Specialized Bicycle Components Health and Welfare Plan

Summary Plan Description

On-Demand Health Insurance

Effective Date: January 1, 2020

bind
on-demand
health insurance

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1. Quick Reference

This section is a quick reference guide. Please review this entire Summary Plan Description (SPD) for additional details.

Website Easy access to what is covered, how much it costs and where you can get care.	**Once enrolled:** MyBind.com **When enrolling:** choosebind.com/specialized **Access Codes:** • Active: Specialized2020 • Active UT: SpecializedUT2020
Phone Numbers Who to contact to help answer any questions	**Core, Add-In, and Retail Pharmacy Questions:** **Bind Help Team** (833) 576-6494 **Monday – Friday** 6:00 am to 9:00 pm CST **Mail Order Pharmacy Questions:** Kroger Mail Order Pharmacy (800) 552-6694 **Monday - Friday** 8:00 a.m. to 8:00 pm CST **Saturday** 11:00 am to 4:00pm CST **Specialty Pharmacy Questions:** Lumicera (855) 847-3553
Mailing Address Where to mail Claims, appeal requests and any written inquiries.	Bind Benefits, Inc. P.O. Box 211758 Eagan, MN 55121
Plan Administrator Who is ultimately responsible for the Bind Medical Plan.	Specialized Bicycle Components, Inc.
Claims Administrator Who processes Claims, administers appeals, and runs the Bind Help team and website.	Bind Benefits, Inc.

The information in this On-demand Health Insurance Benefits Booklet, together with the Specialized Bicycle Components Health and Welfare Plan Wrap Summary Plan Description, serve as the Plan and Summary Plan Description (SPD). With respect to benefit levels and coverage under the Plan, this On-demand Health Insurance Benefits Booklet governs.

2. How Does On-Demand Health Insurance Work?

Bind's on-demand health insurance Plan design allows each enrolled Covered Person to select from a broad menu of coverage options uniquely suited to their needs. The Bind Plan has features that you know and understand – comprehensive coverage, a zero deductible, copays for Covered Services and an annual out-of-pocket maximum. The on-demand feature allows you to add additional coverage if and when needed.

Here is how it works:

When a Covered Person enrolls in Bind, they automatically receive Core coverage. Core coverage provides substantial coverage of Physician and hospital services – including for example preventive care, Emergency and urgent care, office visits, inpatient and outpatient hospital visits and prescription drugs. Core coverage also provides substantial coverage for common conditions and events, such as maternity care, cancer treatment and physical therapy. Core coverage does not provide coverage for certain excluded diagnostic and medical procedures specified below. However, coverage for many of the excluded procedures is available by signing up for "Add-In" (short for "Additional Insurance") coverage.

Add-Ins are separate coverage options for 45 less common procedures including, for example, endoscopies, hernia repairs, hysterectomies, lumbar spine fusion and knee and shoulder arthroscopies. Covered Persons can sign up for Add-In coverage at the time of enrollment (initial enrollment, Open Enrollment, or special enrollment) or at any time during the Plan Year if the Covered Person experiences an Adverse Health Factor. You must purchase Add-In coverage at least three business days prior to the date of when services will be rendered. Each Add-In has a separate copay, which is applied to your annual out-of-pocket maximum. When you sign up for an Add-In, you will also be required to pay an additional premium which will be spread over a number of pay periods.

To summarize, Bind's on-demand health insurance includes both Core coverage, and to the extent a Covered Person pre-purchases one or more Add-Ins, Add-In coverage in any combination selected by the Covered Person. Each combination of Core coverage and Add-In coverage is a "benefit package" under the Plan. This allows you to tailor coverage to your needs.

Covered Person and Plan Sponsor share in the cost of the Plan. Your contribution amount depends on the benefit package you select and the dependents you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld, and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you. Your contributions are subject to review and Plan reserves the right to change your contribution amount from time to time. You can obtain current contribution rates by contacting the Plan Administrator.

3. Am I Eligible and How Do I Enroll?

Core

You are eligible to enroll for Core coverage if you are:

- An eligible employee who is scheduled to work at least 30 hours per week.
- An eligible dependent of the employee. An eligible dependent is:
  - A legal spouse or domestic partner under a legally registered and valid domestic partnership. In the event the domestic partnership is terminated, either partner is required to inform Specialized Bicycle Components, Inc. of the termination of the partnership.
  - You or your spouse/domestic partner's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your spouse are the legal guardian.
  - Your child age 26 or over who is disabled and dependent upon you.
  - A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

An employee must enroll in Core coverage in order to enroll his/her dependents. If both parents are covered as employees, a child may be covered as a dependent of either parent, but not both. Employees and eligible dependents who enroll in coverage may be referred to in this SPD as a Covered Person.

To enroll in Core coverage, call the Plan Administrator within 31 days of the date you first become eligible for Core coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your election. Any changes you make during Open Enrollment will become effective the following Plan Effective Date.

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Plan Administrator within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your election.

Add-Ins

Once you enroll in Core, then you and any eligible dependents are also eligible to sign up for Add-Ins. Add-In coverage is temporary coverage (120 days from enrollment) available for 45 select, plannable procedures that you can add if and when you or a dependent need one of those procedures. An additional copay and a set number of ongoing, pre-tax paycheck deductions will apply for Add-In coverage. For more information about how Add-Ins work, please see Section 5.3.

You may sign up for Add-Ins during initial enrollment or Open Enrollment without regard to an Adverse Health Factor. You may sign up for Add-Ins during the Plan Year only if you or an eligible dependent has an Adverse Health Factor.

Eligible employees should visit MyBind.com or call Bind Help to enroll themselves and any eligible dependents in an Add-In.

Special Enrollment Period for Medicaid and Children's Health Insurance Program (CHIP) Participants

If an eligible employee and/or his/her eligible dependents are covered under a state Medicaid Plan or a state CHIP (if applicable) and that coverage is terminated as a result of loss of eligibility, then such employee may request enrollment in the Plan on behalf of him/herself and/or eligible dependents. Such request shall be submitted to the Plan not later than 60 calendar days after the eligible employee's and/or his/her dependent's coverage ends under such state plans.

If an eligible employee and/or his/her eligible dependents become eligible for coverage under a state Medicaid Plan or a state CHIP (if applicable), and the employer has not opted out of the premium assistance subsidy offered by the state, then such employee may request enrollment in the Plan on behalf of him/herself and/or such eligible dependents. The eligible employee shall request such enrollment in the Plan no later than 60 calendar days after the date the employee and/or his/her eligible dependents are determined to be eligible for coverage under such state plans.

Coverage will be effective on the first day of the first calendar month beginning after the date the Plan receives the request for special enrollment due to eligibility for Medicaid or CHIP payment assistance provided the Plan receives the application for coverage as required.

Unless otherwise noted above, if you wish to change your elections, you must contact Plan Administrator within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Changes to Coverage

You may make coverage changes, other than Add-Ins, during the Plan Year if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g.,

you cover your spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- Your marriage, divorce, legal separation, or annulment.
- The birth, legal adoption, placement for adoption or legal guardianship of a child.
- A change in your spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA Benefits, provided you were paying for premiums on a timely basis.
- Your death or the death of a dependent.
- Your dependent child no longer qualifying as an eligible dependent.
- A change in your or your spouse's position or work schedule that impacts eligibility for Specialized Bicycle Components, Inc. health coverage.
- Contributions were no longer paid by Specialized Bicycle Components, Inc. (this is true even if you or your eligible dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by Specialized Bicycle Components, Inc.)
- You or your eligible dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible dependent.
- Benefits are no longer offered by the plan to a class of individuals that include you or your eligible dependent.
- Termination of your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact human resources within 60 days of termination).
- You or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact human resources within 60 days of the date of determination of subsidy eligibility).
- You or your dependent lose eligibility for coverage in the individual market, including coverage purchased through a public exchange or other public market established under the Affordable Care Act (Marketplace) (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent Claim or an intentional misrepresentation of a material fact) regardless of whether you or your dependent may enroll in other individual market coverage, through or outside of a Marketplace.
- A strike or lockout involving you or your spouse.
- A court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact the Plan Administrator within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

4. When Does My Coverage Begin and End?

4.1 Start Dates

Core

If you enroll in Core coverage during Open Enrollment, coverage begins on the first day of the Plan Year. For employees who are hired mid-year, coverage will begin on first day of the month coinciding with or immediately following the employee's date of hire or becoming newly eligible once Human Resources receives your properly completed enrollment. Coverage for your dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a spouse, domestic partner or dependent stepchild via marriage becomes effective the date of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for dependent children added through birth, adoption, or placement for adoption are effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

Add-Ins

YOU MUST PURCHASE ADD-IN COVERAGE AT LEAST THREE BUSINESS DAYS PRIOR TO THE DATE OF WHEN SERVICES WILL BE RENDERED. If you are enrolled in Core you can enroll in an Add-In by going to the Bind App, MyBind.com, or calling Bind Help. Your Add-In coverage will begin on one of the following dates based on when you sign up:

- If you enroll in Core and purchase an Add-In during Open Enrollment or prior to the Plan Year Effective Date as a new enrollee to the Bind Plan, your Add-In coverage begins on the first day of the Plan Year provided that the Add-In was purchased at least three business days prior to the Plan Year Effective Date.
- If you are already enrolled in Core and purchase an Add-In during the Plan Year, your Add-In coverage will begin on the third business day after you purchase the Add-In and will continue for 120 days after the sign up even if the date of Add-In procedure falls in a subsequent Plan Year, so long as you maintain Core coverage in the subsequent Plan Year.

You can visit the Bind App or MyBind.com anytime to see the Effective Dates of your Add-In(s).

4.2 End Dates

Core

Your coverage will terminate on the earliest of the following dates:

- The date the Plan is terminated;
- The last day of the calendar month in which the covered employee terminates;
- The date your eligibility under the Plan ends;

- When you do not make your required contribution for coverage under the Plan. Termination will be retroactive to the last day for which your required contribution has been timely received; or
- The date you, or someone acting on your behalf, have performed an act or practice that constitutes fraud or made an intentional misrepresentation (including an omission) of material fact under the terms of the Plan.
- The last day of the month in which a covered dependent child turns twenty-six (26); or
- The last day of the month in which a covered disabled dependent child age 26 or over ceases to be disabled.

Add-Ins

Your coverage for an Add-In will terminate on the earliest of the following dates:

- The date your enrollment in Core ends; or
- You reach the end of the Add-In coverage period which is 120 days from Effective Date.

4.3 Leave of Absence

Please contact your Human Resource representative for details on how your coverage is handled and when your coverage ends if you take a leave of absence.

If you are absent from work due to an approved family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), coverage may be continued for the duration of the approved leave of absence as if there was no interruption in employment. Such coverage will continue until the earlier of the expiration of such leave or the date you notify the employer that you do not intend to return to work. You are responsible for all required contributions for Core and Add-In coverage.

If you do not return after an approved leave of absence, coverage may be continued under the “COBRA Continuation Coverage” section, provided that you elect to continue under that provision. If the covered employee returns to work immediately following his/her approved FMLA leave, no new waiting periods will apply.

5. What Are My Benefits?

The Plan includes Core coverage, and if elected and pre-purchased by a Covered Person, Add-In coverage. Plan Benefits are payable only for Covered Services that are Medically Necessary.

There is no deductible for either Core or Add-In coverage. Copays are required for both Core and Add-In coverage. Plan payment begins after you have satisfied the required copay(s).

Discounts are negotiated with in-network Providers. If you use in-network Providers, you will pay lower copays and the Provider will not charge you any additional fees. If you use an out-of-network Provider for Core services, you will pay (in addition to your copay) all charges that exceed the Usual and Customary amount. Copays for Core coverage are listed in Section 5.1. Copays for prescription drugs are listed in Section 5.2. Copays for Add-In coverage are listed in Section 5.3. Add-In services and procedures must be received from in-network Providers.

Once your copays reach your applicable out-of-pocket maximum, the Bind Plan pays 100% of Eligible Charges for both Core and Add-In coverage. Expenses you pay for out-of-network services in excess of the Usual and Customary amount are not counted towards the satisfaction of the out-of-pocket maximums.

In-Network Benefits

As a Covered Person in this Plan, you may choose any eligible Provider of health services each time you need to receive a Covered Service. The choices you make may affect the amount you pay, as well as the level of Benefits you receive. You will receive the best benefit from this Plan when you receive care from in-network Providers; in most instances, your out-of-pocket expenses will be less. The Plan features a large network of in-network Providers.

These Providers will:

1. Accept payment based on the allowed amount previously contracted;
2. File Claims for you; and
3. Be paid based on negotiated rate.

In-network Providers may take care of Prior Authorization, Pre-Admission Notification, pre-admission certification, and/or Emergency admission notification requirements for you. Therefore, it is important that you confirm the Provider's status before you receive services. A Provider's status may change. For current in-network Provider information, refer to MyBind.com or call Bind Help.

You must show your identification "ID" card every time you request health care services from a network Provider. If you do not show your ID card, network Providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Out-of-Network Benefits

If you choose to seek Core services outside the network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Charge. The amount in excess of the Eligible Charge could be significant, and this amount may not apply to the out-of-network out-of-pocket maximum. You may want to ask the out-of-network Provider about their billed charges before you receive care.

Out-of-network Benefits apply to Covered Services that are provided by a non-network or out-of-network Provider, or Covered Services that are provided at a non-network facility.

Out-of-network Providers are not required to file Claims. In that case, contact Bind Help for a Claim form to file the Claim. This may require an itemized bill from the Provider.

Depending on the geographic area and the service you receive, you may have access through the network partner's Shared Savings Program to non-network Providers who have agreed to discount their charges for covered health services. If you receive covered health services from these Providers, the copay will remain the same as it is when you receive covered health services from non-network Providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive covered health services from Shared Savings Program Providers than from other non-network Providers because the eligible expense may be a lesser amount.

Add-Ins are not covered out-of-network.

Copays

The tables below describing the Core and Add-In services include copays applicable to the services. Some copays are listed as a range. Bind assigns Provider copays within the ranges - **and updates those copays on a quarterly basis** - based on Bind's analysis of treatment outcomes and cost information that identifies doctors, clinics and hospitals that provide cost-efficient care.

For current Provider-specific copay information, members should check the MyBind app, MyBind.com, or call Bind Help prior to utilizing any services covered under the Plan. At least 60 days in advance the Bind website and MyBind app will display when a cost for a specific Provider will be moving up or down and the date when the change will occur. It is important to always check the MyBind app, MyBind.com, or call Bind Help prior to utilizing any services covered under the Plan.

The full range of copays displayed may not be available in all areas or for all services. You can find Provider-specific copay amounts by utilizing the Search tool on the MyBind app, MyBind.com, or by calling Bind Help.

You may also be eligible for reduced copays for certain Benefits and for specific condition-based programs and use of in-network Providers that Bind has designated as preferred, high-value Providers.

Core – Benefit Features

The following chart shows the deductibles and out-of-pocket maximums for Core coverage.

Core	In-Network	Out-of-Network
Deductible	$0	$0
Out-of-Pocket Maximum		
Individual	$3,500	$7,000
Family	$7,000	$14,000

Notes:

- If you have other family members in this Plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met. You must pay any amounts greater than the out-of-pocket maximum if any benefit, day, or visit maximums are exceeded. Expenses you pay for any amount in excess of the Usual and Customary amount will not apply towards satisfaction of the out-of-pocket maximum.
- The amount applied to your in-network out-of-pocket maximum also applies to your out-of-network out-of-pocket maximum. The amount applied to your out-of-network out-of-pocket maximum does not apply to your in-network out-of-pocket maximum.

5.1 Core

Acupuncture Services	In-Network	Out-of-Network
Office Visit	$20 copay / visit	$60 copay / visit
Outpatient Hospital Visit	$600 copay / visit	$1,200 copay / visit

Notes:

- Limited to 60 visits or services per Covered Person per Plan Year for in-network and out-of-network Providers combined.

Ambulance Services	In-Network	Out-of-Network
	$350 copay / trip	$350 copay / trip

Notes:

- Ground or air ambulance, as the Claims Administrator determines appropriate.
- Emergency ambulance services and transportation provided by a licensed ambulance service to nearest hospital that offers Emergency health services.
- Ambulance service by air is covered in an Emergency if ground transportation is impossible or would put your life or health in serious jeopardy. If special circumstances exist, Plan Administrator may pay Benefits for Emergency air transportation to a hospital that is not the closest facility to provide Emergency health services.
- Ambulance Services for non-Emergency: this Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as Bind determines appropriate) between facilities when the transport is:
  - From a non-network hospital to a network hospital.
  - To a hospital that provides a higher level of care that was not available at the original hospital.
  - To a more cost-effective acute care facility.
  - From an acute facility to a sub-acute setting.
- Air ambulance services will be reviewed for Medical Necessity.

Autism Spectrum Disorder Services	In-Network	Out-of-Network
Mental Health Office Visit	$20 copay / visit	$60 copay / visit
Outpatient Hospital	$600 copay / visit	$1,200 copay / visit
Inpatient Hospital	$1,000 copay / stay	$2,000 copay / stay

Notes:

- Core pays for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:
  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Provided by a Board-Certified Applied Behavior Analyst (BCBA) or other qualified Provider under the appropriate supervision.
  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.
- These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Service for which Benefits are available under the applicable medical Covered Services categories as described in this section.
- Autism Spectrum Disorder Services are reviewed for Medical Necessity. Have your Provider request a Prior Authorization.
- Benefits include:
  - Diagnostic evaluation assessment and treatment planning
  - Treatment and/or procedures
  - Medication management and other associated treatments
  - Individual, family, and group therapy
  - Provider-based case management services
  - Crisis intervention
  - Residential treatment
  - Partial hospitalization/Day treatment
  - Outpatient treatment
- See Hospital Services for other coverage notes.

Chemotherapy	In-Network	Out-of-Network
Office Visit	$10 to $30 copay / visit	$60 copay / visit
Outpatient Hospital Visit	$600 copay / visit	$1,200 copay / visit
Inpatient Hospital	$1,000 copay / stay	$2,000 copay / stay

Notes:

- The Plan pays Benefits for therapeutic treatments received in an office, outpatient hospital or alternate facility, including intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.
- Covered Health Services include medical education services that are provided in an office, outpatient hospital or alternate facility by appropriately licensed or registered healthcare professionals.
- See Hospital Services for other coverage notes.

Chiropractic Services	In-Network	Out-of-Network
Office Visit	$20 copay / visit	$60 copay / visit
Outpatient Hospital Visit	$600 copay / visit	$1,200 copay / visit

Notes:

- Limited to 60 visits or services per Covered Person per Plan Year for in-network and out-of-network Providers combined.
- Chiropractic Services are limited to manipulative services including chiropractic care and osteopathic manipulation rendered to diagnose and treat acute neuromuscular-skeletal conditions.

Non-Screening Colonoscopy	In-Network	Out-of-Network
Outpatient Hospital Visit	$200 to $600 copay / visit	$1,200 copay / visit

Notes:

- When this procedure is performed to diagnose disease symptoms, a copay applies.
- The copays may vary based on Provider location

Complex Drug Administration	In-Network	Out-of-Network
Office Visit / Home	$200 copay / visit	$400 copay / visit
Outpatient Hospital Visit	$750 copay / visit	$1,500 copay / visit

Notes:

- This copay applies to specific drugs that must be administered in a medical setting or under medical supervision. Call Bind Help to learn which infusions and injections are subject to these copays.
- Subject to Prior Authorization for Medical Necessity review.
- See Hospital Services for other coverage notes.
- See Chemotherapy section for coverage notes related to chemotherapy administration.

Complex Imaging	In-Network	Out-of-Network
Office Visit or Outpatient Hospital Visit	$75 to $400 copay / visit	$800 copay / visit

Notes:

- Coverage includes MRI (Magnetic Resonance Imaging), MRA (Magnetic Resonance Angiography), CT (Computed Tomography), PET (Positron Emission Tomography), and Nuclear Medicine.
- If your Physician suggests a low-dose CT Scan (LDCT) for lung cancer screening, this will require a Prior Authorization. The copays may vary based on Provider location.
- See Hospital Services for other coverage notes.

Dental Services	In-Network	Out-of-Network
Specialist Office Visit	$30 copay / visit	$60 copay / visit
Orthognathic Surgery, Jaw Surgery Outpatient Hospital Visit	$600 copay / visit	$1,200 copay / visit
Orthognathic Surgery, Jaw Surgery Inpatient Hospital	$1,000 copay / stay	$2,000 copay / stay

Notes:

- Bind covers dental services to treat and restore damage done to a sound, natural tooth as a result of an accidental injury. Coverage is for external trauma to the face and mouth only. A sound, natural tooth is a tooth, including supporting structures, that is healthy and would be able to continue functioning for at least one year. Primary (baby) teeth must have a life expectancy of one year before loss. Treatment and repair for services required due to an accidental injury must be started within six months and completed within twelve months of the date of the injury.
- Bind also covers dental services, limited to dental services required for treatment, of an underlying medical condition such as a cleft palate or other congenital defect, oral reconstruction after invasive oral tumor removal, preparation for or as a result of radiation therapy for oral or facial cancer.
- Eligible Charges for hospitalizations are those incurred by a Covered Person who: (1) is a child under age five; (2) is severely disabled; or (3) has a medical condition, unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a Physician, dentist, or dental Specialist.
- Orthognathic surgery is subject to Medical Necessity review and requires Prior Authorization.
- See Hospital Services for other coverage notes.

Additional Notes on Dental Services:

- Benefits are provided for the following limited oral surgical procedures determined to be Medically Necessary and Appropriate:
  - Oral surgery and anesthesia for removal of impacted teeth, removal of a tooth root without removal of the whole tooth, and root canal therapy.
  - Mandibular staple implant provided the procedure is not done to prepare the mouth for dentures.
  - Facility Provider and anesthesia Services rendered in a Facility Provider setting in conjunction with non-covered dental procedures when determined by the Claims Administrator to be Medically Necessary and Appropriate due to your age and/or medical condition.
  - The correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof, and floor of the mouth.

Dialysis Services	In-Network	Out-of-Network
Office Visit	$10 to $30 copay / visit	$60 copay / visit
Outpatient Hospital Visit	$600 copay / visit	$1,200 copay / visit
Inpatient Hospital	$1,000 copay / stay	$2,000 copay / stay

Notes:

- The Plan pays Benefits for therapeutic treatments received in an office, home, outpatient hospital or alternate facility. Benefit includes services and supplies for renal dialysis, including both hemodialysis and peritoneal dialysis. Benefit also includes training of the patient.
- See Hospital Services for other coverage notes.

Durable Medical Equipment (DME)	In-Network	Out-of-Network
Tier 1	$0 copay	$20 copay
Tier 2	$20 copay	$40 copay
Tier 3	$40 copay	$80 copay
Tier 4	$60 copay	$120 copay
Tier 5	$80 copay	$160 copay
Tier 6	$100 copay	$200 copay
Tier 7	$150 copay	$300 copay
Tier 8	$200 copay	$400 copay
Tier 9	$250 copay	$500 copay
Tier 10	$300 copay	$600 copay
Tier 11	$400 copay	$800 copay
Tier 12	$500 copay	$1,000 copay

Notes:

- Coverage includes rental or purchase of DME.
- Visit MyBind.com or call Bind Help to learn what DME items are in which tier. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular DME item has been assigned by contacting the Bind Help or using the Bind app.
- Hearing aids are limited to one hearing aid per ear every 36 months.
- Scalp/cranial hair prostheses (wigs) are a Covered Service for scalp/head wound, burns, injuries, alopecia areata, cancer, and undergoing chemotherapy or radiation therapy and limited to one wig per person per calendar year up to a maximum of $350 for in-network Benefits and out-of-network Benefits combined.
- Cataract surgery or aphakia is limited to one frame and one pair of lenses or one pair of contact lenses or one-year supply of disposable contact lenses.
- DME in Tiers 9 through 12 will be subject to Prior Authorization to ensure Medical Necessity.

- Coverage is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.

Emergency Services	In-Network	Out-of-Network
Emergency Room Visit	$250 copay / visit	$250 copay / visit

Notes:

- Copay applies to Emergency Room facility and professional expenses and includes related expenses.
- If you are admitted as an inpatient directly from the Emergency Room for the same condition, the Emergency Services copay will be waived, and you will be responsible for Inpatient Hospital Services copay.
- If you are admitted to observation directly from the Emergency Room for the same condition, the Emergency Services copay will be waived, and you will be responsible for the Outpatient Hospital Services copay.

Gender Dysphoria Services	In-Network	Out-of-Network
Mental Health Office Visit	$20 copay / visit	$60 copay / visit
Outpatient Hospital Visit	$600 copay / visit	$1,200 copay / visit
Inpatient Hospital	$1,000 copay / stay	$2,000 copay / stay

Notes:

If you need assistance understanding and utilizing your transgender Benefits, please contact Bind Help

- The Plan will pay for Covered Services up to $25,000 per Covered Person, per lifetime, in-network and out-of-network combined.
- The following services are covered for gender dysphoria:
  - Gender reassignment surgery including genital reconstruction, clitoriplasty, vaginoplasty, scrotoplasty
  - Breast augmentation, implants, and reconstruction
  - Mastectomy
- **Gender Dysphoria:** A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association:*
- **Diagnostic criteria for adults and adolescents:** A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

  The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- **Diagnostic criteria for children:** A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
  - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.
  - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.

  - A strong preference for playmates of the other gender.
  - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
  - A strong dislike of ones' sexual anatomy.
  - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender

  The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- These services are subject to Prior Authorization and Medical Necessity review.

Genetic Testing	In-Network	Out-of-Network
Office Visit	$75 copay / visit	$150 copay / visit

Notes:

- The following categories of services are covered:
  - Genetic tests for cancer susceptibility
  - Genetic tests for hereditary diseases
  - Unspecified molecular pathology
  - Fetal aneuploidy testing
- Genetic Testing services requires a Prior Authorization.

Home Health Services	In-Network	Out-of-Network
Home Health Care Visit	$20 copay / visit	$60 copay / visit

Notes:

- Limited to 120 visits per Covered Person per Plan Year for in-network and out-of-network combined.

Hospice Care	In-Network	Out-of-Network
Home Hospice Visit	$20 copay / visit	$60 copay / visit
Inpatient Hospital	$1,000 copay / stay	$2,000 copay / stay

Notes:

- Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual, and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.
- Hospice care requires a Prior Authorization.
- See Hospital Services for other coverage notes.

Hospital Services	In-Network	Out-of-Network
Outpatient Hospital Visit	$600 copay / visit	$1,200 copay / visit
Inpatient Hospital	$1,000 copay / stay	$2,000 copay / stay

Notes:

- The copays above apply unless a benefit is specified in another section of this SPD.
- Outpatient Hospital Visit copay will apply for an Observation Stay.
- Inpatient Hospitalization/Stay Benefits include:
  - Physician and non-Physician services, supplies, and medications received during an inpatient stay.
  - Facility charges, including room and board in a semi-private room (a room with two or more beds).
  - Physician services for lab tests, radiologists, anesthesiologists, pathologists, and Emergency room Physicians.
  - The Plan will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.
- If you are admitted to inpatient from the Emergency department or from observation, the Emergency room copay or observation copay will be waived.

- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.

Infertility Diagnosis and Treatment	In-Network	Out-of-Network
Artificial insemination	$200 copay / visit	Not Covered
Egg Retrieval	$1,500 copay / visit	Not Covered
Embryo Implantation	$1,500 copay / visit	Not Covered
Cryopreservation	$1,000 copay / visit	Not Covered
Storage	$500 copay / visit	Not Covered
Thawing	$1,000 copay / visit	Not Covered
Genetic Testing (PGT)	$1,000 copay / visit	Not Covered

Notes:

Core coverage pays Benefits for infertility services and associated expenses including:

- Diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician;
- Assisted Reproductive Technologies (ART), including but not limited to, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT);
- Embryo transport;
- Donor ovum and semen and related costs, including collection, preparation, and storage of;
- Ovulation stimulation;
- Cryopreservation, also known as embryo freezing, and storage (up to 12 months) for embryos produced from one (1) cycle for a Covered Person who will undergo cancer treatment that is expected to render them infertile; and
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- There is a lifetime maximum of $10,000 per Covered Person for covered infertility treatments, this maximum does not include prescription medications. This lifetime maximum is combined across all Bind health plans sponsored by the Plan Administrator. If a Covered Person is bypassing the IVF reversal and requesting the direct infertility treatment (IVF), even though they had a previous sterilization, it would be covered. Benefits include implanting only one embryo per cycle. A cycle is defined as one partial or complete fertilization attempt extending through the implantation phase only.

- These services are subject to Prior Authorization and Medical Necessity review.

Maternity Care and Delivery	In-Network	Out-of-Network
Routine Pre- and Post-Natal Office Visits, including Labs and Tests	$0 copay / visit	$45 copay / visit
Inpatient Delivery	$400 to $1,000 copay / stay	$2,000 copay / stay

Notes:

- Routine pre- and post-natal maternity services include evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force and Health Resources and Services Administration.
- If a newborn baby stays in the hospital longer than the newborn baby’s mother, then another copay will apply to the baby’s services.
- Coverage is limited to a 48-hour hospital stay following normal vaginal delivery and 96 hours for a normal cesarean section.
- Home visit limited to 1 visit immediately following discharge of mother and newborn.
- The copays for inpatient delivery may vary based on Provider location.
- See Hospital Services for other coverage notes.

Mental Health and Substance Use Disorder Services	In-Network	Out-of-Network
Mental Health Office Visit	$20 copay / visit	$60 copay / visit
Outpatient Hospital Visit	$600 copay / visit	$1,200 copay / visit
Inpatient Hospital	$1,000 copay / stay	$2,000 copay / stay
Residential Treatment Facility	$1,000 copay / stay	$2,000 copay / stay
Partial Hospitalization/Day Treatment	$600 copay / visit	$1,200 copay / visit

Notes:

- Benefits include:
  - Diagnostic evaluations, assessment, and treatment planning
  - Treatment and/or procedures
  - Medication management and other associated treatments
  - Individual, family, and group therapy
  - Provider-based case management services
  - Crisis intervention
  - Residential treatment
  - Partial hospitalization/Day treatment
  - Outpatient treatment
- All inpatient services require Pre-Admission Notification if planned and notification within 24 hours of admission if emergent.
- Substance Use Disorder inpatient residential and partial hospitalization services require Prior Authorization and are subject to Medical Necessity review.
- See Hospital Services for other coverage notes.

Occupational Therapy	In-Network	Out-of-Network
Occupational Therapy Visit	$10 to $80 copay / visit	$160 copay / visit

Notes:

- Limited to 60 visits for occupational therapy per Covered Person per Plan Year for in-network and out-of-network Providers combined. The copays may vary based on Provider location.
- Occupational therapy for mental health condition such as autism disorder will follow mental health office visit copay.
- See Hospital Services for other coverage notes.

Office Visit and Diagnostic Visit	In-Network	Out-of-Network
Office Visit — Primary Care / Specialist Visit	$10 to $30 copay / visit	$60 copay / visit
Mental Health Office Visit	$20 copay / visit	$60 copay / visit
E-Visit and Telephone Visit with Physician	$20 copay / visit	Not Covered
Convenience Care/Retail visit	$10 copay / visit	Not Covered
Lab / X-Ray	$0 copay / visit	$0 copay / visit
Allergy Injection Visit	$0 copay / visit	$60 copay / visit
Allergy Testing and Treatment	$30 copay / visit	$60 copay / visit
Complex Office Visit: **Examples include: Vein Ablation, Chemodenervation, Implantation of Drug Delivery Device, Eye Cryotherapy and Photocoagulation, Spinal Ablation.**	$75 copay / visit	$150 copay / visit

Notes:

- See Virtual Visit section for virtual visit details.

Palliative Care	In-Network	Out-of-Network
Office Visit / Home	$10 to $30 copay / visit	$60 copay / visit
Inpatient Hospital	$1,000 copay / stay	$2,000 copay / stay

Notes:

- Core covers palliative care for members with a new or established diagnosis of progressive debilitating illness. The services must be within the scope of the Provider's license to be covered. Palliative care does not include hospice or respite care.
- See Hospital Services for other coverage notes.

Physical Therapy	In-Network	Out-of-Network
Physical Therapy Visit	$10 to $80 copay / visit	$160 copay / visit

Notes:

- Limited to 60 visits for physical therapy per Covered Person per Plan Year for in-network and out-of-network Providers combined. The copays may vary based on Provider location.
- Physical therapy for mental health condition such as autism disorder will follow mental health office visit copay.
- See Hospital Services section for other coverage notes.

Prescription Drugs	In-Network	Out-of-Network
	See Section 5.2 for details	Not Covered

Preventive Care	In-Network	Out-of-Network
Office Visit	$0 copay / visit	$45 copay / visit

Notes:

- Services include evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, Bright Futures, Health Resources and Services Administration and Advisory Committee on Immunization Practices.
- Examples include:
  - Pediatric preventive services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations, up to age 18. Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once a year from 24 months to age six.
  - Routine physical exams.
  - Routine screenings for certain cancers and other conditions.
  - Routine screening colonoscopy is covered as preventive with diagnosis of family history.
  - Routine immunizations.
  - Routine lab tests, pathology, and radiology.
  - Hearing and vision screening limited to one exam per calendar year for children up to age of 21.
  - Routine pre-natal and postpartum care services.
  - One routine postnatal care exam that includes a health exam, assessment, education, and counseling provided during the period immediately after childbirth.

Preventive Contraceptive Methods and Counseling for Women	In-Network	Out-of-Network
Office Visit	$0 copay / visit	$45 copay / visit

Notes:

- For Prescription Drug Coverage see Section 5.2.
- Includes certain approved contraceptive methods for women with reproductive capacity, including contraceptive drugs, devices, and delivery methods.
- Includes at least one of each of the 18 FDA approved contraceptive methods for women, as prescribed, along with counseling and related services.

Radiation Therapy	In-Network	Out-of-Network
Outpatient Hospital Visit	$600 copay / visit	$1,200 copay / visit

Notes:

- See Hospital Services for other coverage notes.

Reconstructive Surgery	In-Network	Out-of-Network
Outpatient Hospital Visit	$600 copay / visit	$1,200 copay / visit
Inpatient Hospital	$1,000 copay / stay	$2,000 copay / stay

Notes:

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

Skilled Nursing Facility Services	In-Network	Out-of-Network
Skilled Nursing Facility	$1,000 copay / stay	$2,000 copay / stay

Notes:

- Limited to 120 days per Covered Person per Plan Year for in-network and out-of-network Providers combined.
- Benefits include:
  - Facility services for an inpatient stay in a Skilled Nursing Facility or inpatient rehabilitation facility are covered by Core and require Prior Authorization.
  - Supplies and non-Physician services received during the inpatient stay.
  - Room and board in a semi-private room (a room with two or more beds).
  - Physician services for radiologists, anesthesiologists, and pathologists.
  - Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or inpatient rehabilitation facility for treatment of a sickness or injury that would have otherwise required an inpatient stay in a hospital.
- Benefits are available only if both of the following are true:

  - The initial confinement in a Skilled Nursing Facility or inpatient rehabilitation facility was or will be a cost-effective alternative to an inpatient stay in a hospital; and
  - You will receive skilled care services that are not primarily Custodial Care.
- Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:
  - It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
  - It is ordered by a Physician.
  - It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair.
  - It requires clinical training in order to be delivered safely and effectively.
- You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.
- The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in the Glossary.
- All Skilled Nursing Facility admissions require a Prior Authorization.
- See Hospital Services for other coverage notes.

Speech Therapy	In-Network	Out-of-Network
Speech Therapy Visit	$10 to $80 copay / visit	$160 copay / visit

Notes:

- Limited to 60 visits for speech therapy per Covered Person per Plan Year for in-network and out-of-network Providers combined. The copays may vary based on Provider location.
- Speech therapy for mental health condition such as autism disorder will follow mental health office visit copay.
- See Hospital Services for other coverage notes.

Temporomandibular Joint (TMJ) Services	In-Network	Out-of-Network
Specialist Office Visit	$30 copay / visit	$60 copay / visit
Outpatient Hospital Visit	$600 copay / visit	$1,200 copay / visit
Inpatient Hospital	$1,000 copay / stay	$2,000 copay / stay

Notes:

- Includes orthodontic services and supplies and surgical and non-surgical options for the treatment of TMJ.
- These services require Prior Authorization and Medical Necessity review.
- See Hospital Services for other coverage notes.

Transplant Services	In-Network	Out-of-Network
Specialist Office Visit	$30 copay / visit	Not Covered
Outpatient Hospital Visit	$600 copay / visit	Not Covered
Inpatient Hospital	$1,000 copay / stay	Not Covered

Notes:

- Transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/intestine, pancreas, intestine and cornea. Transplant Services, except for corneal transplant, require Prior Authorization. Bind has identified quality Providers for Transplant Services referred to as the Transplant Center of Excellence (See Section 5.5 Clinical Programs for additional information). Transplant Services must be received at a location specified as a Center of Excellence.
- Benefits are available to the donor and the recipient when the recipient is covered under Core. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's Core coverage.
- Bind has specific guidelines regarding Benefits for transplant services. Contact Bind Help at the number on your ID card for information about these guidelines.

- Core covers expenses for travel and lodging for the patient, and a companion as follows, up to a maximum of $10,000 per transplant procedure (for example, the limit would apply in the event of a heart and lung transplant performed during the same procedure):
  - Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by an in-network Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
  - The eligible expenses for lodging for the patient (while not a hospital inpatient) and one companion.
  - If the patient is an enrolled dependent minor child, the transportation expenses of two companions will be covered.
  - Travel and lodging expenses are only available if the patient resides more than 50 miles from the in-network Provider.
  - Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Covered Person if the reimbursement exceeds the per diem rate.
- The Claim Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:
- **Lodging**
  - A per diem rate, up to $50 per day, for the patient (when not in the hospital) or the caregiver.
  - Per diem is limited to $100 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.
- **Travel**
  - Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the in-network Provider
  - Taxi fares (not including limos or car services)
  - Economy or coach airfare
  - Parking
  - Trains
  - Boat
  - Bus
  - Tolls
- **Examples of items that are not covered**
  - Groceries
  - Alcoholic beverages
  - Personal or cleaning supplies
  - Meals
  - Over-the-counter dressings or medical supplies
  - Deposits
  - Utilities and furniture rental, when billed separate from the rent payment
  - Phone calls, newspapers, or movie rentals.
- All Transplant Services with the exception of Corneal transplant require Prior Authorization.
- See Hospital Services for other coverage notes.

Urgent Care	In-Network	Out-of-Network
Urgent Care Visit	$60 copay / visit	$200 copay / visit

Notes:

- Visit at a center that treat injuries or illnesses requiring immediate care, but not serious enough to require an Emergency department visit.

Virtual Visits	In-Network	Out-of-Network
Virtual Visit (Designated Provider)	$0 copay / visit	Not Covered

Notes:

- Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical and mental health conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care Specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).
- Benefits are available only when services are delivered through a designated virtual network Provider.
- No virtual visit coverage for out-of-network.
- Please visit MyBind.com to locate a designated virtual network Provider.

Clinical Trials

Clinical trials are research studies designed to find ways to improve health care or to improve prevention, diagnosis, or treatment of health problems. The purpose of many clinical trials is to find out whether a medicine or treatment is safe and effective for treating a certain condition or disease. Clinical trials compare the effectiveness of this medicine or treatment against standard, accepted treatment, or against a placebo if there is no standard treatment. Participants in clinical trials are typically randomized to different treatment arms and based on that randomization may receive either the study intervention or the control intervention. Services provided in a clinical trial typically include the interventions being evaluated (study agent and control agent) and other clinical services required to evaluate the effectiveness and safety of the interventions being compared.

In compliance with federal law, your Benefits cover routine health care costs for qualifying individuals participating in approved clinical trial.

All participation in clinical trials requires Prior Authorization.

Coverage with Evidence Development

Bind implements written “coverage with evidence development” (“CED”) medical policies in order to accelerate the discovery and adoption of healthcare services that generate better clinical outcomes at lower cost. CED medical policies provide coverage for promising new technologies that have not yet been established as effective according to generally accepted professional medical standards, but

1. Are not eligible to be covered under the clinical trials policy;
2. Would otherwise be considered Medically Necessary;
3. Are safe;
4. Show substantial potential to improve health outcomes and reduce waste and inefficiency in the health care system;
5. Are being evaluated in a high-quality research or clinical study;
6. Can be operationally administered by Bind;
7. Do not substantially increase healthcare costs;
8. And meet all of the requirements defined by the Bind clinical rationale policy and procedures.

Services covered by a CED policy are covered according to the Core benefit design and do not require Prior Authorization.

5.2 Prescription Drugs

Core includes coverage for prescription drugs dispensed at in-network pharmacies with the copays listed below. There is no coverage for out-of-network pharmacies. A Formulary is used to determine which prescription drugs are covered. The Formulary is subject to regular review and modification. You can use the Bind app or contact Bind Help to find in-network pharmacies, Formulary medications, drug tiers and Specialty Drugs.

Bind works with the following vendors to administer the pharmacy Benefits.

- Navitus Health Solutions is the Pharmacy Benefits Manager (PBM) for retail pharmacies.
- Navitus Health Solutions' Specialty Pharmacy (Lumicera) is the specialty pharmacy.
- Kroger is the mail-order pharmacy.

Prescription Drug Tiers

If your copay is higher than the retail price, you pay the lower amount.

Use the Bind app, visit MyBind.com or call Bind Help to determine the tier of your drug or to learn more about Preventive medications.

	30-Day Supply		90-Day Supply	
	Preferred In-Network Pharmacies	**All Other In-Network Pharmacies**	**Preferred In-Network Pharmacies and Mail Order Pharmacy**	**All Other In-Network Pharmacies**
Preventive	$0 copay	$0 copay	$0 copay	$0 copay
Tier 1	$5 copay	$10 copay	$15 copay	$25 copay
Tier 2	$30 copay	$30 copay	$75 copay	$75 copay
Tier 3	$60 copay	$60 copay	$150 copay	$150 copay

Specialty Drug Tiers

If your copay is higher than the retail price, you pay the lower amount.

Lumicera Specialty Pharmacy	
	30-Day Supply
Tier 1	$150 copay
Tier 2	$200 copay
Tier 3	$250 copay

Notes:

- **General**
  - You pay the listed copay or price of prescription, whichever is less.
  - You must present your Bind ID card or otherwise provide notice of coverage at the time of purchase to receive the highest level of Benefits. If you do not present your ID card or otherwise provide notice of coverage at the time of

purchase, the pharmacy may charge you the full amount of the prescription drug as well as require payment prior to rendering a service. To request reimbursement, contact Bind Help. Prescription drugs and diabetic supplies are generally covered up to a 90-day supply. Some medications may be subject to a quantity limitation per day supply or to a maximum dosage per day. More information can be found on the Bind App or by contacting Bind Help.
  - Drugs that require Prior Authorization submitted by the prescriber are indicated as such within the Formulary. Contact Bind Help or use the Bind App to determine if a particular drug requires a Prior Authorization.
  - Drugs that require step therapy or that may be subject to a quantity limitation per day supply or to a maximum dosage per day are indicated on the Formulary and can be also obtained by contacting Bind Help or using the Bind App.
  - When identical chemical entities are from different manufacturers or distributors, the PBM's clinical coverage committee may determine that only one of those drug products is covered and the other equivalent products are not covered.
  - Bind-applies on-demand health insurance principles to prescription Benefits with the objective of discounting copays for the most appropriate medication(s) for a given member, based on Bind's Clinical Policy committee. Bind's Clinical Policy committee reviews evidence-based guidelines, real-world evidence, peer-reviewed studies, etc. to determine treatment pathways that improve long-term health outcomes and target specific members. Members will see eligible benefit adjustments on Bind's search app or at the pharmacy when picking up their prescription. Contact Bind Help or use the Bind App to learn more.
- **Specialty Drugs**
  - Lumicera is the specialty pharmacy. Specialty Drugs are designated complex injectable and oral drugs that have very specific manufacturing, storage, and dilution requirements.
  - Specialty Drugs are drugs including, but not limited to drugs used for: growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia.
  - Specialty Drugs are generally only covered up to a 30-day supply.
  - A current list of designated Specialty Drugs and suppliers is available on the Bind App or by contacting Bind Help.
- **Other Drugs/Supplies**
  - Prescription Benefits will cover prescription tobacco cessation drugs and products and over-the- counter (OTC) tobacco cessation drugs and products with a Physician's prescription at a $0-dollar copay. Some quantity limitation may apply. Contact Bind Help to learn more.
  - Navitus Health Solutions applies medical management in determining which contraceptives are included on your specified preferred drug list, as well as a subset of contraceptive medications where a $0 copay applies as indicated on the Formulary. To view a current list of contraceptive medications that are eligible for coverage without member cost-sharing under your Plan use the Bind App or call Bind Help. For supplies or appliances, except as provided in Section 5.1, refer to Durable Medical Equipment (DME).
  - When you pay for any reimbursement-eligible prescriptions yourself, you are required to submit the drug receipt(s) with the Claim form for reimbursement. For prescription drugs dispensed and used during a covered hospital stay, refer to Section 5.1 Hospital Services.
- **Non-Covered Drugs**
  - Drugs that are excluded from the Formulary are not covered under the Plan unless approved in advance through an exception to coverage process managed by Navitus on the basis that the drug requested is (1) Medically Necessary and essential to the patient's health and safety and/or (2) all Formulary drugs comparable to the excluded drug have been tried by the patient. If approved through that process, the applicable Formulary copay would apply for the approved drug based on the Plan's cost share structure. Without this approval, if you or a covered dependent selects drugs excluded from the Formulary, you will be required to pay the full cost of the drug without any reimbursement under the Plan. If your Physician believes that an excluded drug meets the requirements described above, your Physician should take the necessary steps to initiate an exception to coverage review.

5.3 Add-Ins

For an additional premium, Covered Persons may enroll in Add-Ins. Add-In coverage includes select, planned procedures that often have treatment and location options. Service(s) must be provided within the time frame shown in the Add-In coverage period column below. Add-In coverage is only available for in-network Providers and the procedure must be Medically Necessary.

ADD-IN COVERAGE MUST BE PURCHASED THREE BUSINESS DAYS PRIOR TO RECEIVING SERVICES RELATED TO THE ADD-IN COVERAGE. Add-In coverage is effective three business days after it is purchased, and all services related to the Add-In must be complete within 120 days of its Effective Date. Failure to purchase Add-In Coverage prior to receiving the services may result in an adverse benefit determination (e.g., denial of Claim, reduction of Benefits, etc.). If you need any of these procedures because it directly relates to an Emergency, trauma event or cancer-related treatments (i.e., post-diagnosis) including surgery, you do not need to purchase an Add-In as these situations are covered in Core.

The copays listed for Add-In coverage are maximum copays for each Add-In. You may be eligible for reduced copays if you use in-network Providers that Bind has designated as preferred, high-value Providers. Bind determines which in-network Providers are preferred, high value Providers by considering, for example, their rates of effectiveness, low risk of complications and the total cost charged by the Provider.

Add-In coverage is for in-network only. Some Add-Ins may be covered under Core if you or your dependent meet certain age requirements. Please call Bind Help for additional information.

Name	Max Copay	Coverage Period
Ankle and Foot Bone Fusion	$2,500	120 days
Ankle Arthroscopy and Ligament Repair	$2,600	120 days
Ankle Replacement and Revision	$3,000	120 days
Back Surgery, Cervical Spine Disc Decompression	$2,900	120 days
Back Surgery, Cervical Spine Fusion	$2,600	120 days
Back Surgery, Lumbar Spine Disc Decompression	$2,900	120 days
Back Surgery, Lumbar Spine Fusion	$2,900	120 days
Bariatric Surgery	$2,400	120 days
Breast Reduction Surgery *	$2,500	120 days
Bunionectomy and Hammertoe Surgery	$2,200	120 days
Cardiac Ablation	$3,000	120 days
Carotid Endarterectomy and Stents	$2,600	120 days
Carpal Tunnel Surgery	$2,500	120 days
Cataract Surgery	$2,000	120 days
Coronary Artery Bypass Graft Surgery	$3,000	120 days

Name	Max Copay	Coverage Period
Coronary Catheterization and Percutaneous Coronary Intervention	$2,600	120 days
Ear Tubes	$2,400	120 days
Elbow Arthroscopy and Tenotomy	$2,100	120 days
Elbow Replacement and Revision	$3,000	120 days
Fibroid Removal (Myomectomy)	$2,700	120 days
Gallbladder Removal Surgery (Cholecystectomy)	$2,350	120 days
Ganglion Cyst Surgery	$2,400	120 days
Hernia Repair	$2,500	120 days
Hip Arthroscopy and Repair	$2,500	120 days
Hip Replacement and Revision	$2,600	120 days
Hysterectomy *	$2,300	120 days
Hysteroscopy and Endometrial Ablation	$2,100	120 days
Kidney Stone Ablation and Removal (Lithotripsy)	$2,250	120 days
Knee Arthroscopy and Repair	$2,500	120 days
Knee Replacement and Revision	$2,600	120 days
Morton's Neuroma Surgery	$1,900	120 days
Pacemakers and Defibrillators	$3,000	120 days
Plantar Fasciitis Surgery	$2,100	120 days
Prostate Removal Surgery	$2,250	120 days
Reflux and Hiatal Hernia Surgery	$2,500	120 days
Shoulder Arthroscopy and Repair	$2,600	120 days
Shoulder Replacement and Revision	$2,600	120 days
Sinus and Nasal Septum Surgery	$2,700	120 days
Sling Surgery for Female Urinary Incontinence	$2,300	120 days
Spinal Cord Stimulator	$2,000	120 days
Tonsillectomy and Adenoidectomy	$2,200	120 days
Upper GI Endoscopy	$2,500	120 days
Valve Replacement	$3,000	120 days
Wrist and Hand Joint Replacement	$2,250	120 days
Wrist Arthroscopy and Repair	$2,150	120 days

*Hysterectomy procedure and Breast reduction surgery for the treatment of Gender Dysphoria are covered under Core coverage and do require prior authorization.

Add-Ins provide coverage on the same date of the surgery or during the same hospital admission, for the following associated health care services:

- Anesthesia
- Facility charges

- Labs
- Medications administered by a Provider
- Pathology
- Provider services
- Radiology
- Supplies

Exclusions to Add-Ins

- For Add-In procedures performed in a clinic or outpatient facility: health care services provided prior to and after the date of the Add-In procedure unless such services are directly related to the same or similar Add-In body part. Core coverage may be available.
- For Add-In procedures performed in an inpatient facility: health care services provided prior to an admission and after a discharge from an inpatient facility unless such services are directly related to the same or similar Add-In body. Core coverage may be available.
- Care that is not Medically Necessary.
- Items listed in Section 6 What is Not Covered.

5.4 Prior Authorization and Pre-Admission Notification

For Providers that are in-network, Prior Authorization is required for certain Covered Services in Core. Prior Authorization is not required for Add-In procedures; however, notification of an inpatient stay, also known as Pre-Admission Notification, is required for all inpatient stays. Inpatient stays will be reviewed for Medical Necessity, length of stay and level of care. All acute inpatient rehabilitation (AIR) admissions; long-term acute care (LTAC) admissions; and Skilled Nursing Facility admissions are subject to Medical Necessity review pre-admission. If you have questions about Prior Authorization or Pre-Admission Notification, please contact Bind Help.

If you are using an out-of-network Provider, you are responsible for ensuring that any necessary Prior Authorizations and Pre-Admission Notifications have been obtained or you could be subject to “balance billing” by your Provider. Balance billing occurs when an out-of-network Provider bills you for the balance remaining on your bill for services not covered by the Plan.

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

Prior Authorization is recommended for certain services including but not limited to:

- All non-Emergency inpatient admissions (hospital, skilled nursing, residential programs, etc.)
- Dental and oral surgery services that are accident-related for the treatment of injury to sound and healthy, natural teeth; temporomandibular joint (TMJ) surgical procedures; and orthognathic surgery

- Auditory implants
- Mental health services (inpatient/residential, partial residential, outpatient programs, ABA therapy)
- Bone growth stimulators
- Cancer treatments including radiation and chemotherapy
- Clinical Trials and services considered Investigative or Experimental
- Drugs or procedures that could be construed to be Cosmetic
- Durable medical equipment (DME), orthotics and prosthesis in Tier 9 and above
- Gender Dysphoria services
- Genetic tests
- Home health care
- Hospice services
- Infertility Treatment
- Injectable medications
- Joint replacement and spine surgeries (not included in Add-Ins)
- Neurostimulation
- Non-Emergency air transportation
- Outpatient surgeries and therapies
- Sleep apnea procedures and studies in the lab setting
- Transplant services, except cornea
- Certain Formulary medications (see Section 5.2)

5.5 Clinical Programs

Bind Care Management

Bind Care Management offers support to help you use your Benefits, improve your health, and achieve an optimal quality of life. At Bind, we believe that people who are more involved in their health care are happier with their decisions and more likely to follow their treatment plans, which leads to better health. We care about your preferences for treatment and about the costs to you.

Our care managers act as an advocate for you and your family by:

- Identifying available treatment options
- Assisting you in making important healthcare decisions
- Coordinating your care with your healthcare Providers
- Researching resources, such as condition-focused programs, support groups and financial assistance

- Offering personalized coaching to help you live better with illness or recover from an acute condition
- Helping you develop self-management skills

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

It is your choice to participate in Bind Care Management. There are no extra charges for these services, and you can end your participation at any time, for any reason. Participation in this program will not affect your Benefits. Contact Bind Help if you think you can use this support.

Transplant Centers of Excellence Case Management

For a Solid Organ and Blood/Marrow transplant to be a Covered Service, you must use a facility designated as a Transplant Center of Excellence. Most transplants are expensive and complicated. At Bind, we ensure you are going to a reputable facility that has expertise in the specific type of transplant you need. Contact Bind Help at the number on your ID card for information on who is in the Transplant Center of Excellence network and to get access to their services.

A dedicated nurse case manager who specializes in transplant cases will provide assistance in:

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

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

5.6 Transition of Care and Continuity of Care

Bind offers Transition of Care and Continuity of Care for Core coverage. If you are new to Bind and are actively receiving treatment from a Provider who is not in our network, you may be eligible to receive Transition of Care Benefits. Transition of Care Benefits allows you to see the out-of-network Provider at the in-network co-pay for a limited time due to a qualifying medical condition until the safe transfer to an in-network Provider can be arranged. If you are currently covered by Bind, and your health care Provider leaves the network, you have the opportunity to apply for Continuity of Care. Continuity of Care Benefits, if approved, allow you to continue to see the out-of-network Provider while paying in-network copays until a safe transition can be made to an in-network Provider. As Add-In services must be with an in-network Provider, the Transition of Care benefit does not apply to Add-Ins.

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

- You are currently enrolled in Core and actively receiving care for a Covered Service and your Provider is no longer in-network; or
- You are newly eligible for Bind and currently receiving care for a Covered Service and your current Provider is not in-network.

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

- **Serious Acute Condition:** A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration such as a heart attack or stroke.
- **Scheduled Surgery/Procedure:** Surgery or another procedure which has been recommended and documented by the Provider and scheduled to take place within 120 days of the enrollee's Effective Date or Provider termination date and is authorized for continued care by Bind.
- **Pregnancy:** For Covered Persons in their second trimester of pregnancy extending through two months after giving birth, or if the pregnancy is considered high risk at any time.
- **Serious Chronic Condition:** A medical condition due to a disease, illness, or other medical problem or mental health disorder that is serious in nature and that persists without full cure or worsens over time or requires ongoing treatment to maintain remission or prevent deterioration.
- **Terminal Illness:** An incurable or irreversible condition that has a probability of causing death within one year or less. Coverage extends for the duration of the terminal illness.
- **Transplant:** A transplant recipient in need of ongoing care due to complications associated with the transplant.

To request an application for Transition of Care (new members) or Continuity of Care (existing members), call Bind Help at the member number on your Bind ID card. The application must be completed and returned within 30 days of the Effective Date of coverage for new members or within 30 days of the Provider leaving the network for existing members. After receiving your request, Bind will review and evaluate the information provided and send you a letter to let you know if your request was approved or denied. A denial will include information about how to appeal the determination.

6. What Is Not Covered

Core does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a Provider or are the only available treatment for your condition unless specifically described or listed in Section 5.1.

Add-Ins

1. Health care services listed as an Add-In in Section 5.3, are not covered in Core except for Emergency, trauma, or cancer-related services.

Alternative Treatments

2. Health care services ordered or rendered by Providers or para-professionals unlicensed by the appropriate regulatory agency.
3. Aromatherapy.
4. Hypnotism.
5. Massage therapy that is not Physical Therapy or prescribed by a licensed Provider as a component of a multi-modality rehabilitation treatment plan.
6. Rolfing.
7. Vocational therapy.
8. Homeopathic or naturopathic medicine, including dietary supplements.
9. Holistic medicine and services, including dietary supplements.
10. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.

Dental

11. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care required for the direct treatment of a medical condition.
12. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.
13. Endodontics, periodontal surgery, and restorative treatment are excluded.
14. Preventive care, diagnosis, treatment of or related to the teeth, jawbones, or gums.
15. Dental implants, bone grafts, and other implant-related procedures.
16. Dental braces (orthodontics).
17. Treatment of congenitally missing, malposition or supernumerary (extra) teeth, even if part of a congenital anomaly.

Devices, Appliances, Supplies and Prosthetics

18. Devices used specifically as safety items or to affect performance in sports-related activities.
19. Orthotic appliances and devices that straighten or re-shape a body part. Examples of excluded orthotic appliances and devices include but are not limited to some types of braces, arch supports, and include orthotic braces available over-the-counter.
20. Shoe inserts and orthotics, except as prescribed by a Provider for a Covered Person with diabetic foot disease.
21. Shoes, except as prescribed by a Provider for a Covered Person with diabetic foot disease. Limited to one (1) pair per Plan Year.
22. Cranial banding.
23. Repairs to prosthetic devices due to misuse, malicious damage, or gross neglect.
24. Replacement of prosthetic devices due to misuse, malicious damage, or gross neglect or to replace lost or stolen items.
25. Devices and computers to assist in communication and speech.
26. Oral appliances for snoring.
27. Home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits.
28. Over-the-counter medical equipment or supplies such as saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a prescription even if a prescription has been ordered.
29. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, diapers, incontinence supplies.
30. Supplies, equipment, and similar incidentals for personal comfort. Examples include air conditioners, air purifiers, humidifiers, recliners, exercise equipment, Jacuzzis, and vehicle modifications such as van lifts.
31. Communication aids or devices; equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication board, or computer or electronic assisted communication.
32. Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds.
33. Vehicle/car or van modifications including, but not limited to, handbrakes, hydraulic lifts, and car carrier.

Drugs

34. Charges for giving injections that can be self-administered.
35. Over-the-counter drugs, except as specified in Section 5.2 Prescription Drugs.

36. Investigative or non-FDA approved drugs.
37. Vitamin or dietary supplements, except as specified in Section 5.2 Prescription Drugs.
38. Non-prescription supplies.
39. Selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects.
40. Drugs dispensed by a Physician or Physician's office for outpatient use.
41. All non-Formulary drugs.

Experimental or Investigational or Unproven Services

42. Services that are considered Experimental or Investigational as determined by Bind are excluded. The fact that an Experimental or Investigational treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational in the treatment of that particular condition.

Foot Care

43. Routine foot care (except for standard diabetic foot care), examples include the cutting or removal of corns and calluses.
44. Hygienic and preventive maintenance foot care.

Gender Dysphoria Cosmetic Procedures

45. Cosmetic procedures related to a diagnosis of Gender Dysphoria including:
    a) Abdominoplasty
    b) Blepharoplasty
    c) Body contouring, such as lipoplasty or liposuction
    d) Breast augmentation, implants, and reconstruction
    e) Brow lift, face lift, forehead lift, or neck tightening
    f) Calf implants
    g) Cheek, chin, and nose implants
    h) Chondrolaryngoplasty
    i) Injection of fillers or neurotoxins
    j) Hair removal and transplantation
    k) Head width reduction
    l) Lip reduction and augmentation
    m) Mastopexy
    n) Skin resurfacing
    o) Voice modification surgery
    p) Voice lessons and voice therapy

Mental Health/Substance Use Disorder

46. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association*.
47. Intense Early Intervention Using Behavioral Therapy (IEIBT) and Lovaas.
48. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association*.
49. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.
50. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction, and learning.
51. Tuition for or services that are school based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
52. Outside of initial assessment, unspecified disorders for which the Provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association*.
53. Transitional living services.
54. Inpatient or intermediate or outpatient care services that were not pre-authorized.
55. Investigative therapies for treatment of autism.
56. Vagus nerve stimulator treatment for the treatment of depression and quantitative electroencephalogram treatment of behavioral health conditions.

Nutrition

57. Nutritional or Cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).
58. Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU).

Physical Appearance

59. Cosmetic Procedures such as:
    a) Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple
    b) Pharmacological regimens, nutritional procedures, or treatments
    c) Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)

d) Hair removal or replacement by any means
e) Treatments for skin wrinkles or any treatment to improve the appearance of the skin
f) Treatment for spider veins
g) Skin abrasion procedures performed as a treatment for acne
h) Treatments for hair loss
i) Varicose vein treatment of the lower extremities when it is considered Cosmetic

60. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
61. Reconstructive surgery where there is another more appropriate covered surgical procedure or when the proposed Reconstructive surgery offers minimal improvement in your appearance. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.
62. Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.
63. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.
64. Wigs (scalp/cranial hair prostheses) except for members with scalp/head wound, burns, injuries, alopecia areata, cancer, and undergoing chemotherapy or radiation therapy.

Procedures and Treatments

65. Treatment of benign gynecomastia (abnormal breast enlargement in males).
66. Biofeedback.
67. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
68. Rehabilitation services and manipulative treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
69. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.
70. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
71. Psychosurgery (e.g. lobotomy).
72. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care Providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

73. Chelation therapy, except to treat heavy metal poisoning.
74. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
75. Breast reduction surgery that is determined to be a Cosmetic procedure except as required by the Women's Health and Cancer Rights Act of 1998.
76. Elective abortion, except in situations where the life of Covered Person would be endangered if the fetus is carried to full term.

Providers

77. Services performed by a Provider who is a family member by birth or marriage, including your spouse, brother, sister, parent, or child. This includes any service the Provider may perform on himself or herself.
78. Services performed by a Provider with your same legal residence.
79. Services ordered or delivered by a Christian Science practitioner.
80. Services performed by an unlicensed Provider or a Provider who is operating outside of the scope of his/her license.

Reproduction

81. The following infertility treatment-related services:
    a) Investigational and Experimental procedures as outlined by The American College of Obstetricians and Gynecologists
    b) Donor services and non-medical costs of oocyte or sperm donation (e.g., donor agency fees).
    c) All costs associated with surrogate parenting including donor oocytes (eggs), donor sperm and host uterus; non-medical costs associated with a gestational carrier.
    d) Services for partner, spouses, and the maternity expenses of gestational carriers not insured by Bind
    e) Ovulation predictor kits.
    f) The reversal of voluntary sterilization.
    g) Multi-embryo implantation
    h) Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
    i) Cloning.
    j) Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
    k) Cryopreservation and storage is not covered unless it is embryo freezing and storage (up to 12 months) for embryos produced from one (1) cycle for a Covered Person who will undergo cancer treatment that is expected to render them infertile.

l) Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma.

Services Provided Under Another Plan

82. Services for which coverage is available:
    a) Under another medical plan, except for eligible expenses payable as described in this SPD.
    b) Under workers' compensation, or similar legislation if you could elect it, or could have it elected for you.
    c) Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
    d) While on active military duty.
    e) For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

83. Health services for transplants involving permanent mechanical or animal organs.
84. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Medical coverage.)

Travel

85. Health services provided in a foreign country, unless determined to be an Emergency.
86. Travel or transportation expenses, even if ordered by a Physician, except as identified under Ambulance and Transplant in Section 5.1.

Types of Care

87. Custodial Care.
88. Domiciliary Care.
89. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
90. Private Duty Nursing.
91. Respite care except as defined under Hospice Care in Section 5.1.
92. Rest cures.
93. Services of personal care attendants.
94. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision, Hearing and Voice

95. Implantable lenses used only to correct a refractive error, radial keratotomy or related procedure, and artificial retinal devices or retinal implants.
96. Routine eye exams, eyeglasses, contact lenses and any fittings associated with them except as identified in the Covered Services section above.
97. Refractive surgery (e.g. Lasik) for ophthalmic conditions that are correctable by contacts or glasses.
98. Bone anchored hearing aids except when either of the following applies:
    a) For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
    b) For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
    c) Bind will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in Bind. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.
99. Eye exercise or vision therapy.
100. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.
101. Any type of communicator, voice enhancement, voice prosthesis, electronic voice producing machine, or any other language assistive devices.

All Other Exclusions

102. Health care services that Bind determines are not Medically Necessary.
103. Autopsies and other coroner services and transportation services for a corpse.
104. Charges for:
    a) Missed appointments.
    b) Room or facility reservations.
    c) Completion of Claim forms.
    d) Record processing.
105. Charges prohibited by federal anti-kickback or self-referral statutes.
106. Over-the-counter self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.
107. Retail genetic tests direct to consumer.

108. Expenses for health services and supplies:
    a) That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
    b) That are received after the date your coverage ends, including health services for medical conditions which began before the date your coverage ends.
    c) For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under Bind.
    d) That exceed eligible expenses or any specified limitation in this SPD.
109. Foreign language and sign language services.
110. Long term (more than 30 days) storage of blood, umbilical cord, or other material.
111. Physical, psychiatric, or psychological exams, testing, all forms of vaccinations and immunizations or treatments when:
    a) Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage, or adoption; or as a result of incarceration.
    b) Conducted for purposes of medical research.
    c) Related to judicial or administrative proceedings or orders.
    d) Required to obtain or maintain a license of any type.

7. Claims Procedures

When you use in-network services, the Provider will generally collect your copay from you at the time of your treatment and send a Claim to the Plan for payment. Sometimes out-of-network Providers will do the same. Other times, out-of-network Providers may bill you for the total cost of your treatment, and you will need to submit the Claim to the Plan to be paid. Whether you pay out-of-pocket or your Provider bills the Plan directly, you are still entitled to the same Benefits.

If you receive a bill from your Provider (whether in-network or out-of-network) for the Plan's portion of the costs, or you pay for your medical care out-of-pocket and need to be reimbursed, you must submit a Claim to the Plan. This section summarizes the procedures you must follow to submit a Claim for payment, and the procedures the Plan will use to determine whether and how much to pay for that Claim.

If you would like more details about Claims procedures and your rights and responsibilities, contact Bind Help.

Regular Post-Service Claims

Post-service Claims are non-urgent Claims after you have received treatment. (Urgent care and concurrent care Claims have different timelines and requirements; see below.) Generally, you do not need to file a Claim for services from in-network Providers, the Provider will handle the filing of the Claim. For out-of-network Providers that do not file insurance Claims or if you receive Emergency care outside the United States and are seeking reimbursement from the Plan, you can submit a Claim using this procedure.

You can submit a post-service Claim by mail to the address on your ID card. You will need to provide several pieces of information for Bind to be able to process your Claim and determine the appropriate Plan Benefits:

- The name and birthdate of the Covered Person who received the care
- The member ID listed on the Bind ID card
- An itemized bill from your Provider, which should include:
  - The Provider's name, address, tax identification number, NPI number, and license number (if available)
  - The date(s) the Covered Person received care
  - The diagnosis and procedure codes for each service provided
  - The charges for each service provided
- Information about any other health coverage the Covered Person has
- Proof of payment may be requested to substantiate your Claim but is not required upon initial submission to Bind

Regular Post-Service Pharmacy Claims

Post-service Claims are non-urgent Claims after you have received a prescription. Generally, you do not need to file a Claim for services from in-network pharmacies, the pharmacy will handle the filing of the Claim. If you receive Emergency care outside the United States and are seeking reimbursement from the Plan, you can submit a Claim using this procedure.

Manual submission of Claims does not guarantee reimbursement. If the prescription drug(s) is non-Formulary or has Prior Authorization, step therapy, quantity limits requirements or is restricted in some other way, Navitus will make a coverage determination according to our coverage determination and exceptions process. Requests which require an exception to coverage should be submitted to Navitus for review.

You can submit a post-service Claim by mail or fax to Navitus:

Mail

Navitus Health Solutions, LLC
P.O. Box 999
Appleton, WI 54912-0999

Fax

(920)735-5315

You will need to provide several pieces of information for Navitus to be able to process your Claim and determine the appropriate Plan Benefits:

- Navitus manual Claims form. This can be obtained online: https://www.navitus.com/members/filing-a-claim
- The member ID listed on the ID card
- Copies of receipts showing proof of out-of-pocket payment
- Information about any other health coverage the Covered Person has
- Proof of payment may be requested to substantiate your Claim but is not required upon initial submission to Bind

Contact Bind Help if you have any questions on the items above.

Other General Claims Procedures

Your medical and/or pharmacy Claim must be submitted within one year from the date you received the healthcare services. If you are not capable of submitting a Claim within one year, you must submit the Claim as soon as reasonably possible. If your Claim relates to an inpatient stay, the date you were discharged counts as the date you received the healthcare service for Claims purposes.

Within 30 days of submitting your Claim, you will receive a decision. If we need more information on a Claim, we will reach out to you to provide that additional information, but we will still make a

decision on your Claim within 30 days. If you are able to submit the requested additional information after a decision has been made, we may adjust our decision and reprocess your Claim accordingly.

Claims for pharmacy Benefits will be reviewed by Navitus. Claims for medical (non-pharmacy) Benefits will be reviewed by Bind. If more time is needed to decide your Claim, we may request a one-time extension of not more than 15 days.

If your Claim is ultimately denied, you will receive an explanation of why it was denied and how you can appeal.

Urgent Care Claims

An urgent care Claim is a special type of Prior Authorization that occurs when a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. Because your Provider is the one who initiates Prior Authorization, it will usually be your Provider who will request expedited processing. Urgent care Claims will be decided within 72 hours after submission. Urgent care Claims filed improperly, or missing information may be denied.

If your urgent care Claim is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request expedited review).

Concurrent Care Claims

In some cases, you may have an ongoing course of treatment approved for a specific period of time or a specific number of treatments, and you will want to extend that course of treatment. This is called a concurrent care Claim.

If your extension request is not “urgent” (as defined in the previous section), your request will be considered a new request and will be decided according to the applicable procedures and timeframes. If your request for an extension is urgent you may request expedited processing.

8. What Do I Do If My Claim Is Denied?

If Your Claim is Denied

If a Claim for Benefits is denied in part or in whole, you may call Bind Help before requesting a formal appeal. If they cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

To submit an appeal:

1. Contact Bind Help to request an Appeal Filing Form or refer to the Appeal Filing Form included with your Explanation of Benefits
2. Complete the Appeal Filing Form
3. Submit the Appeal Filing Form and your denial notice to:

   Bind Benefits, Inc.
   PO Box 211758
   Eagan, MN 55121

Review of an Appeal

Bind will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

  Once the review is complete, if Bind upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal within 60 days from receipt of the first level appeal determination.

Bind will review your appeal and will notify you of its decision within 30 days of receipt.

Access to Relevant Documents

Upon written request and free of charge, any Covered Persons may examine their Claim and/or appeals file(s). Covered Persons may also submit evidence, opinions, and comments as part of the internal Claims review process. Bind will review all Claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the Claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Timing of Appeals Determinations

Separate schedules apply to the timing of Claims appeals, depending on the type of Claim. There are three types of Claims:

- **Urgent Care Request for Benefits:** A request for Benefits provided in connection with urgent care services.
- **Pre-Service Request for Benefits:** A request for Benefits which the Plan must approve or in which you must notify Bind before non-urgent care is provided.
- **Post-Service Request for Benefits:** A Claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Plan Administrator's decision letter to you.

The tables below describe the time frames which you and the Plan Administrator are required to follow.

Urgent Care Request for Benefits*

Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, Bind must notify you within:	**24 hours**
You must then provide completed request for Benefits to bind within:	**48 hours** after receiving notice of additional information required
Bind must notify you of the benefit determination within:	**72 hours**
If Bind denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
Bind must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*Follow the procedure for an Expedited Appeal provided in your denial of coverage letter.

Pre-Service Request for Benefits*

Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, Bind must notify you within:	**5 days**
If your request for Benefits is incomplete, Bind must notify you within:	**15 days**
You must then provide completed request for Benefits information to Bind within:	**45 days**
Bind must notify you of the benefit determination:	
• If the initial request for Benefits is complete, within:	**15 days**

Type of Request for Benefits or Appeal	Timing
• After receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
Bind must notify you of the first level appeal decision within:	**15 days** after receiving a complete first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
Bind must notify you of the second level appeal decision within:	**15 days** after receiving a complete second level appeal

*Bind may require a one-time extension for the initial Claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims

Type of Claim or Appeal	Timing
If your Claim is incomplete, Bind must notify you within:	**30 days**
You must then provide completed Claim information to Bind within:	**45 days**
Bind must notify you of the benefit determination:	
• If the initial Claim is complete, within:	**30 days**
• After receiving the completed Claim (if the initial Claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
Bind must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
Bind must notify You of the second level appeal decision within:	**30 days** after receiving the second level appeal

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Bind, or if Bind fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Bind's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling Bind Help or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received Bind's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). Bind has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by the Claims Administrator of the request.
- A referral of the request by the Claims Administrator to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, Bind will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that Bind may process the request.

After Bind completes the preliminary review, they will issue a notification in writing to you. If the request is eligible for external review, Bind will assign an IRO to conduct such review. Bind will assign requests by either rotating assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

Bind will provide to the assigned IRO the documents and information considered in making the determination. The documents include:

- All relevant medical records.
- All other documents relied upon by the Plan Administrator.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and Bind will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the Claim as new and not be bound by any decisions or conclusions reached by Bind. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and Bind, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing Bind’s determination, the Plan will immediately provide coverage or payment for the benefit Claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a Claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the

individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.

- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received Emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, Bind will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that Bind may process the request.

After Bind completes the review, Bind will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, Bind will assign an IRO in the same manner Bind utilizes to assign standard external reviews to IROs. Bind will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the Claim as new and not be bound by any decisions or conclusions reached by Bind. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to Bind.

You may contact Bind Help for more information regarding external review rights, or if making a verbal request for an expedited external review.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Bind will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according

to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against the Plan Administrator or Claim Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your Claim have been completed. If you want to bring a legal action against the Plan Administrator or Claim Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the Plan Administrator or Claim Administrator.

9. What are My Rights under ERISA?

Please refer to the Specialized Bicycle Components Health and Welfare Plan Wrap Summary Plan Description for explanation of your ERISA Rights.

10. Continuation of Coverage

Please refer to the Specialized Bicycle Components Health and Welfare Plan Wrap Summary Plan Description for an explanation of Continuation of Coverage: COBRA and USERRA

11. What Else Do I Need to Know?

11.1 Important Administrative Information

Name and Address of Plan	Specialized Bicycle Components Health and Welfare Plan 15130 Concord Circle Morgan Hill, CA 95037
Plan Sponsor's Employer Identification Number (EIN)	94-2441412
Plan Number	501
Plan Year	1/1/2020 through 12/31/2020
Agent for Service of Process	Service may be made on the Plan Administrator at the address listed below: Specialized Bicycle Component, Inc. 15130 Concord Circle Morgan Hill, CA 95037
Type of Plan	Welfare benefit Plan providing group health Benefits
Funding	This Plan is self-insured, meaning that Benefits are paid from the general assets of the Plan Sponsor and are not guaranteed under an insurance policy or contract. The Plan Sponsor determines the amount of employee contributions to the Plan, based on estimates of Claims and administrative costs.
Plan Administrator	Specialized Bicycle Component, Inc. 15130 Concord Circle Morgan Hill, CA 95037
Plan Sponsor	Specialized Bicycle Component, Inc.] 15130 Concord Circle Morgan Hill, CA 95037

11.2 Coordination of Benefits

When Coordination of Benefits Applies

Coordination of Benefits sets out rules for the order of payment of covered charges when two or more plans including Medicare are paying. When a Covered Person is covered by this Plan and one or more other plans, the plans will coordinate Benefits when a Claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable charge (defined below). A Covered Person will need to purchase Add-In Coverage for this Plan regardless of whether this Plan is paying as primary or subsequent.

Benefit Plan

This provision will coordinate the medical Benefits of a Plan. The term Benefit Plan means this Plan or any one of the following plans:

- Group or group type plans, including franchise or blanket benefit plans.

- Group practices and other group prepayment plans.
- Federal government plans or programs. This includes but is not limited to, Medicare and TRICARE.
- Other plans required or provided by law. This does not include Medicaid or any other legally required benefit plan that, by its terms, does not allow coordination.

Excess Insurance

If at the time of injury, illness, disease, or disability, there is available, or potentially available any coverage (including coverage resulting from a judgment at law or settlements), the Benefits under this Plan shall apply only as an excess over such other sources of coverage. The Plan's Benefits will be in excess to, whenever possible:

- Any primary payer besides the Plan;
- Any first party insurance through medical payment coverage, personal injury protection, no-fault auto insurance coverage, uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Workers' compensation or other liability insurance company; or
- Any other source, including crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Allowable Charge

For a charge to be "allowable" it must not exceed the Usual and Customary charge for any Medically Necessary, reasonable, and eligible item of expense, and at least part of which is covered under this Plan ("Allowable Charge").

This Plan will not consider any charges in excess of what an in-network Provider has agreed to accept as payment in full. Also, when an HMO (Health Maintenance Organization) or other in-network only plan is primary and the Covered Person does not use an HMO or network Provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network Health Care Provider.

Other Coverage

When medical payments are available under other coverage, this Plan shall always be considered secondary to such plans and/or policies. Other coverage shall include, but is not limited to:

- Any primary payer besides the Plan;
- Any other group health plan;
- Any other coverage or policy covering the Covered Person;
- Any first party insurance through medical payment coverage, personal injury protection, no-fault auto insurance coverage, uninsured or underinsured motorist coverage;

- Any policy of insurance from any insurance company or guarantor of a responsible party;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Workers' compensation or other liability insurance company; or
- Any other source Including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Benefit Plan Payment Order

When two or more benefit plans provide benefits for the same allowable charge, benefit payment will follow these rules.

- Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- Plans with a coordination provision will pay their benefits up to the allowable charge:
  - The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan, which covers the person as a dependent ("Plan B").
  - The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
  - The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
  - When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:
    - The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
    - If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
  - When a child's parents are divorced or legally separated, these rules will apply:
    - This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
    - This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the

stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.

- This rule will be in place of above items when it applies. A court decree may state which parent is financially responsible for medical benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.
- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.
- For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
- If there is still a conflict after these rules have been applied, the benefit plan which has covered the person for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

- Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
- If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first, and this Plan will pay second.
- The Plan will pay primary to Tricare to the extent required by federal law.

Claims Determination Period

Benefits will be coordinated on a Plan Year basis. This is called the Claims determination period.

Right to Receive or Release Necessary Information

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. Each and every Covered Person hereby authorizes the Plan to give or obtain any medical or other personal information reasonably necessary to apply these provisions. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery

Whenever payments have been made by this Plan with respect to allowable charges in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine:

- Any person to or with respect to whom such payments were made, or such person's legal representative;
- Any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such allowable charges; and
- Any future Benefits payable to the Covered Persons.

Medicaid Coverage

A Covered Person's eligibility for any State Medicaid Benefits will not be taken into account in determining or making any payments for Benefits to or on behalf of such Covered Person. Any such benefit payment will be subject to the State's right to reimbursement for Benefits it has paid on behalf of the Covered Person, as required by the State Medicaid program; and the Plan will honor any subrogation rights the State may have with respect to Benefits which are payable under the Plan.

Worker's Compensation

Coverage under this Plan is not in lieu of worker's compensation.

11.3 Subrogation, Overpayment and Reimbursement

Subrogation and Refund

A Covered Person may incur medical expenses due to illness or injuries that may be caused by the act or omission of a Third Party. Also, a Third Party (such as an insurance company) may be responsible for payment on account of the actions of another person or entity. In such circumstances, the Covered Person may have a Claim against the Third Party for payment of medical expenses. Accepting Benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any rights the Covered Person may have to Recoveries from any Third Party up to the full amount of such Benefits. This Subrogation right allows the Plan to pursue any Claim that the Covered Person has against any Third Party, whether or not the Covered Person chooses to pursue that Claim. The Plan may make a Claim directly against the Third Party, but in any event, the Plan has an equitable lien on any amount of the Recovery of the Covered Person whether or not designated as payment for medical expenses. In addition, each Covered Person agrees to hold Recoveries in a constructive trust for the benefit of the Plan. The equitable lien and constructive trust shall remain in effect until the Plan is repaid in full. In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor Claim is asserted against a Third Party, the Plan's Subrogation and Refund rights shall still apply.

Assignment of Interest and Plan's Recovery Right

The Covered Person:

- Automatically assigns to the Plan his or her rights against any Third Party when this provision applies; and
- Must repay to the Plan the Benefits paid on his or her behalf out of any Recovery.

Each Covered Person is individually obligated to comply with the provisions of this section. When a Covered Person receives or claims Plan Benefits for an illness or injury caused by another, the Covered Person agrees to immediately reimburse the Plan from any Recovery for Benefits paid out by the Plan.

Make Whole and Common Fund Doctrines Inapplicable

This Plan expressly disavows and repudiates the make whole doctrine, which, if applicable, would prevent the Plan from receiving a Recovery unless a Covered Person has been "made whole" with regard to illness or injury that is the responsibility of a Third Party. This Plan also expressly disavows and repudiates the common fund doctrine, which, if applicable, would require the Plan to pay a portion of the attorney fees and costs expended in obtaining a Recovery. These doctrines have no application to this Plan since the Plan's Refund rights apply to the first dollars payable by a Third Party.

Duty to Cooperate

Covered Persons are required to cooperate with the Plan Administrator to effectuate the terms of this section. Specifically, it is the Covered Person's obligation at all times, both prior to and after payment of medical Benefits by the Plan:

- To cooperate with the Plan, or any representatives of the Plan, in protecting the Plan's rights, including discovery, attending depositions, and/or cooperating at trial;
- To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information, and any other requested additional information;
- To take such action and execute such documents as the Plan may require to facilitate enforcement of its Subrogation and reimbursement rights;
- To do nothing to prejudice the Plan's rights of Subrogation and Refund;
- To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received; and
- To not settle or release, without the prior consent of the Plan, any Claim to the extent that the Covered Person may have Recovery rights against any Third Party.

If the Covered Person and/or his or her attorney fails to reimburse the Plan for all Benefits paid or to be paid from any Recovery, the Covered Person will be responsible for any and all expenses

(including attorney fees and costs) associated with the Plan's attempt to recover such money from the Covered Person or a Third Party.

Conditions Precedent to Coverage

The Plan shall have no obligation whatsoever to pay medical Benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's Subrogation and Refund rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its Subrogation and Refund rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical Benefits incurred on account of injury or illness caused by a Third Party until after the Covered Person or his or her authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first-dollar Subrogation and Refund rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Offset

Failure by a Covered Person and/or his or her attorney to comply with any of the requirements described in this section may, at the Plan's discretion, result in a forfeiture of payment by the Plan of future medical Benefits, and any funds or Benefits otherwise payable under this Plan to or on behalf of the Covered Person may be withheld until the Covered Person satisfies his or her obligation.

Defined Terms

The following terms have special meanings for purposes of this section:

- "Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid by a Third Party to, or on behalf of, a Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by an injury or illness, whether or not said monies are characterized as medical expenses covered by the Plan. "Recoveries" includes, but is not limited to, recoveries for medical expenses, attorney's fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages, and any other recovery of any form of damages or compensation whatsoever.
- "Refund" means repayment to the Plan for medical Benefits that the Plan has paid toward care and treatment of an Injury or Illness suffered by a Covered Person as the result of acts or omissions of a Third Party. This right of Refund includes Recoveries by a Covered Person under an uninsured or underinsured motorist insurance policy, homeowner's policy, renter's policy, medical malpractice policy, or any liability insurance policy (each of which will be treated as Third Party coverage under this Article).
- "Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's Claims for medical expenses against the other person.
- "Third Party" means any individual or entity (including an insurance company) who is legally obligated to pay a Recovery to, or on behalf of, a Covered Person.

Erroneous Payments

To the extent payments made by this Plan with respect to a Covered Person are in excess of the maximum amount of payment necessary under the terms of the Plan, the Plan shall have the right to recover such payments, to the extent of such excess from any one or more of the following sources, as this Plan shall determine any person to or with respect to whom such payments are made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are either responsible for payment or received payment in error, and any future Benefits payable to the Covered Person.

Excess Insurance

Except as otherwise provided under the Plan's Coordination of Benefits section, the following rule applies:

- If there is available, or potentially available, any coverage (including coverage resulting from a judgment at law or settlements), the Benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.
- The Plan's Benefits shall be excess to:
  - The responsible party, its insurer, or any other sources on behalf of that party;
  - Any first party insurance through medical payment coverage, personal injury protection, no-fault auto insurance coverage, uninsured or underinsured motorist coverage;
  - Any policy of insurance from any insurance company or guarantor of a third party;
  - Worker's compensation or other liability insurance company; or
  - Any other source, including crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to Subrogation and reimbursement.

Severability

In the event that any provision of this section is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this section and Plan. The provision shall be fully severable. The Plan shall be construed, and provisions enforced as if such invalid or illegal provision had never been inserted in the Plan.

11.4 Plan Administrator's Responsibilities

Specialized Bicycle Components, Inc is the sponsor of this benefit Plan of Specialized Bicycle Components, Inc. The Plan Administrator is Specialized Bicycle Components, Inc. The Plan must be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or a committee may be appointed by Specialized Bicycle Components, Inc to act on its behalf as the Plan Administrator.

The Plan Administrator will have the powers and duties of the general administration of this Plan, including the following:

- To administer the Plan in accordance with its terms;
- Interpret this SPD;
- Develop policies, practices, and procedures for this Plan; and
- Administer the Plan in accordance with those policies, practices, and procedures.

The Plan Administrator will exercise its discretion and fulfill its responsibilities in accordance with the provisions of ERISA. The Plan Administrator may delegate some of its responsibilities to Bind or to the individuals or entities as appropriate. Bind may make fiduciary decisions in its role as Claims Administrator, including but not limited to, developing, interpreting and relying upon policies, practices and procedures for the administration of this Plan, but is not generally designated as an ERISA fiduciary, and is not financially responsible for Claims.

The Plan Administrator serves without compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

11.5 Other Information About Your Plan

Non-Discrimination Policy

Please refer to the Specialized Bicycle Components Health and Welfare Plan Wrap Summary Plan Description for an explanation.

Mental Health Parity

Please refer to the Specialized Bicycle Components Health and Welfare Plan Wrap Summary Plan Description for an explanation.

Newborns' and Mothers' Health Protection Act (NMHPA)

Please refer to the Specialized Bicycle Components Health and Welfare Plan Wrap Summary Plan Description for an explanation.

Qualified Medical Child Support Order Procedures

Please refer to the Specialized Bicycle Components Health and Welfare Plan Wrap Summary Plan Description for an explanation.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

Please refer to the Specialized Bicycle Components Health and Welfare Plan Wrap Summary Plan Description for an explanation.

Genetic Information Nondiscrimination Act of 2008 (GINA)

Please refer to the Specialized Bicycle Components Health and Welfare Plan Wrap Summary Plan Description for an explanation.

12. Glossary

Add-In(s)	The coverages that a Covered Person may enroll in in addition to the Core Benefits.
Adverse Health Factor	A new or deteriorating health or medical condition that coincides with the treatment(s) described in a specific Add-In (in Section 5.3), and to which you must self-attest that you have as part of the process to purchase Add-In Benefits.
Autism Spectrum Disorder	A range of complex neurodevelopmental disorders, characterized by persistent deficits in social communication and interaction across multiple contexts, restricted repetitive patterns of behavior, interests, or activities, symptoms that are present in the early development period that cause clinically significant impairment in social, occupational, or other important areas of functioning and are not better explained by intellectual disability or global developmental delay. Such disorders are determined by criteria set forth in the most recent edition of the *Diagnostic* and Statistical Manual of Mental Disorders by the American Psychiatric Association.
Benefits	The health care services covered under Core and/or Add-In approved by the Plan Administrator as Covered Services, as explained in this SPD and any amendments.
Claim	A request for Benefits made by a Covered Person or his/her authorized representative in accordance with the procedures described in this SPD. It includes Prior Authorization requests.
Claim Administrator	Also known as a third-party administrator, or TPA, provides administrative services to the Plan Administrator in connection with the operation of the Plan, including processing of Claims, as may be delegated to it.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 as amended from time to time.
Continuity of Care	The option for existing members to request continued care from their current health care professional if he or she is no longer working with their health Plan and is now considered out-of-network.
Core	The Core Benefits that all Covered Persons have under the Bind Plan.
Cosmetic	Services, medications, and procedures that improve physical appearance but do not correct or improve a physiological function or are not Medically Necessary.
Covered Person	The person who is enrolled in Core, and eligible for Add-Ins, under the eligibility rules in Section 3.
Covered Service	Health care services that are provided by your Provider or clinic and are covered by Core or Add-Ins subject to all of the terms, conditions, limitations, and exclusions.
Custodial Care	Services to assist in activities of daily living and personal care that do not seek to cure or do not need to be provided or directed by a skilled medical professional, such as assistance in walking, bathing, and feeding.
Domiciliary Care	Living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.
Effective Date	The date your coverage under this SPD is effective, which depends on the date that you timely complete all applicable enrollment requirements imposed by the Plan Administrator.
Eligible Charge	A charge for health care services, subject to all of the terms, conditions, limitations and exclusions of Core and Add-Ins for which Bind, or Covered Person will pay.

Emergency	The sudden onset or change of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in: 1. Placing the Covered Person's health in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
ERISA	The Employee Retirement Income Security Act of 1974 as amended from time to time.
E-Visit and Telephone Visit with Physician	Care provided by designated participating Providers performed without physical face to face interaction, but through electronic (including telephonic) communication allowing evaluation, assessment and the management of health care services that leads to a treatment plan provided by a participating Provider who is a licensed Physician or a participating Provider who is a qualified licensed health care professional.
Explanation of Benefits (EOB)	The EOB provides details about a Claim and explains what portion was paid to the Provider and what portion (if any) is the Covered Person's responsibility. The EOB is not a bill.
Formulary	A list, which may change from time to time, of preferential prescription drugs that is used by the health Plan.
Investigative / Experimental Treatment	A procedure, study, test, drug, or equipment will be considered Experimental and/or Investigational if it is not subject to a Bind Coverage with Evidence Development Policy and any of the following criteria/guidelines is met: • It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose, or effectiveness in comparison to conventional treatments. • It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS). • Other facilities/Providers/etc. studying substantially the same drug, device, medical treatment, or procedure refer to it as Experimental or as a research project, a study, an invention, a test, a trial, or other words of similar effect. • The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings. • It is not Experimental or investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy). • It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use. • It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA. • It is the subject of an ongoing Clinical Trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS). • It is being used for off-label therapies for a non-indicated condition – even if FDA approve for another condition.
Medically Necessary / Medical Necessity	A health care service is deemed Medically Necessary when it is delivered or supervised by a licensed healthcare Provider according to the current standard of care, and is generally considered safe and effective for the prevention, diagnosis, or treatment of a covered health condition, as indicated by it being: • Supported by two or more high-quality clinical trials published in peer-reviewed journals • Consistent with clinical guidelines generally accepted in practice

	• Clinically appropriate – type, frequency, extent, and duration of service must be appropriate for you as an individual • Cost effective – services must not be more costly than alternative services that are at least as likely to produce equivalent therapeutic and diagnostic results • Or subject to a Bind Coverage with Evidence Development Policy Bind ensures Medical Necessity through Utilization Management processes.
Observation Stay	Observation care consists of evaluation, treatment and monitoring services (beyond the scope of the usual outpatient care episode) that are reasonable and necessary to determine whether the patient will require further treatment as an inpatient or can be discharged from the hospital.
Open Enrollment	A period of time where eligible persons are able to enroll, disenroll, and make Plan changes without a Life Status Change or Adverse Health Factor.
Payroll Deductions	Premiums for Core and Add-In Benefits are paid by reducing the Covered Person's pay, typically on a pre-tax basis, as allowed by the IRS guidelines.
Pharmacy Benefit Manager (PBM)	A Third-Party Administrator of prescription drug programs for commercial health plans and self-insured employer plans. Navitus is the PBM for Bind.
Physician	Any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law. Any podiatrist, dentist, psychologist, chiropractor, optometrist or other Provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a Provider is described as a Physician does not mean that Benefits for services from that Provider are available to you under the health Plan.
Plan Administrator	The entity, as defined under Section (3)(16) of ERISA, that has the exclusive, final and binding discretionary authority to administer the Plan, to make factual determinations, to construe and interpret the terms of the SPD, Plan, and amendments (including ambiguous terms), and to interpret, review and determine the availability or denial of Benefits. The Plan Administrator may delegate discretionary authority and may employ or contract with individuals or entities to perform day-to-day functions, such as processing Claims and performing other Plan-connected administrative services.
Plan Sponsor	The entity that establishes and maintains the Plan, has the authority to amend and/or terminate the Plan and is responsible for providing funds for the payment of Benefits.
Plan Year	The period following the Effective Date of the Plan and each subsequent period (generally 12 months) this Plan remains in force.
Pre-Admission Notification	Process whereby the Provider or you inform the Plan that you will be admitted to the inpatient hospital, Skilled Nursing Facility, long term acute care facility, inpatient rehabilitation facility, partial hospitalization, or Residential Treatment Facility. This notice is required in advance of being admitted for inpatient care for any type of non-Emergency admission and for partial hospitalization. All contracted facilities are required to provide Pre-Admission Notification.
Prior Authorization	Pre-service benefit coverage decision for a service, procedure or test that has been subject to an evidence-based review resulting in a Medical Necessity determination.

Private Duty Nursing	Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true: • No skilled services are identified. • Skilled nursing resources are available in the facility. • The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose. The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.
Provider	A health care professional, Physician, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide health care services to you. The term "Provider" refers to an in-network Provider unless specified otherwise.
Reconstructive	Surgery to restore or correct: • A defective body part when such defect is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved body part; or • A congenital disease or anomaly which has resulted in a functional defect as determined by a Physician; or • A physical defect that directly adversely affects the physical health of a body part, and the restoration or correction is determined by the Claim Administrator to be Medically Necessary.
Residential Treatment Facility	A facility that is licensed by the appropriate state agency and provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, or treatment for sickness related to mental health and substance use related disorders.
Shared Savings Program	A program in which the network partner may obtain a discount to a non-network Provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-network Provider. When this happens, you may experience lower out-of-pocket amounts. Plan copays would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by the network partner. In this case the non-network Provider may bill you for the difference between the billed amount and the rate determined by the network partner. If this happens you should call the number on your medical ID Card. Shared Savings Program Providers are not network Providers and are not credentialed by the network partner.
Skilled Nursing Facility	A Medicare licensed bed or facility (including an extended care facility, a long-term acute care facility, a hospital swing-bed, and a transitional care unit) that provides skilled care.
Specialist	Providers other than those practicing in the areas of family practice, general practice, internal medicine, OB/GYN or pediatrics.
Specialty Drugs	Injectable and non-injectable prescription drugs, as determined by the Claim Administrator, which have one or more of the following key characteristics: • Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes; • Intensive patient training and compliance assistance are required to facilitate therapeutic goals; • There is limited or exclusive product availability and/or distribution; • There are specialized product handling and/or administration requirements; or • Are produced by living organisms or their products.
Summary Plan Description (SPD)	The document describing, among other things, the Benefits offered under the Specialized Bicycle Components Health and Welfare Plan and your rights and obligations under such benefit option as required by ERISA.

Transition of Care	The option for a new member to request coverage from your current, out-of-network health care professional at in-network rates for a limited time due to a specific medical condition, until the safe transfer to an in-network health care professional can be arranged.
Usual and Customary	The amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service. The Usual and Customary amount is used to determine the amount that may be charged by a Provider for the Benefits.
Utilization Management	Utilization Management processes are conducted by Bind to ensure that certain services are Medically Necessary. Utilization Management processes include clinical, medical, and pharmacy policy management, pre-service review (e.g., Prior Authorization), concurrent review (e.g., during a hospital stay), and post-service review (review of Claims to ensure services were Medically Necessary).