverse benefit determination carefully. The notice may contain updated information in the event the external appeals process changes. These new requirements apply to any claim (or, to the extent required by law, any appeal) which is properly filed on or after January 1, 2012.

Types of Eligible Determinations

The external review process under this Plan gives you the opportunity to receive review of a final internal adverse benefit determination (and in limited cases, an adverse benefit determination conducted pursuant to applicable law. Your request will be eligible for External Review only if it qualifies as one of the following:

Medical Judgment Claims and Appeals: External review procedures apply to adverse benefit determinations that involve medical judgments (including those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a benefit or experimental or investigational determinations).

Rescissions of Coverage: External review procedures apply to rescissions of coverage and whether a rescission has any effect on a particular benefit at the time of a rescission.

Surprise Medical Bills: External review procedures apply to adverse benefit determinations that involve consideration of whether the Medical Plan has complied with the surprise billing protections and cost-sharing protections under the No Surprises Act and its implementing regulations.

External review procedures do not apply to any other adverse determination, including eligibility appeals.

External Review Request

You must submit the Request for External Review Form to the Claims Administrator within 123 calendar days of the date you received the notice regarding your final internal adverse benefit determination (or adverse benefit determination, if applicable). If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal

holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file for a voluntary external review, any applicable statute of limitations will be tolled while the external review is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However external review is voluntary, and you are not required to undertake it before pursuing legal action.

If you choose not to file for external review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Within 5 business days following the date the external review request is received, the Claims Administrator will complete a preliminary review to determine whether you meet the requirements for an external review. To be eligible, you must meet the following requirements:

You are or were covered under the Medical Benefit Plan at the time the item or service was requested or, in the case of a retrospective review, were covered under the Medical Plan at the time the health care item or service was provided;

The denied appeal does not relate to your failure to meet the requirements for eligibility under the terms of the Medical Plan;

You have exhausted the internal appeal process; and

You have provided all the information and forms required to process an external review.

If the Claims Administrator does not adhere to the federal requirements for handling internal claims and appeals, you are deemed to have exhausted the internal claims and appeal process unless such failure was (1) de minimis; (2) nonprejudicial; (3) attributable to good cause or matters beyond the Plan's control; (4) in the context of an ongoing good faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance. Upon written request, you are entitled to an explanation of the Plan's basis for asserting that it meets this standard.

Within 1 business day after completing the preliminary review, the Claims Administrator will send you a written notice regarding your request. If the request is complete but not eligible for external review, the notice will include the reasons for its ineligibility and contact information. If the request is not complete,

the notice will describe the information or materials needed to make the request complete and you will have the later of the remaining time within the 4-month filing period or 48 hours following receipt of the notification to perfect your external review request.

Procedures After your Request is Approved

If your external review request is eligible, the Claims Administrator will assign it to an Independent Review Organization (IRO) as required under federal law to conduct the external review. The assigned IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the assigned IRO within 10 business days following the date the notice is received additional information that the IRO must consider when conducting the external review. Any additional information received by the IRO from you will be shared with the Claims Administrator and the Plan. Upon receipt of this information by the Claims Administrator and the Plan, the Claims Administrator may reconsider its prior appeal decision and may reverse the prior denial of the internal appeal. If the Claims Administrator reverses its decision and fully approves the internal appeal, then your claim will be paid accordingly, and the external review will be terminated.

If the external review is not terminated as noted above, the IRO will review all information and documents related to your denied internal appeal. The IRO is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision to the extent required under applicable law:

Your medical records;

The attending health care professional's recommendation;

Reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treating provider;

The terms of your Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

Any applicable clinical review criteria developed and used by the Claims Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

The assigned IRO must provide written notice of the Final External Review Decision within 45 days after the IRO receives the request for External Review. After a Final External Review Decision, the IRO must maintain records of all claims and notices associated with the External Review process for six years. An IRO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.

The IRO will deliver a notice of the final external review decision to you and the Claims Administrator. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review Requests

You may also make an expedited external review request to the Claims Administrator at the time you receive (1) a denied urgent care internal claim if you have also filed at the same time an internal appeal; (2) a denied urgent care internal appeal; or (3) a denied internal appeal, which concerns an admission, availability of care, conducted stay or medical care item or service for which you have received emergency services and have not been discharged from the facility. Upon receipt of such a request, the Claims Administrator will determine whether you are eligible for an expedited external review. If you are eligible, the Claims Administrator will notify you immediately. The IRO will follow the procedures discussed above with respect to standard external reviews, provided that certain procedures will be provided on an expedited basis as follows:

The Claims Administrator must provide all documentation with respect to the denied internal claim or appeal immediately to the IRO; and

Upon a determination that a request is eligible for External Review following preliminary review, the Claims Administrator will assign an IRO. The IRO will provide notice of the external review decision, as expeditiously as the circumstances require, but in no event more than 72 hours after the IRO receives the request for the expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you, the Claims Administrator and the Plan.

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, 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.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other 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 plan benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report 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 a suit in a state or federal court but only after you have exhausted the plan's claims and appeals procedure as described in the section "Internal Claims and Appeals Process." In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

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

HIPAA PRIVACY RIGHTS AND PROTECTED HEALTH INFORMATION

The Dun & Bradstreet Corporation has certain legal obligations regarding the privacy of your personal health care information according to the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Dun & Bradstreet or any Dun & Bradstreet company that participates in the Medical Plan may only use and disclose protected health information it receives in ways that are permitted by, required by and consistent with the HIPAA privacy regulations. This includes, but is not limited to, the right to use and disclose participant's protected health information in connection with payment, treatment and health care operations.

NO GUARANTEE OF EMPLOYMENT

Your participation in, eligibility for or your right to benefits under the Medical Plan described in this booklet is no guarantee of continued employment with Dun & Bradstreet or any Dun & Bradstreet company that participates in the Medical Plan.

In accordance with ERISA, this booklet provides a summary plan description of the Medical Plan, a part of The Dun & Bradstreet Corporation Welfare Benefit Plan. The information in this booklet does not constitute a commitment to continued employment.

Dun & Bradstreet reserves the right to change, modify or terminate any of the plans at any time.

GLOSSARY OF OTHER IMPORTANT TERMS

Ambulance — A vehicle that is staffed by medical personnel and equipped to transport an ill or injured person by ground, air or water.

Autism Spectrum Disorder — A condition which is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Applied Behavioral Analysis — An educational service that is the process of applying interventions that (1) systematically change behavior, and (2) are responsible for the observable improvement in behavior.

Behavioral Health Provider/Practitioner — A licensed organization or professional providing diagnostic, therapeutic or psychological services for Mental Disorders and Substance Abuse.

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

Cosmetic — Services or supplies that alter, improve or enhance appearance.

Coinsurance — The percentage of covered hospital, medical, prescription drug and surgical expenses, as determined by the Claims Administrator, that you are responsible for paying after you satisfy the applicable deductible.

Common Accident Deductible — If two or more covered persons in the same family are injured in the same accident, only one annual deductible will be applied for the covered services and supplies needed as a result of the accident.

Copayment — The flat dollar amount you must pay for certain covered services. This SPD describes which covered services are subject to a copayment. With respect to the PPO Select plan, the in-network provider will usually collect the copayment from you at the time the covered service is provided.

Custodial Care — Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;

- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

Deductible — The annual amount you must pay for covered medical services before the Medical Plan pays anything. Each of the medical options has two deductibles:

Individual deductible — The annual amount you and/or your covered dependent(s) will pay before the plan pays coinsurance for covered medical expenses.
Family deductible — Under the PPO Select plan, once two family members have satisfied their individual deductibles in the same year, the family deductible has been met. Family members will not have to pay more medical deductibles for the rest of the year. An individual family member cannot exceed the individual deductible. For the CDHP plan, the deductible can be satisfied by any combination of family members, including one individual family member.

Durable medical equipment (DME) -- Equipment and the accessories needed to operate it, that is:
- Made to withstand prolonged use;
- Mainly used in the treatment of an illness or injury;
- Suited for use in the home;
- Not normally used by people who do not have an illness or injury; and
- Not for altering air quality or temperature

Emergency Medical Condition — A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:
- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Services – Treatment given in certain emergency facilities, including a hospital's emergency room or in an independent freestanding emergency department, for an Emergency Medical Condition. This includes evaluation of, and treatment to stabilize, an Emergency Medical Condition.

Experimental or Investigational – A drug, device, procedure, supply, treatment, test, or technology is considered by us to be experimental, investigational, or unproven if any of the following apply:

- It hasn't been shown through well-conducted clinical trials or cohort studies published in peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which it's meant.
  - A well-conducted clinical trial means a randomized, controlled trial where the experimental intervention is compared to a control group receiving care according to best practice and study participants are randomly assigned to the experimental or control group.
  - A well-conducted cohort study means a prospective cohort study from more than one institution where the experimental intervention is compared to a group of subjects receiving care according to best practice and where the comparison group is well matched to the experimental intervention group.
- There isn't FDA approval or clearance to market it for the proposed use.
- A national medical society, dental society, or regulatory agency has written that it's experimental, investigational, or unproven, or mainly for research purposes.
- It's the subject of a Phase I, Phase II, or the experimental or research arm of a Phase III clinical trial. The FDA and Department of Health and Human Services define these.
- Written procedures or consent form used by a facility provider says it's experimental, investigational, or unproven.

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

Formulary — A list of FDA-approved generic and brand-name prescription drugs that are covered by the health plan. Each plan may have its own formulary.

Lifetime Maximum — The most the plan will pay for medical expenses over each Covered Person's lifetime.

Mental Disorder — An illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, a psychologist or a psychiatric social worker. Mental Disorder does not include Substance Abuse disorders.

Morbid Obesity — This means a Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

Non-Occupational Illness — A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury — A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

Out-of-pocket maximum — The most you and your eligible dependents will pay for deductibles and coinsurance each year. This includes deductibles, coinsurance, copays and prescription drug expenses. However, the out-of-pocket maximum does not limit your payments for non-covered expenses, including amounts in excess of reasonable and customary charges, deductibles or coinsurance.

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

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP **provider** for whom we access NAP rates. Claims for services received from a NAP **provider** and paid at the NAP contracted rate are not subject to the federal surprise bill law. Through NAP, the Recognized Charge is determined as follows:

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

- If your service was not received from a NAP **provider**, a claim specific rate or discount may be negotiated by Aetna or a third-party vendor.

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

- Professional services: An amount determined by Aetna, or its third-party vendors, based on data resources selected by Aetna, reflecting typical costs, competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.

- Inpatient and outpatient charges of hospitals: An amount determined by Aetna (such as FCR), or its third-party vendors, based on data resources selected by Aetna, reflecting typical costs, competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.

- Inpatient and outpatient charges of facilities other than hospitals: Facility Charge Review.

Important Note: If the provider bills less than the amount calculated using the method above, the Recognized Charge is what the provider bills.

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

If NAP does not apply to you, the Recognized Charge for specific services or supplies will be the out-of-network plan rate set forth above. The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following: (1) performed at a network facility by certain out-of-network providers, (2) not available from an in-network provider, (3) Emergency Services and (4) air ambulance services from an out-of-network provider.
Your cost share for involuntary services will be calculated in the same way that it would be if you received the services from a network provider. If you receive a surprise bill, your cost share will be calculated at the median contracted rate, as determined in accordance with applicable law.

Important Note: In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from a network provider. The cost share will be based on the median contracted rate. Contact Aetna immediately if you receive such a bill.

As used above, Facility Charge Review Rate and Geographic Area are defined as follows:

Facility Charge Review (FCR) Rate: The amount determined by Aetna to be enough to cover the facility provider's estimated costs for the service (as determined by Aetna) and leave the facility provider with a reasonable profit. For hospitals and other facilities which report costs (or cost-to-charge ratios) to Centers for Medicare and Medicaid Services (CMS), the FCR rate is based on what the facilities report to CMS. For facilities which do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. The formula may be adjusted as needed to maintain the reasonableness of the Recognized Charge.

Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If Aetna determines it needs more data for a particular service or supply, Aetna may base rates on a wider geographic area, such as an entire state.

Important Note

The Recognized Charge is based on the version of the schedule or rates that is in use by Aetna on the date that the service or supply was provided.

Aetna may also reduce the Recognized Charge by applying Aetna Reimbursement Policies. Aetna Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

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

Aetna Reimbursement Policies may consider (1) the Centers for Medicare and Medicaid Services' National Correct Coding Initiative and other external materials regarding what billing and coding practices are and are not appropriate; (2) the generally accepted standards of medical and dental practice; and (3) the views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies. These policies may be different for professional services and facility services.

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

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

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

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

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

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

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

Substance Abuse — This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent, and is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a Mental Disorder that are a focus of attention or treatment, or an addiction to nicotine products, food or caffeine intoxication.

Urgent Care Provider — defined as the following:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.
  - Is run by a staff of physicians. At least one physician must be on call at all times.
  - Has a full-time administrator who is a licensed physician.

- A physician's office, but only one that:
  - Has contracted with Aetna to provide urgent care; and
  - Is, with Aetna's consent, included in the directory as a network urgent care provider.
- It is not the emergency room or outpatient department of a hospital.

Urgent Condition — a sudden illness; injury; or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

Walk-In Clinic — network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.

Who provides the care

Network providers: We have contracted with providers to provide covered services to you. These providers make up the network for your plan.

To get network benefits, you must use network providers. There are some exceptions:

Emergency services – see the description of emergency services in the Coverage and exclusions section.

Transplants – see the description of transplant services in the Coverage and exclusions section.

You may select a network provider from the online directory through your member website.

You will not have to submit claims for services received from network providers. Your network provider will take care of that for you. And we will pay the network provider directly for what the plan owes.

Your PCP

We encourage you to get covered services through a PCP. They will provide you with primary care.

How you choose your PCP

You can choose a PCP from the list of PCPs in our directory. Each covered family member is encouraged to select a PCP. You may each choose a different PCP. You should select a PCP for your covered dependent if they are a minor or cannot choose a PCP on their own.

What your PCP will do for you

Your PCP will coordinate your medical care or may provide treatment. They may send you to other network providers.

Changing your PCP

You may change your PCP at any time by contacting us.

Out-of-network providers

You can also get care from out-of-network providers. When you use an out-of-network provider, your cost share is higher. You are responsible for:

- Your out-of-network deductible
- Your out-of-network coinsurance
- Any charges over the recognized charge
- Submitting your own claims and getting precertification

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

You may have to find a new provider when:

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

But, in some cases, you may be able to keep going to your current provider to complete treatment or to have treatment that was already scheduled. This is called continuity of care.

If this situation applies to you, contact us for details. If you are undergoing treatment for an acute or chronic condition and the provider didn't leave the network based on fraud or lack of quality standards, you'll be able to receive transitional care from your provider for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

Important note:

If you are pregnant and have entered your second trimester, transitional care will be through the time required for postpartum care directly related to the delivery.

You will not be responsible for an amount that exceeds the share cost that would have applied had your **provider** remained in the network.

Treatment Outcomes of Covered Services

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of Aetna or its affiliates.