BAE Systems, Inc. Medical Benefits
Copay Plan

Administered by Cigna

Summary Plan Description (SPD)

Electronic Systems (AI4, CAS, CAU, CS1, CS2, CSU, IE1, IE6, IS4, RS1)

INC Headquarters (NA1)

International Assignments (IA1)

Platforms & Services (LA2, LAN, LAR, LAU, LLU, LMP, LSU, LYK, LYU, MPP, RDS, RDU, ROD, SD01, SD02, SD03, SD05, SE1, SE2, SE3, SN01, SN02)

Shared Services (COE, ESS, HRF)

Space & Mission Systems (BAL, GFL)

Issued Date: 2024
SPD #: 0277

Introduction

This Summary Plan Description (SPD) describes certain benefits provided by BAE Systems, Inc. ("BAE Systems" or "the company") under the BAE Systems Funded Welfare Benefit Plan (the "Funded Plan"), the BAE Systems Unfunded Welfare Benefit Plan (the "Unfunded Plan") and the BAE Systems Retiree Welfare Benefit Plan (the "Retiree Plan") (the "BAE Plans"). This booklet applies to you if you are an eligible employee, as described in the BAE Systems, Inc. eligibility provisions of a participating BAE Systems company ("Employer") enrolled in a benefit option under a BAE Plan on or after the applicable effective date of this SPD.

This document does not apply to you if you are eligible for the BAE Systems, Inc. Retiree Health Reimbursement Account Plan (the "Retiree HRA Benefit"), a component plan of the Retiree Plan. Any retiree benefits described in this document refer to retiree benefits under the Retiree Plan for participants covered under certain collective bargaining agreements. This document does not describe the Retiree HRA Benefit. Please contact the BAE Systems Benefit Center at 1-888-900-4223 for additional information about the Retiree HRA Benefit.

The information presented in this SPD is only a summary and does not include all of the specific details of the BAE Plans. The applicable Plan Documents, as defined below, remain the final authority in determining eligibility and benefits under each BAE Plan. The Plan Documents also govern the administration of the plans and payment of benefits. In the case of a dispute, the information in the Plan Documents will control to the extent permitted by law. If any oral or written representations made by any BAE Systems representative conflict with this SPD or the Plan Documents, the SPD and Plan Documents will control and take the place of any prior oral or written communication on the subject of the benefit. If there is a conflict between this SPD and the Plan Documents, the Plan Documents control.

For the Funded Plan, the Plan Documents consist of the Funded Plan document (including all articles and appendices), as well as the Welfare Program Documents for the Welfare Programs incorporated within the Plan Document. A Welfare Program Document means a written arrangement, including any contract between an Employer and an insurance company, health maintenance organization, administrative service organization or other similar organization to provide benefits, a plan document or other written instrument under which a Welfare Program is established and operated.

For the Unfunded Plan, the Plan Documents consist of the Unfunded Plan document (including all articles and appendices), as well as the Welfare Program Documents for the Welfare Programs incorporated within the Plan document, such as insurance contracts and contracts with administrative service organizations.

For the Retiree Plan, the Plan Documents consist of the Retiree Plan document (including all articles and appendices), as well as the Welfare Program Documents for the Welfare Programs incorporated within the Plan document, such as insurance contracts and contracts with administrative service organizations.

For specific eligibility requirements, benefits, terms, conditions, limitations and provisions that govern each BAE Plan, and that are not contained in this SPD, refer to the applicable Plan Documents, contact the Claims Administrator (the insurance company, third party administrator or other entity designated by the Plan Administrator to determine eligibility and availability and/or pay claims for benefits under the plan) or call the Benefit Center at 1-888-900-4223.

The current electronic version of the SPD, which can be found at https://benefitsnavigator.baesystems.com, represents the official legal SPD under ERISA for the BAE Plans described here and controls over any other printed, electronic or copied version of this SPD that is not identical to it in all respects. This electronic SPD is subject to revision by BAE Systems from time to time in its sole discretion. This SPD is effective as of January 1, 2024. For a summary of plan provisions applicable before January 1, 2024, consult your prior SPD.

It is important for you to read this SPD to understand what is covered under the plan, when you are entitled to this benefit and the extent of your coverage. When you join the plan, you (and your dependents and beneficiaries who receive coverage or benefits under the plan) agree to accept the plan as it is today or as it may be amended in the future.

If you have difficulty understanding this benefit description in English, we will provide you with translation assistance. If you need assistance or have any questions after reading this SPD, contact the Benefit Center at 1-888-900-4223 (within the U.S.) or 1-718-354-1341 (outside the U.S.).

Si tiene dificultades para entender esta descripción beneficio en inglés, le proporcionará ayuda en la traducción. Si usted necesita ayuda o tiene alguna pregunta después de leer este SPD, póngase en contacto con el Centro de Beneficio al 1-888-900-4223 (en los EE. UU.) o 1-718-354-1341 (fuera de los EE. UU.).

The information contained in this document is intended to meet the federal disclosure requirements for SPDs of welfare benefit plans. This booklet does not create a contractual right to employment or continued employment by BAE Systems (all employment is “at will”) or create other legal or equitable rights not specifically set out in this SPD.

BAE Systems, Inc. (including its divisions or subsidiaries) intends to continue the BAE Plans indefinitely. However, BAE Systems reserves the right to amend, terminate or suspend all or part of the BAE Plans at any time and for any reason. In addition, BAE Systems reserves the right to change insurers, administrators, benefits or costs at any time and for any reason. An amendment, termination or suspension may occur without the consent of and without prior notice to any active or former employee, participant or dependent.

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How the Medical Plan Works

This medical plan option provided by BAE Systems, Inc. ("BAE Systems" or the "Company") under the BAE Systems Funded Welfare Benefit Plan (the "Funded Plan") and the BAE Systems Retiree Welfare Benefit Plan ("the Retiree Plan") (the "BAE Plans") provides coverage for a broad range of medical services and supplies. This section describes how the medical plan options under the BAE Plans work.

Note: *Any dependent child born while you are covered under this plan is covered on the date of his/her birth if you elect dependent coverage no later than 31 days after the birth. If you do not elect to cover your newborn child within 31 days, coverage for that child will end 48 hours after a vaginal delivery or 96 hours after a caesarian section. The plan will not pay benefits for any expenses incurred beyond these timeframes for the child.*

Providers

The plan provides you with access to a network of providers, including primary care physicians, specialists, hospitals, clinics, labs, etc., that have agreed to provide services to participants at lower, negotiated rates. A participating provider has a direct or indirect contractual arrangement with the Claims Administrator to provide services and/or supplies for covered expense charges. You and your covered dependents must use network providers for expenses to be covered under the plan. However, out-of-network provider care is covered in limited instances as describe in the ***Out-of-Network Providers*** section.

When you use an in-network provider, your provider files claims for you and is responsible for getting any preauthorization required.

To determine if your physician, hospital or other health care provider is in the network, contact the Claims Administrator as listed in the ***Your Summary of Benefits*** section.

Primary Care Physicians

This plan does not require you to select a primary care physician to receive plan benefits. However, a primary care physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your dependents. For this reason, you and your dependents have the opportunity to select a primary care physician from a list provided by the Claims Administrator. If you select a primary care physician, the primary care physician you select for yourself may be different from the primary care physician you select for each of your dependents.

Referrals

You can see any qualified provider; no referrals are required.

Out-of-Network Providers

In general, the plan does not provide benefits if you use an out-of-network provider. However, this does not apply if:

- You are receiving emergency or urgent care; or
- Your network provider determines that your condition requires special care that is not available within the network, in which case the Claims Administrator may approve benefits to be paid at the in-network level.

When you use an out-of-network provider, payments are based on the maximum reimbursable charge. The provider may bill you for the difference between the provider's normal charge and the maximum reimbursable charge, in addition to any cost sharing you are responsible for paying (see the ***Your Rights and Protections Against Surprise Medical Bills*** section for additional information).

See the ***Your Summary of Benefits*** section for more specific coverage details.

Maximum Reimbursable Charge

The maximum reimbursable charge is determined based on the lesser of:

- A provider's normal charge for a similar service or supply; or
- A percentage of a schedule that is based on a methodology similar to a methodology used by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule is not used and the maximum reimbursable charge for covered services is determined by the provider's contract.

Note: *Some providers forgive or waive your cost share obligation (e.g., a deductible or coinsurance) that this plan may require you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan. For more details, see the* ***Exclusions and Limitations*** *section.*

Cost Sharing

For most covered health care services, other than preventive care services, you and the plan share the cost. What you pay is explained below and detailed in the ***Your Summary of Benefits*** section.

Note: *The following provides a general overview of some features that may apply to this plan. Refer to the* ***Your Summary of Benefits****,* ***Covered Expenses*** *and* ***Exclusions and Limitations*** *sections for specific information about what is and what is not covered under this plan.*

Premium Contributions

As an employee, your premium contribution is the amount that you authorize BAE Systems to deduct from your pay each pay period to cover your portion of the cost of medical coverage. The contribution required for participation in your medical option appears on Benefits Navigator and may vary from year to year.

If you are a retiree, your premium contribution is the amount you are responsible for paying to cover your portion of the cost of medical coverage. This contribution is not paid on a pre-tax basis. You will be notified of the amount, which may vary from year to year.

Copays

A copayment, or copay, is a flat dollar amount you pay at the time of service, such as an in-network provider office visit or emergency room visit. Generally, once you pay your copayment, the plan pays the remainder of the cost. For more copay information, see the ***Your Summary of Benefits*** section.

Note: *Copayments apply toward any out-of-pocket maximums, but do not apply toward your deductible.*

Deductibles

A deductible is an amount of covered expenses that you or your dependent must pay each year before the plan begins to pay for most covered expenses.

Once the deductible is met, no further deductibles are required for the rest of the year and most covered expenses are paid at the plan's coinsurance. There are individual and family deductibles:

- An individual **deductible** is the amount of covered expenses that you must pay each year before the plan begins to pay for most covered expenses. If you are the only individual covered under the plan, the individual deductible amount applies. If you cover any dependents under the plan, the family deductible amount applies.

- A family **deductible** is the amount of covered expenses that all covered family members combined must pay each year before the plan begins to pay for most covered expenses. The plan has an embedded individual deductible within the family deductible. If any one family member meets the individual deductible, the plan begins to pay for most covered expenses for that individual at the plan's coinsurance. No one individual can contribute more than the individual deductible amount to the family deductible.

The deductible does not apply to in-network preventive care services, which are covered at 100%.

Coinsurance

You and the plan share the cost of most covered services. Coinsurance is the percentage of the cost that you pay for covered charges, after any required deductible.

The coinsurance percentage you pay varies depending on the type of service provided. Coinsurance payments are based on the negotiated rate for in-network providers and the maximum reimbursable charge for out-of-network providers.

Certain limitations may apply to specific benefits, such as:

- **Assistant Surgeon:** The maximum amount paid for an assistant surgeon is limited to a percentage of the surgeon's allowable charge (as specified in the Claims Administrator's reimbursement polices), which is the amount payable to the surgeon before any cost sharing is applied.

- **Co-Surgeon:** The maximum amount paid for a co-surgeon is limited to a percentage of the surgeon's allowable charge (as specified in the Claims Administrator's reimbursement policies). For this limitation, the allowable charge is the amount payable to the surgeon before any cost-sharing is applied.

Note: *Multiple surgeries performed during one operating session will result in a payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.*

Out-of-Pocket Maximum

An annual out-of-pocket maximum limits what you pay out of pocket each year; protecting you and your family from unusually high costs for your health care during a year. Once the annual out-of-pocket maximum is met, the plan generally pays 100% of eligible expenses for the remainder of the year. There are individual and family maximums:

- An individual **annual out-of-pocket maximum** limits the out-of-pocket amount that any one covered person must pay each year. If you are the only individual covered under the plan, the individual out-of-pocket maximum applies. If you cover any dependents under the plan, the family annual out-of-pocket maximum applies.

- A family **annual out-of-pocket maximum** limits the out-of-pocket amount that all covered family members combined must pay each year. The plan has an embedded individual annual out-of-pocket maximum within the family annual out-of-pocket maximum. If any one family member meets the individual annual out-of-pocket maximum, the plan generally pays 100% of eligible expenses for that individual for the remainder of the year. No one individual can contribute more than the individual annual out-of-pocket amount to the family annual out-of-pocket amount. All combined family members collectively will not go over the family annual out-of-pocket maximum.

Amounts that apply toward meeting the out-of-pocket maximum include amounts you pay towards deductibles, copayments, coinsurance and amounts you pay for prescription drug expenses. Certain amounts do not apply toward meeting the out-of-pocket maximum, and you are responsible for these amounts even after you meet the maximum, including any health care expense that this plan does not cover, non-compliance penalties and charges in excess of the maximum reimbursable charge.

Benefit Maximums

The plan may have maximum amounts it will pay per person for certain medical benefits, as follows:

- An **annual** maximum is the maximum the plan will pay per person (or collectively for family coverage) for a particular benefit during a plan year.

- A **lifetime** maximum is the maximum the plan will pay per person for a particular benefit during an individual's lifetime.

The ***Your Summary of Benefits*** section provides information on any annual and/or lifetime maximums.

The plan does not impose any overall lifetime maximum on essential health benefits. Any annual or lifetime maximum complies with the Patient Protection and Affordable Care Act.

Preventive Care Services

The plan includes coverage for wellness services for men, women and children to help keep you well, rather than just provide coverage for an illness or injury. Covered preventive care services include:

- Evidence-based items or services that have a rating of "A" or "B" in the United States Preventive Services Task Force current recommendations;

- Immunizations that have a recommendation from the Advisory Committee on Immunization Practices (for additional information on immunizations, visit www.cdc.gov);

- The American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;

- The Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and

- For women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

Detailed information is available at www.healthcare.gov/coverage/preventive-care-benefits. This is general information and does not guarantee coverage for these preventive services. Always discuss your preventive care needs with your doctor. Your doctor will determine the tests that are right for you based on your age, gender and family history.

Immunizations for travel are generally not covered. Other non-covered services may include any medical service or device that is not medically necessary and any services and supplies for or in connection with experimental, investigational or unproven services.

The plan pays the entire cost of preventive care services.

Emergency Services

Emergency services are covered without any prior authorization. Emergency services are those provided for a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services may include:

- A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and
- Further medical examination and treatment, to the extent within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Preauthorization

Preauthorization determines if a service, treatment, supply or facility is medically necessary (or appropriate) for the care and treatment of an illness or injury. It also lets you know what benefits, if any, are payable under the plan.

Certain types of treatment, such as certain outpatient and diagnostic testing procedures, require preauthorization and preauthorization is also required for out-of-network services where in-network services are not available. If pre-authorization is not sought or granted when required, then the plan may not cover all or part of the expense. Services that require preauthorization include, but are not limited to:

- Inpatient hospital services, except for 48/96 hour maternity stays;
- Inpatient services at any participating other health care facility;
- Residential treatment services;
- Outpatient facility services;
- Partial hospitalization services;
- Advanced radiological imaging services;

- Non-emergency ambulance services;
- Certain medical pharmaceuticals;
- Home health care services;
- Radiation therapy services; and
- Transplant services.

You or your provider must contact the Claims Administrator for preauthorization when required. While in-network providers generally handle preauthorization for you, it is always good to check with the provider to be sure that this has been done when required.

Preauthorization does not restrict the course of treatment that you and your provider may decide is appropriate or necessary. You and your provider are ultimately responsible for determining the course of treatment to be followed, whether or not the plan applies a benefit penalty.

More details about preauthorization requirements can be found in the ***Your Summary of Benefits*** section.

Managing Your Care

The plan offers several special features to help you and your covered family members receive the most appropriate care and treatment during emergencies or conditions that extend beyond acute care. Special health care features also help you manage the extraordinary cost of long-term or acute, but extensive, medical treatment. The information in this section outlines those features.

Case Management

Case Management is a service provided through a review organization to assist individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that you receive appropriate care in the most effective setting possible whether at home, as an outpatient or an inpatient in a hospital or specialized facility. If the need for Case Management arises, a Case Management professional works closely with you, your family and your attending physician to determine appropriate treatment options that will best meet your needs.

Case Managers are registered nurses and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. In addition, Case Managers are supported by a panel of physician advisors who offer guidance on up-to- date treatment programs and medical technology.

You, your dependent or your attending physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. The Review Organization assesses each case to determine if Case Management is appropriate. While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost- effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

Here is how it works:

- You or your dependent is contacted by an assigned Case Manager who explains how the program works. Participation in the program is voluntary; there are no penalties or benefit reductions if you do not want to participate.

- Following an initial assessment, the Case Manager works with you, your family and physician to determine what is needed and identify any alternate treatment programs available (for example, in-home medical care instead of an extended hospital stay). You are not penalized if the alternate treatment program is not followed. The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a hospital bed and other durable medical equipment for the home). While a Case Manager may recommend alternate treatment programs and help coordinate needed resources, your attending physician remains responsible for actual medical care.

- The Case Manager also acts as a liaison between you, the insurer, your family and physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).

- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate.

Disease Management

The plan offers targeted disease management programs for eligible participants with certain diseases.

You will be contacted and offered the option to participate in one of these programs when disease management is recommended by your physician. The programs provide:

- Support and access to specially trained registered nurses, dieticians and educators who can answer medical questions 24 hours a day.

- Education materials, integrated assessments and reports personally tailored to your individual needs.

Strict privacy guidelines are followed in handling your protected health information, as noted in the ***Keeping Your Information Private*** section.

Claims

When you use an in-network provider, your provider files claims for you.

You can call your Claims Administrator to talk to a health care professional during normal business hours, Monday through Friday, simply by calling the toll-free number shown on your ID card.

The Claims Administrator can provide you with the names of in-network providers. If you or your dependents need medical care, you may consult the network's physician directory located at www.myCigna.com or call the Claims Administrator's toll-free number for assistance. If you or your dependents need medical care while away from home, you may have access to a national network of providers. Before making an appointment, call the provider to confirm that he or she is a current participant in the network.

Note: *Claims are processed based on the diagnosis and procedure information billed by your provider. This may include a doctor, surgeon, hospital, anesthesiologist, radiology and pathology.*

Note: *Facility, physician, and professional charges will be processed separately (independently) according to the plan's benefits and information included on the claim.*

See the ***Claims Payment and Appeals Process*** section for more information.

Uncashed Checks

If you or a covered dependent receives a check reimbursement from the Claims Administrator, the following provisions apply:

- If a check has not been cashed and is considered void, the Claims Administrator will send out a letter to the recipient to reissue the check. Replacements checks must be issued by the following calendar year in which the original check was issued.
- If there is no response, the funds will be forfeited.
- **If the check is lost, then the participant can request a replacement check by contacting the Claims Administrator. Replacement checks must be issued by December 31 in the year following the original check date. For example, a check issued on June 3, 2024, must be reissued no later than December 31, 2025.**

Your Summary of Benefits

	Coverage
Plan Facts	
Member services	1-800-530-1314
Nurseline or health information number	Call the number on your Cigna ID card and follow the voice prompts
Web Site	www.mycigna.com
Claims Administrator: Medical	Cigna
Claims Administrator: Mental Health/Substance Abuse/Behavioral Health	Cigna
Claims Administrator: Prescription Drugs	CVS Caremark
Cost Sharing	
Usual, Customary and Reasonable/Maximum Allowable Charge	Not applicable
Does this plan have a deductible?	Yes
Annual deductible: Individual/Family	$500 Individual $1,000 Individual + Spouse/Domestic Partner $1,000 Individual + Child(ren) $1,000 Family
Is the deductible aggregate or embedded?	Embedded
Are there other deductibles for specific services?	No
Are there services covered before you meet the deductible?	Yes
Coinsurance percentage	80% covered
Is there an out-of-pocket limit on my expenses?	Yes
Out-of-pocket maximum: Individual/Family	$2,500 Individual $5,000 Individual + Spouse $5,000 Individual + Child(ren) $5,000 Family Plan year deductible and copays apply toward out-of-pocket maximum
Is the out-of-pocket maximum aggregate or embedded?	Embedded
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges (unless balance billing is prohibited), health care this plan doesn't cover, preauthorization penalties
Lifetime coverage limit	Limit does not apply
Is there an overall annual limit on what the plan pays?	No
Policies/Requirements	
Need to file claims	No
Preauthorization/Prior authorization	Yes
Preadmission certification	Yes
Precertification	Yes
Predetermination of benefits	No
Primary Care Physician required?	No

	Coverage
Referral required for certain services/procedures?	No
Access	
Is a referral required to see a specialist?	No
Ability to self-refer to OB/GYN	Yes
Ability to self-refer to specialists	Yes
In-network only or use of preferred providers required?	Yes; see www.cigna.com or call 1-800-530-1314 for a list of network providers
Out-of-area dependent coverage	Yes
Guest privileges program/out-of-area employees coverage	No
Urgent care while away from home	Yes
Non-emergency care when traveling outside the US	Not covered
Outpatient Services	
Primary Care	
Primary doctor office visit	$25 copay
Specialist office visit	$50 copay
Urgent care center	$50 copay after deductible is met
Second surgical opinion	$25 PCP copay, $50 specialist copay
Preventive Care	
Routine physical exam	100% covered
Immunizations (adult)	100% covered
Well child exams	100% covered
Immunizations (child)	100% covered
School physicals	100% covered if part of a routine physical
Well-woman exam (includes pap)	100% covered
Mammogram	100% covered
Human papillomavirus (HPV) DNA testing for women 30 years and older	100% covered
Sexually-transmitted infection counseling	100% covered
Human immunodeficiency virus (HIV) screening and counseling	100% covered
Domestic violence screening and counseling	100% covered
Colorectal cancer screenings	100% covered
Other cancer screenings	100% covered
Cardiovascular screenings	100% covered
Allergy tests and treatments	Lesser of actual charge or PCP or specialist copay
Outpatient Care	
Outpatient surgery - hospital outpatient dept	$150 copay per visit after deductible is met
Outpatient surgery - ambulatory surgery facility	$150 copay per visit after deductible is met
Outpatient surgery - doctor’s office	$25 PCP copay; $50 specialist copay
Outpatient surgery - anesthetics	Once deductible is met, covered as part of $150 outpatient surgery copay
Outpatient surgery - physician/surgeon fees	Once deductible is met, covered as part of $150 outpatient surgery copay
Outpatient chemotherapy	$150 copay per visit after deductible is met

	Coverage
Outpatient laboratory services	**Physician Office:** PCP or specialist copay **Independent Lab:** Lesser of actual charge or $50 copay **Otherwise:** Outpatient benefit applies
Outpatient physical therapy	PCP or specialist copay; 60 days/year; includes medically necessary physical, speech, occupational, ASD and other therapies; excludes developmental delay
Outpatient X-ray/Diagnostic imaging services	**Physician Office:** $50 copay **Otherwise:** Outpatient benefit applies **Advanced Radiological Imaging:** $50 copay after deductible is met
Outpatient occupational therapy	PCP or specialist copay; 60 days/year; includes medically necessary physical, speech, occupational, ASD and other therapies; excludes developmental delay
Outpatient speech therapy	PCP or specialist copay; 60 days/year; includes medically necessary physical, speech, occupational, ASD and other therapies; excludes developmental delay
Outpatient kidney dialysis	$150 copay per visit after deductible is met
Outpatient growth hormone therapy	**Physician Office:** PCP or specialist copay **Otherwise:** Outpatient benefit applies when deemed medically necessary by plan administrator
Outpatient cardiac rehabilitation	PCP or specialist copay; limited to 36 days per calendar year
Outpatient obesity treatment	**Physician Office:** PCP or specialist copay **Otherwise:** Outpatient benefit applies when deemed medically necessary by plan administrator
Habilitation services	PCP or specialist copay; when medically necessary to treat a mental health condition (e.g., autism)
Family Planning/Maternity Care	
Office visit: Pre/postnatal	PCP or specialist copay for initial visit only; enroll in Cigna Healthy Pregnancies, Healthy Babies program to get support staying healthy during and after pregnancy
Gestational diabetes screenings	100% covered as part of preventive care benefit
Child Birth/Delivery Professional Services	Once deductible is met, covered as part of $300 inpatient admission copay
In-hospital delivery services	Once deductible is met, covered as part of $300 inpatient admission copay
Birthing center delivery services	Once deductible is met, covered as part of $300 inpatient admission copay
Midwife delivery services	Once deductible is met, covered as part of $300 inpatient admission copay
Newborn nursery services	100% covered during mother’s hospitalization
Breastfeeding support, supplies and counseling	100% covered as part of preventive care benefit

	Coverage
FDA-approved contraception methods and contraceptive counseling	100% covered as part of preventive care benefit
Infertility services/treatment	**Physician Office:** PCP or specialist copay **Otherwise:** Inpatient or outpatient benefit applies includes artificial insemination, IVF, GIFT, etc. through WINFertility
Lifetime coverage limit - Fertility treatment	$20,000 medical lifetime maximum plus related prescription drug expenses
In vitro fertilization	**Physician Office:** PCP or specialist copay **Otherwise:** Inpatient or outpatient benefit applies fertility treatment lifetime maximum applies
Artificial insemination	**Physician Office:** PCP or specialist copay **Otherwise:** Inpatient or outpatient benefit applies fertility treatment lifetime maximum applies
Female tubal ligation	100% covered as part of preventive care benefit
Male vasectomy	**Physician Office:** PCP or specialist copay **Otherwise:** Inpatient or outpatient benefit applies
Birth control devices and implants	100% covered as part of preventive care benefit
Pregnancy termination	**Physician Office:** PCP or specialist copay **Otherwise:** Inpatient or outpatient benefit applies
Hearing	
Routine hearing exam	100% covered if part of a preventive care exam **Otherwise:** PCP or specialist copay
Hearing evaluations	100% covered if part of a preventive care exam **Otherwise:** PCP or specialist copay
Hearing aids	80% covered after deductible is met; limited to $2,000 every 3 calendar years per individual; contact customer service before purchase to verify applicable vendors
Vision	
Routine eye care for adults	Not covered
Routine vision exams	**Vision Screenings:** 100% covered if performed as part of a well child exam; otherwise not covered
Regular lenses and frames	Not covered
Contact lenses	Not covered
Vision therapy	Not covered
Eye exam for children	Not covered
Glasses for children	Not covered
Inpatient Services	
Inpatient Room and Board	
Hospital copay	$300 copay per admission after deductible is met
Hospital semi-private room	100% covered after hospital copay
Inpatient Care	
Pre-admission testing	Once deductible is met, covered as part of $300 inpatient admission copay
Inpatient lab and X-ray	Once deductible is met, covered as part of $300 inpatient admission copay

	Coverage
Inpatient physician and surgeon services	Once deductible is met, covered as part of $300 inpatient admission copay
Private duty nursing services	Not covered
Inpatient chemotherapy	Once deductible is met, covered as part of $300 inpatient admission copay
Inpatient rehabilitation therapy	Once deductible is met, covered as part of $300 inpatient admission copay
Inpatient anesthetics	Once deductible is met, covered as part of $300 inpatient admission copay
Inpatient cardiac rehabilitation	Once deductible is met, covered as part of $300 inpatient admission copay
Bariatric surgery	Once deductible is met, covered as part of $300 inpatient admission copay
Inpatient obesity treatment	Once deductible is met, covered as part of $300 inpatient admission copay; when deemed medically necessary by plan administrator
Organ and tissue transplants	**LifeSource Facilities:** $300 copay per admission **Other Participating Facilities:** $300 copay per admission after deductible is met
Organ transplant travel and transportation	Only available through LifeSource facility; limited to $10,000 per transplant
Cosmetic surgery	Not covered
Emergency Care	
Emergency room (not followed by admission)	$250 copay after deductible is met
Emergency room (followed by admission)	$250 copay after deductible is met; copay waived if admitted
Urgent care clinic visit	$50 copay after deductible is met
Ambulance services	80% covered after deductible is met
Air Ambulance	80% covered after deductible is met
Prescription Drug Coverage	
General	
Prescription drug vendor	CVS Caremark
Prescription drug Web site	www.caremark.com
Prescription drug member services	1-866-236-8236
Prescription benefits are subject to medical deductible	No
Annual prescription deductible	Not applicable
Prescription drugs subject to medical deductible and medical out-of-pocket?	Not applicable
Prescription drugs subject to medical out-of-pocket?	Yes
Annual Rx out-of-pocket maximum	Not applicable
Annual prescription maximum benefit	Not applicable
Specialty drugs	$0 copay when you register with PrudentRx, otherwise you pay 30%; 30-day supply
Drugs requiring preauthorization	Some prescription drugs may require preauthorization

	Coverage
Dispense As Written Rules	Yes. If a brand is dispensed when a generic is available, you will pay the cost difference between the brand and generic medication, plus the brand copay
Mandatory generic requirement	Yes
90 day supply at retail	Yes
Mail order prescription is mandatory	Yes
Retail	
Retail generic	**In-Network:** $15 copay; 30-day supply **Out-of-Network:** $15 copay+diff between network/submitted charge; 30-day supply **Maint Med (fills 4+):** 90-day supply at CVS or mail order only or not covered
Retail formulary brand	**In-Network:** $50 copay; 30-day supply **Out-of-Network:** $50 copay+diff between network/submitted charge; 30-day supply **Maintenance med (fills 4+):** 90-day supply at CVS or mail order only or not covered
Retail nonformulary brand	**In-Network:** $100 copay+gener/brand cost diff; 30-day supply **Out-of-Network:** $100 copay+gener/brand & network/submitted cost diff **Maint Med-Fills 4+:** 90-day supply at CVS or mail order or not covered
Mail Order	
Mail order generic	**In-Network:** $37.50 copay; 90-day supply **Out-of-Network:** Not covered
Mail order formulary brand	**In-Network:** $125 copay; 90-day supply **Out-of-Network:** Not covered
Mail order nonformulary brand	**In-Network:** $250 copay, plus cost diff between generic and brand; 90-day supply **Out-of-Network:** Not covered
Other Prescription Drugs	
Oral contraceptives	**In-Network:** Retail and mail order; 100% covered for generic/single-source brands; copays apply to multi-source brands **Out-of-Network:** Retail only
Fertility drugs	**In-Network:** Retail and mail order **Out-of-Network:** Retail only; you pay 100% of drug cost
Lifetime maximum - Prescription drugs for fertility treatment	$20,000 medical lifetime maximum plus related prescription drug expenses
Lifestyle drugs	Refer to www.caremark.com for more details
Other Services	
Mental Health	
Mental health/substance abuse administrator	Cigna
Mental health/substance abuse member services	1-800-530-1314
Mental health/substance abuse web site	www.cigna.com
Mental Health: Annual deductible	Subject to medical deductible

	Coverage
Mental Health: Annual out-of-pocket maximum	Subject to medical out-of-pocket maximum
Mental Health: Lifetime maximum benefit	None
Mental Health: Preauthorization	Yes
Mental Health: Outpatient coverage	**Physician Office:** $25 copay **Otherwise:** 100% covered after deductible is met
Mental Health: Intensive Outpatient coverage	**Physician Office:** $25 copay **Otherwise:** 100% covered after deductible is met
Mental Health: Inpatient coverage	$300 copay per admission after deductible is met
Mental Health: Partial Hospitalization	**Physician Office:** $25 copay **Otherwise:** 100% covered after deductible is met
Mental Health: Learning disabilities/developmental/educational therapy	**Physician Office:** $25 copay **Otherwise:** 100% covered after deductible is met; covered when part of approved treatment for ASD
Mental Health: Psychological testing	**Physician Office:** $25 copay 100% covered after deductible is met
Substance Abuse	
Substance Abuse: Annual deductible	Subject to medical deductible
Substance Abuse: Annual out-of-pocket maximum	Subject to medical out-of-pocket maximum
Substance Abuse: Lifetime maximum benefit	None
Substance Abuse: Preauthorization	Yes
Detox: Outpatient coverage	**Physician Office:** $25 copay **Otherwise:** 100% covered after deductible is met
Detox: Inpatient coverage	$300 copay per admission after deductible is met
Rehab: Outpatient coverage	**Physician Office:** $25 copay **Otherwise:** 100% covered after deductible is met
Rehab: Inpatient coverage	$300 copay per admission after deductible is met
Substance Abuse: Intensive Outpatient coverage	**Physician Office:** $25 copay **Otherwise:** 100% covered after deductible is met
Other	
Routine foot care	Not covered
Long-term care	Not covered
Home health care (noncustodial)	80% covered after deductible is met; includes private duty nursing; limited to 112 hours per week
Hospice care	**Inpatient:** 100% covered after deductible is met **Outpatient:** 80% covered after deductible is met
Skilled nursing facility (noncustodial care)	100% covered after deductible is met; limited to 90 days per calendar year; preauthorization required
Durable medical equipment	80% covered after deductible is met; includes up to 1 wig per year
Prosthetic appliances	80% covered after deductible is met
Orthotics	80% covered after deductible is met; when deemed medically necessary by plan administrator
Medical supplies	80% covered after deductible is met
Craniomandibular Disorder (CMD)	**Physician Office:** PCP or specialist copay **Otherwise:** Inpatient or outpatient benefit applies when deemed medically necessary by plan administrator

	Coverage
Cleft Palette/Cleft Lip	**Physician Office:** PCP or specialist copay **Otherwise:** Inpatient or outpatient benefit applies when deemed medically necessary by plan administrator
Transgender Benefits: Gender Reassignment Surgery	Covered same as other medical expenses
Transgender Benefits: Mental Health Counseling	Covered same as other medical expenses
Transgender Benefits: Hormone Therapy	Covered same as other medical expenses
Transgender Benefits: Subsequent Medical Treatment while employee is receiving hormone therapy (e.g., blood tests to measure hormone levels)	Covered same as other medical expenses
Transgender Benefits: Other Associated Surgical Procedures aimed primarily at improving cosmetic appearance	Check with plan
Transgender Benefits: Lifetime benefit maximum for transgender benefits	Not applicable
Autism Spectrum Disorders (ASD) Benefits: Applied Behavioral Analysis (ABA)	Covered same as other medical expenses
Autism Spectrum Disorders (ASD) Benefits: Habilitative therapy for individuals with ASD	Services are covered when deemed medically necessary by plan administrator to treat a mental health condition
Alternative Care	
Chiropractic	PCP or specialist copay; limited to 20 days per calendar year
Acupuncture	PCP or specialist copay; limited to 12 days per calendar year
Naturopath	Not covered
Dental	
Accidental injury to teeth	**Physician Office:** PCP/specialist copay **Otherwise:** In/outpatient benefit limited to charges for continuous course of dental treatment started w/in 6 months of accident/injury to sound natural teeth
Surgical removal of tumors, cysts, and impacted teeth	**Physician Office:** PCP or specialist copay **Otherwise:** Inpatient or outpatient benefit applies removal of impacted teeth, when medically necessary, only hospitalization and anesthesia fees are covered
Surgical and non-surgical treatment for TMJ	**Physician Office:** PCP or specialist copay **Otherwise:** Inpatient or outpatient benefit applies
Dental check-up for children	Not covered
Dental care for adults	Not covered
Care Management Programs	
Coordination through behavioral health coordinator?	Yes
Coronary Artery Disease (CAD) care management	Yes
Congestive Heart Failure (CHF) care management	Yes
Diabetes care management	Yes

	Coverage
Asthma care management	Yes
Low back pain management	Yes
Prenatal care management	Yes
Cancer care management	No; assistance is offered along with other care management programs
Smoking cessation program	Yes
Weight control program	Yes
End stage renal disease (ESRD)/chronic kidney disease management	Yes
Administrative Information	
Administration Type (Contract or Insured)	Contract
Funding Type (Self-Funded or Insured)	Self-Funded
Fiduciary Decision Maker: Medical	Cigna
Fiduciary Decision Maker: Mental Health/Substance Abuse	Cigna
Fiduciary Decision Maker: Prescription Drugs	CVS Caremark
Important Addresses	
Claims Filing Address: Medical	P.O. Box 188050 Chattanooga, TN 37422-8050
Claims Filing Address: Mental Health/Substance Abuse	P.O. Box 188050 Chattanooga, TN 37422-8050
Claims Filing Address: Prescription Drugs	CVS Caremark P.O. Box 52116 Phoenix, AZ 85072
Appeals Filing Address: Medical	National Appeals Unit PO Box 188011 Chattanooga, TN 37422-8011
Appeals Filing Address: Mental Health/Substance Abuse	National Appeals Unit PO Box 188011 Chattanooga, TN 37422-8011
Appeals Filing Address: Prescription Drugs	CVS Caremark Appeals Dept. MC109 P.O. Box 52084 Phoenix, AZ 85072-2084
Corporate Address: Medical Claims Administrator	P.O. Box 188050 Chattanooga, TN 37422-8050
Corporate Address: Mental Health/Substance Abuse Claims Administrator	P.O. Box 188050 Chattanooga, TN 37422-8050
Corporate Address: Prescription Drug Claims Administrator	CVS Caremark Corporate Headquarters One CVS Drive Woonsocket, RI 02895

Covered Expenses

Covered expenses are expenses you incur for the charges listed below if you incur them after you are covered under this plan. Expenses incurred are considered covered to the extent that the services or supplies provided are recommended by a physician and are medically necessary for the care and treatment of an injury or a sickness, as determined by the Claims Administrator. Covered expenses may also include charges made by an entity that has directly or indirectly contracted with the Claims Administrator to arrange, through contracts with providers of services and/or supplies, for the provision of any services listed below. Any applicable cost sharing or limits are shown in the ***Your Summary of Benefits*** section.

Note: *Charges means the actual billed charges, except when the Claims Administrator has contracted directly or indirectly for a different amount, including where the Claims Administrator has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers for the services and/or supplies.*

- Charges for inpatient room and board and other necessary services and supplies made by a hospital.
- Charges for inpatient room and board and other necessary services and supplies made by an other health care facility, including a skilled nursing facility, rehabilitation hospital or subacute facility.
- Charges for licensed ambulance service to the nearest hospital where the needed medical care and treatment can be provided.
- Charges for outpatient medical care and treatment received at a hospital.
- Charges for outpatient medical care and treatment received at a free-standing surgical facility.
- Charges for emergency services.
- Charges for urgent care.
- Charges by a physician or psychologist for professional services.
- Charges by a nurse for professional nursing service.
- Charges for anesthetics, including, but not limited to, supplies and their administration.
- Charges for diagnostic X-ray.
- Charges for advanced radiological imaging, including, for example, CT, MRI, MRA and PET scans and laboratory examinations, X-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
- Charges for chemotherapy.

- Charges for blood transfusions.
- Charges for oxygen and other gases and their administration.
- Charges for medically necessary foot care for diabetes, peripheral neuropathies and peripheral vascular disease.
- Charges for screening Prostate-Specific Antigen (PSA) testing.
- Charges for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- Charges made for family planning, including medical history, physical exam, related laboratory tests, medical supervision per generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- Charges for the following preventive care services as defined by recommendations from:
    - The U.S. Preventive Services Task Force (A and B recommendations);
    - The Advisory Committee on Immunization Practices (ACIP) for immunizations;
    - The American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
    - The Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
    - For women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.
- Charges for medical diagnostic services to determine the cause of erectile dysfunction; penile implants are covered for an established medical condition that is clearly the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes; penile implants are not covered as treatment of psychogenic erectile dysfunction.
- Gender transition charges for services related to gender transition, including gender reassignment surgery; coverage when applicable includes behavioral counseling, hormone therapy, genital reconstructive surgical procedures and initial mastectomy or breast reduction and specific services including, but not limited to, breast augmentation with or without prosthetic implant.
- Charges for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).

- Charges for hearing aids and associated exam for device testing and fitting, including, but not limited to, semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs); a hearing aid is any device that amplifies sound.

- Medically necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.

- Convenience care clinic services, which provide for common ailments and routine services, including, but not limited to, strep throat, ear infections or pink eye, immunizations and flu shots.

- Charges for nutritional counseling when diet is a part of the medical management of a medical or behavioral condition.

- Enteral nutrition, which includes medically approved formulas prescribed by a physician for treatment of inborn errors of metabolism (e.g., disorders of amino acid or organic acid metabolism); enteral nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

- Charges for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts are covered; medically necessary repair, maintenance or replacement of a covered appliance is also covered.

- Charges for acupuncture.

Breast Reconstruction and Breast Prostheses

The Plan covers charges made for reconstructive surgery following a mastectomy; benefits include:

- Surgical services for reconstruction of the breast on which surgery was performed;

- Surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;

- Postoperative breast prostheses; and

- Mastectomy bras and prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Chiropractic Care Services

The plan covers charges for diagnostic and treatment services utilized in an office setting by chiropractic physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment provided to specific joints to restore motion, reduce pain and improve function. For these services you have direct access to qualified chiropractic physicians.

Exclusion: Chiropractic care not provided in an office setting is not covered.

Clinical Trials

The plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and either the:

- Referring health care professional is a participating health care provider and has concluded that the individual's participation in the trial would be appropriate; or
- Individual provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria for patient care costs and services to be covered. The clinical trial must be a Phase I, II, III or IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition that is:

- A federally funded trial; this means the study or investigation is approved or funded, which may include funding through in-kind contributions by one or more of the following:
    - The National Institutes of Health (NIH);
    - The Centers for Disease Control and Prevention (CDC);
    - The Agency for Health Care Research and Quality (AHRQ);
    - The Centers for Medicare and Medicaid Services (CMS);
    - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or Department of Veterans Affairs (VA);

- A qualified non-governmental research entity identified in NIH guidelines for center support grants; or

- The Department of Energy, Department of Defense or Department of Veterans Affairs if both the study or investigation:

  - Has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and

  - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

- Study or investigation that is conducted under an investigational new drug application reviewed by the FDA; or

- Study or investigation that is a drug trial that is exempt from having such an investigational new drug application.

The plan does not cover any of the following services associated with a clinical trial:

- Services that are not considered routine patient care costs and services, including:

  - The investigational drug, device, item or service that is provided solely to satisfy data collection and analysis needs;

  - An item or service that is not used in the direct clinical management of the individual; and

  - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

- An item or service provided by the research sponsors free of charge for any person enrolled in the trial.

- Travel and transportation expenses unless otherwise covered under the plan, including, but not limited to:

  - Fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline or train;

  - Mileage reimbursement for driving a personal vehicle;

  - Lodging; or

  - Meals.

- Routine patient costs obtained out-of-network when out-of-network benefits are not covered under the plan.

Examples of routine patient care costs and services include radiological services, laboratory services, intravenous therapy, anesthesia services, physician services, office services, hospital services, room and board and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

Durable Medical Equipment

The plan covers charges made for the purchase or rental of durable medical equipment that is ordered or prescribed by a physician and provided by a vendor approved by the Claims Administrator for use outside a hospital or other health care facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are not covered and are the individual's responsibility. Durable medical equipment:

- Are items that are designed for and able to withstand repeated use by more than one person;
- Is customarily used to serve a medical purpose;
- Generally is not useful in the absence of injury or sickness;
- Is appropriate for use in the home; and
- Is not disposable.

This equipment includes, but is not limited to, crutches, hospital beds, ventilators, insulin pumps and wheel chairs.

Exclusions: Durable medical equipment that is not covered includes, but is not limited to:

- Bed related items, such as bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- Bath related items, such as bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats and spas.
- Fixtures to real property, such as ceiling lifts and wheelchair ramps.
- Car/van modifications.
- Air quality items, such as room humidifiers, vaporizers and air purifiers.

- Other equipment, including centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets that emit Ultraviolet A (UVA) rays, sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment and diathermy machines.

External Prosthetic Appliances and Devices

The plan covers charges made or ordered by a physician for the initial purchase and fitting of external prosthetic appliances and devices only available by prescription and that are necessary for the alleviation or correction of injury sickness or congenital defect.

External prosthetic appliances and devices include:

- Prostheses/prosthetic appliances and devices;
- Orthoses and orthotic devices;
- Braces; and
- Splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- Limb prostheses;
- Terminal devices, such as hands or hooks;
- Speech prostheses; and
- Facial prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. The plan provides coverage for:

- Non-foot orthoses, limited to:
    - Rigid and semi-rigid custom fabricated orthoses;
    - Semi-rigid prefabricated and flexible orthoses; and
    - Rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints;

- Custom foot orthoses, limited to:
    - Coverage for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g., diabetic neuropathy and peripheral vascular disease);
    - When the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
    - When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g., amputated toes) and is necessary for the alleviation or correction of injury, sickness or congenital defect; and
    - For persons with neurologic or neuromuscular condition (e.g., cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment or pathological positioning of the foot and there is reasonable expectation of improvement.

Exclusions: The following orthoses and orthotic devices are not covered:

- Pre-fabricated foot orthoses.
- Cranial banding and/or cranial orthoses. Other similar devices are not covered except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to any external prosthetic appliances and devices benefit limitations and maximums.
- Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers.
- Non-foot orthoses primarily used for cosmetic rather than functional reasons.
- Non-foot orthoses primarily for improved athletic performance or sports participation.

Braces

A brace is as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

Exclusion: The plan does not cover Copes scoliosis braces.

Splints

A splint is as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts. Coverage for replacement of external prosthetic appliances and devices is limited to replacement:

- Due to regular wear (replacement for damage due to abuse or misuse by the person is not covered);

- Required because anatomic change has rendered the external prosthetic appliance or device ineffective (anatomic change includes significant weight gain or loss, atrophy and/or growth); and

- Due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited to no more than once every:

- 24 months for covered individual age 19 or older; or

- 12 months for covered individuals age 18 or younger.

Exclusions: Except when medically necessary as determined by the Plan Administrator, the following are not covered:

- External and internal power enhancements for external prosthetic devices.

- Microprocessor controlled prostheses and orthoses.

- Myoelectric prostheses and orthoses.

Gene Therapy

Charges for gene therapy products and services directly related to their administration are covered when medically necessary. Gene therapy is a category of pharmaceutical products approved by the FDA to treat or cure a disease by:

- Replacing a disease-causing gene with a healthy copy of the gene;

- Inactivating a disease-causing gene that may not be functioning properly; or

- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. The Claims Administrator determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of:

- The gene therapy product;

- Medical, surgical and facility services directly related to administration of the gene therapy product; and

- Professional services.

Gene therapy products and their administration are covered when prior authorized to be received at in-network facilities specifically contracted with the Claims Administrator for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

Gene Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations:

- Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy and when the gene therapy products and services directly related to their administration are received at a participating in-network facility specifically contracted with the Claims Administrator for the specific gene therapy service. The term recipient includes a person receiving prior authorized gene therapy related services during evaluation, candidacy, event or post care.

- Travel expenses for the person receiving the gene therapy include charges for transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility) and lodging while at or traveling to and from the site.

In addition to your coverage for the charges associated with the items above, the charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

Exclusions: The following travel expenses are not covered:

- Any expenses that if reimbursed would be taxable income.

- Travel costs incurred due to travel within 60 miles of your home.

- Food and meals.

- Laundry bills.

- Telephone bills.

- Alcohol or tobacco products.

- Charges for transportation that exceed coach class rates.

Home Health Care Services

Charges for skilled care provided by certain health care providers during a visit to the home, when the home is determined to be a medically appropriate setting for the services. A visit is a period of two hours or less. Home health care services are subject to a maximum of 16 hours total per day.

Home health care services are covered when skilled care is required when:

- The required skilled care cannot be obtained in an outpatient facility;
- Confinement in a hospital or other health care facility is not required;
- The patient's home is determined by the Claims Administrator to be the most medically appropriate place to receive specific services.

Covered services include:

- Skilled nursing services provided by a Registered Nurse (RN), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN) or Advanced Practice Registered Nurse (APRN);
- Services provided by health care providers such as physical therapist, occupational therapist or speech therapist;
- Services of a home health aide when provided in direct support of those nurses and health care providers; and
- Necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

Note: *Physical, occupational and other outpatient therapy services provided in the home are covered under the plan's outpatient therapy services coverage.*

Exclusions: The following are not covered:

- Services provided by a person who is a member of the patient's family, even when that person is a health care provider.
- Services provided by a person who normally resides in the patient's house, even when that person is a health care provider.
- Non-skilled care, custodial services and assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other services, self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

Home health care services for a patient who is dependent upon others for non-skilled care and/or custodial services is provided only when there is a family member or caregiver present in the home at the time of the health care visit to provide the non-skilled care and/or custodial services.

Home health services include outpatient private duty nursing days when approved as medically necessary. Private duty nursing is limited a maximum of 112 hours per week; there is no daily or per visit maximum.

Hospice Care Services

Hospice care services included charges for services for a person diagnosed with advanced illness having a life expectancy of 12 months or less. Services provided by a hospice care program are available to those who have ceased treatment and to those continuing to receive curative treatment and therapies. Hospice care programs provided by hospice facilities or hospitals include:

- Hospice facility room and board and services and supplies;
- Hospice facility services provided on an outpatient basis;
- Physician professional services;
- Psychologist, social worker, family counselor and ordained minister services for individual and family counseling; and
- Pain relief treatment, including drugs, medicines and medical supplies.

To the extent charges would have been covered under the plan if a covered individual had had remained or been confined in a hospital or hospice facility, the plan covers hospice care program services provided in home or by other health care facilities. Services covered include:

- Part-time or intermittent nursing care by or under the supervision of a nurse;
- Part-time or intermittent services of an other health professional;
- Physical, occupational and speech therapy;
- Medical supplies;
- Drugs and medicines lawfully dispensed only on the written prescription of a physician; and
- laboratory services.

Exclusions: The following hospice care service charges are not covered:

- Services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house.

- Services for any period when you or your dependent is not under the care of a physician.
- Services or supplies not listed as covered by a hospice care program.
- Benefits payable under any part of this plan.
- Services or supplies that are primarily to aid you or your dependent in daily living.

Infertility and Conception Services

Services offered through WINFertility. You must contact WINFertility at 1-855-620-0989 for prior authorization before initiating fertility treatment.

The plan covers:

- Testing and treatment services performed in connection with an underlying medical condition;
- Testing performed specifically to determine the cause of infertility;
- Treatment and/or procedures performed specifically to restore fertility (e.g., procedures to correct an infertility condition);
- Artificial insemination/intrauterine insemination, regardless of an infertility condition, in-vitro, GIFT, ZIFT, etc.;
- Fertility preservation when an infertility condition is imminent; and

Access to reproductive services for Pre-Implantation Genetic Diagnosis (PGD) and embryo selection when parent(s), though fertile, are known carriers of genes associated with birth defects.

Lifetime Maximum: There is a $20,000 medical lifetime maximum along with corresponding prescription drugs for approved treatments until the medical lifetime maximum is met. Medical infertility services are subject to a lifetime maximum benefit and limited to in-network coverage only.

Covered Services: Specific covered services include:

- Timed Intercourse (TI) cycles, includes natural cycles and ovulation induction cycles with clomid or letrozole);
- Intrauterine Insemination (IUI), includes natural cycles and ovulation induction cycles with clomid or letrozole);
- Assisted Reproductive Treatment (ART) cycles and procedures, including:
    - In-Vitro Fertilization (IVF), including Intracytoplasmic Sperm Injection (ICSI);

- Gamete Intrafallopian Cycle (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- Oocyte cryopreservation and sperm cryopreservation with one year of storage, as directed by the Claims Administrator medical policy;
- Oocyte Thaw Cycles (OTC);
- Cryopreservation of blastocysts(s) and embryo(s) from covered IVF or OTC with storage for up to one year;
- Embryo biopsy for PGT, as directed by the Claims Administrator medical policy and subject to the following indications:
  - Recurrent pregnancy loss (three or more unexplained clinical pregnancy losses) or previously diagnosed aneuploid pregnancies or births;
  - Recurrent implantation failure (three or more failed embryo transfers); and

- Frozen Embryo Transfer (FET) cycles;
- Pathology and laboratory services, including, but not limited to:
  - Hormonal assays;
  - Semen analysis, as appropriate;
  - Ultrasound exams;
  - Fertilization and appropriate embryology services;
  - Ova identification; and
  - Embryo transfer; and
- Medications necessary to the provisions above, including parenteral injection, are included for infertility treatment while the member is a covered by this Plan and has benefit dollars remaining for infertility services.

Note: *Cycle means ovarian stimulation with oocyte retrieval, fertilization of oocyte and followed by a subsequent single embryo transfer. Embryo transfer may utilize a fresh or frozen embryo.*

Exclusions: Infertility services do not cover:

- Related medical and non-medical donor expenses for donated oocytes or sperm, including, travel expenses, agency, laboratory and donor fees, psychological screening, FDA testing for the donor and partner, genetics screening.

- Fallopian tube ligations and vasectomy reversals.
- Medical and surgical procedures that are experimental or investigational unless a denial is overturned through the appeals process.
- Services requested that are not medically appropriate.
- Services not specifically listed as covered.
- Intrauterine insemination or timed intercourse cycles stimulated with gonadotropin or menotropin (e.g., FSH/IUI cycles), unless the member has a diagnosis of hypogonadotropic anovulatory disorders or hypopituitarism or after the member has not ovulated or conceived after a prior trial of three cycles of clomid or letrozole.
- Elective egg freeze.
- Out-of-network provider services.
- Infertility services for dependent children unless an infertility condition is imminent and fertility preservation is needed.

Medical Pharmaceuticals

The plan covers charges made for medical pharmaceuticals that are administered in an inpatient setting, outpatient setting, physician's office or in a covered person's home.

These benefits are only provided for medical pharmaceuticals that, due to their characteristics (as determined by the Claims Administrator), are required to be administered or the administration of which must be directly supervised by a qualified physician or other health professional. These benefits include medical pharmaceuticals whose administration may initially or typically require physician or other health professional oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

Certain medical pharmaceuticals are subject to pre-authorization requirements or other coverage conditions. Additionally, certain medical pharmaceuticals are subject to step therapy requirements. This means that to receive benefits for these medical pharmaceuticals, you are required to try a different medical pharmaceutical and/or prescription drug product first.

Utilization management requirements or other coverage conditions are based on a number of factors such as:

- Clinical factors, which may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of medical pharmaceuticals as well as whether certain supply limits or other utilization management requirements should apply; and/or

- Economic factors, which may include, but are not limited to, the medical pharmaceutical's cost, including, but not limited to, assessments on the cost effectiveness of the medical pharmaceuticals and available rebates.

Regardless of its eligibility for coverage under the plan, whether a particular prescription drug product is appropriate for you or any of your dependents is a determination that is made by you (or your dependent) and the prescribing physician.

Coverage criteria for a medical pharmaceutical may change periodically for various reasons. For example:

- A medical pharmaceutical may be removed from the market;

- A new medical pharmaceutical in the same therapeutic class as a medical pharmaceutical may become available; or

- Other market events may occur; market events that may affect the coverage status of a medical pharmaceutical include, but are not limited to, an increase in the cost of a medical pharmaceutical.

Mental Health and Substance Use Disorder Services

Mental health services are services required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits, charges made for the treatment of any physiological conditions related to mental health will not be considered to be charges made for treatment of mental health.

Substance use disorder services are services to treat the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and treatment. In determining benefits, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of substance use disorder.

Inpatient Mental Health Services

Inpatient mental health services are services provided by a hospital while you or your dependent is confined in a hospital for the treatment and evaluation of mental health. Inpatient mental health services include mental health residential treatment services.

Mental health residential treatment services are services provided by a hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute mental health conditions.

A mental health residential treatment center is an institution that:

- Specializes in the treatment of psychological and social disturbances that are the result of mental health conditions;
- Provides a subacute, structured, psychotherapeutic treatment program, under the supervision of physicians;
- Provides 24-hour care, in which a person lives in an open setting; and
- Is licensed according to the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a mental health residential treatment center when they are a registered bed patient in the mental health residential treatment center upon the recommendation of a physician.

Outpatient Mental Health Services

Outpatient mental health services are services of providers who are qualified to treat mental health when treatment is provided:

- On an outpatient basis while you or your dependent is not confined in a hospital; and
- On an individual, group or mental health partial hospitalization or intensive outpatient therapy program.

Covered services include, but are not limited to:

- Outpatient treatment of conditions, such as anxiety or depression, which interfere with daily functioning;
- Emotional adjustment or concerns related to chronic conditions, such as psychosis or depression;
- Emotional reactions associated with marital problems or divorce;
- Child/adolescent problems of conduct or poor impulse control;
- Affective disorders;
- Suicidal or homicidal threats or acts;

- Eating disorders; or

- Acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Mental health partial hospitalization services are for not less than 4 hours and not more than 12 hours in any 24-hour period when provided by a certified/licensed mental health program according to the laws of the appropriate legally authorized agency.

A mental health intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed mental health program according to the laws of the appropriate, legally authorized agency. Intensive outpatient therapy programs provide a combination of individual, family and/or group therapy in a day totaling nine or more hours in a week.

Inpatient Substance Use Disorder Rehabilitation Services

Inpatient substance use disorder rehabilitation services are services provided for rehabilitation while you or your dependent is confined in a hospital when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient substance use disorder services include residential treatment services. Substance use disorder residential treatment services are services provided by a hospital for the evaluation and treatment of the psychological and social functional disturbances that are due to subacute substance use disorder conditions.

A substance use disorder residential treatment center is an institution that:

- Specializes in the treatment of psychological and social disturbances due to a substance use disorder;

- Provides a subacute, structured, psychotherapeutic treatment program under the supervision of physicians;

- Provides 24-hour care, in which a person lives in an open setting; and

- Is licensed according to the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a substance use disorder residential treatment center when they are a registered bed patient in the substance use disorder residential treatment center upon the recommendation of a physician.

Outpatient Substance Use Disorder Rehabilitation Services

Outpatient substance use disorder rehabilitation services are services provided for the diagnosis and treatment of a substance use disorder or addiction to alcohol and/or drugs while you or your dependent is not confined in a hospital, including outpatient rehabilitation in an individual or a substance use disorder partial hospitalization or intensive outpatient therapy program.

Substance use disorder partial hospitalization services are for no less than 4 hours and not more than 12 hours in any 24-hour period when provided by a certified/licensed substance use disorder program according to the laws of the appropriate legally authorized agency.

A substance use disorder intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed substance use disorder program according to the laws of the appropriate legally authorized agency. Intensive outpatient therapy programs provide a combination of individual, family and/or group therapy in a day totaling nine or more hours in a week.

Substance Use Disorder Detoxification Services

Substance use disorder detoxification services include detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs. The Claims Administrator will decide, based on the medical necessity of each situation, whether the services will be provided in an inpatient or outpatient setting.

Exclusions

The following mental health and substance use disorder services are not covered under the plan:

- Treatment of disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including, but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial care, including, but not limited to, geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Outpatient Therapy Services

The plan covers the following therapy services:

- Cognitive therapy, occupational therapy, osteopathic manipulation, physical therapy, pulmonary rehabilitation speech therapy when provided as part of a program of treatment; and

- Cardiac rehabilitation, which includes charges for Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when medically necessary. Phase II is a hospital-based outpatient program following an inpatient hospital discharge; the Phase II program must be physician directed with active treatment and EKG monitoring.

  Exclusion: Phase III and IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III that includes more active participation and weight training.

Coverage is provided when medically necessary in the most medically appropriate setting to:

- Restore function (rehabilitative), which includes to:

  - Restore function that has been impaired or lost; and

  - Reduce pain due to sickness, injury or loss of a body part;

- Improve, adapt or attain function (habilitative), which includes to improve, adapt or attain function that has been impaired or was never achieved due to:

  - Congenital abnormality (birth defect); or

  - Mental health and/or substance use disorder conditions, which includes conditions such as autism, intellectual disability or mental health and/or substance use disorder conditions that result in a developmental delay.

Coverage is provided as part of a program of treatment when the:

- The covered individual's condition has the potential to improve or is improving in response to therapy and maximum improvement is yet to be attained;

- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period;

- The therapy is provided by or under the direct supervision of a licensed health care professional acting within the scope of the license; and
- The therapy is medically necessary and medically appropriate for the diagnosed condition.

Limitations:

- Coverage for occupational therapy is only provided to enable individuals to perform the activities of daily living after an injury or sickness.
- Multiple therapy services provided on the same day constitute one day of service for each therapy type.
- A separate copayment, if applicable, applies to the services provided by each provider for each therapy type per day.

Exclusions: Therapy services that are not covered include:

- Sensory integration therapy.
- Treatment of dyslexia.
- Maintenance or preventive treatment provided to prevent recurrence or to maintain the patient's current status.
- Vitamin therapy.

Reconstructive Surgery

The plan covers charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement accompanied by functional deficit (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that:

- The surgery or therapy restores or improves function;
- Reconstruction is required due to medically necessary, non-cosmetic surgery; or
- The surgery or therapy is performed before age 19 and is required due to the congenital absence or agenesis (lack of formation or development) of a body part.
- Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review physician.

Transplant Services and Related Specialty Care

The plan covers charges made for human organ and tissue transplant services that include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include:

- The recipient's medical, surgical and hospital services;
- Inpatient immunosuppressive medications; and
- Costs for organ or bone marrow/stem cell procurement.

Transplant services are covered only if they are required to perform any of the following human-to-human organ or tissue transplants:

- Allogeneic bone marrow/stem cell;
- Autologous bone marrow/stem cell;
- Cornea;
- Heart;
- Heart/lung;
- Kidney;
- Kidney/pancreas;
- Liver;
- Lung;
- Pancreas; or
- Intestine, which includes small bowel-liver or multi-visceral.

Covered implantation procedures include:

- Artificial heart;
- Percutaneous Ventricular Assist Device (PVAD);
- Extracorporeal Membrane Oxygenation (ECMO);

- Ventricular Assist Device (VAD); and
- Intra-Aortic Balloon Pump (IABP).

The plan covers transplant and related specialty care services as follows:

- All transplant services and related specialty care services, other than corneal transplants, are covered when received at Cigna LifeSource Transplant Network facilities.
- Transplant services and related specialty care services received at participating provider facilities specifically contracted with the Claims Administrator for those transplant services and related specialty care services, other than Cigna LifeSource Transplant Network facilities, are paid at the in-network benefits level.
- Transplant services and related specialty care services received at any other facility, including non-participating provider facilities and participating provider facilities not specifically contracted with the Claims Administrator for transplant services and related specialty care services are not covered.
- Corneal transplants received at a facility that is specifically contracted with the Claims Administrator for this type of transplant are paid at the in-network benefits level.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Organ procurement costs consist of hospitalization and surgery necessary for removal of an organ and transportation of a live donor (see the ***Transplant and Related Specialty Care Travel Services*** section). Compatibility testing undertaken before procurement is covered if medically necessary. Costs related to the search for and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Advanced cellular therapy, including, but not limited to, immune effector cell therapies and Chimeric Antigen Receptor Therapy (CAR-T) cellular therapy, is covered when performed at a Cigna LifeSource Transplant Network facility with an approved stem cell transplant program. Advanced cellular therapy received at participating provider facilities specifically contracted with the Claims Administrator for advanced cellular therapy, other than Cigna LifeSource Transplant Network facilities, are paid at the in-network benefits level. Advanced cellular therapy received at any other facility, including non-participating provider facilities and participating provider facilities not specifically contracted with the Claims Administrator for advanced cellular therapy, are not covered.

Transplant and Related Specialty Care Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations:

- Transplant and related specialty care travel benefits are not available for corneal transplants.

- Transportation and lodging benefits and/or related specialty care from a designated Cigna LifeSource Transplant Network facility are available to the recipient of a pre-approved organ/tissue transplant.

- A recipient is a person receiving authorized transplant related services during evaluation, candidacy, the transplant event or post-transplant care.

- Travel expenses for the person receiving the transplant include charges for:

    - Transportation to and from the designated Cigna LifeSource Transplant Network facility (including charges for a rental car used during a period of care at the designated Cigna LifeSource Transplant Network facility); and

    - Lodging while at or traveling to and from, the designated Cigna LifeSource Transplant Network facility.

    - In addition to your coverage for the charges associated with the above, travel charges for one companion to accompany you are also covered. A companion includes your spouse, a member of your family, your legal guardian or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

Exclusions: The following are specifically excluded travel expenses:

- Any expenses that if reimbursed would be taxable income.

- Travel costs incurred due to travel within 60 miles of your home.

- Food and meals.

- Laundry bills.

- Telephone bills.

- Alcohol or tobacco products.

- Charges for transportation that exceed coach class rates.

Transplant services and related specialty care and transplant and related specialty care travel services benefits are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered and no benefits are available when the covered person is a donor. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant; the transplant recipient's plan would cover all donor costs.

Travel Benefits

Charges for non-taxable travel and lodging expenses incurred by you and one accompanying companion/caregiver (or up to two caregivers for a dependent minor) are covered in connection with designated services.

Travel services for a designated covered service may be authorized for coverage when an in-network facility/provider is not available within a 60-mile radius of your primary home residence. Travel and lodging expenses are covered for designated services administered at a participating in-network facility/provider, subject to the maximum shown in ***Your Summary of Benefits*** section.

Travel is available for:

- Services with state legislative limitations on access including, but not limited to, abortion and gender affirmation services; and
- Mental health and substance use disorder services.

Pre-authorization of travel is required by contacting the Claims Administrator at the number on the back of your ID card. Pre-authorization of the covered designated service may also be required.

The companion/caregiver can be your spouse, a member of your family, your legal guardian or any person not related to you, but actively involved as your caregiver who is age 18.

Covered travel expenses are reimbursed within daily limits as defined by the Internal Revenue Service and include charges for:

- Airfare (coach or economy), including baggage fees;
- Bus fare, train fare, taxi/Uber/Lyft, etc.;
- Vehicle rental;
- Gasoline;
- Highway tolls (not prepaid);
- Parking;
- Shuttle service;
- Wheelchair van service to travel from local housing to facility/provider; and
- Lodging up to $50 per night per person for up to two people (maximum of $100 per night, inclusive of taxes and nonrefundable fees); lodging may include, but is not limited to, hotel, motel, rental from businesses, such as Airbnb, VRBO, etc.

Exclusions: Travel expenses not covered include, but are not limited to:

- Any expense that if reimbursed would be taxable income.
- Travel within a 60-mile radius of your primary home residence.
- Food and meals.
- Mileage.
- Incidentals, including, but not limited to, laundry bills, telephone bills, alcohol or tobacco products.
- Charges for transportation that exceed coach class rates.
- Durable medical equipment, medical supplies, ambulance.
- Refundable deposits for housing, utilities, etc.
- Travel for services not designated as covered.
- Services that are not covered by the plan.

Virtual Care

Virtual care includes:

- Dedicated virtual provider charges for the delivery of real-time medical, health-related and mental health and substance use disorder-related services, consultations and remote monitoring by dedicated virtual providers as appropriate through audio, video and secure internet-based technologies.
- Virtual physician service charges for the delivery of real-time:
    - Medical and health-related services, consultations and remote monitoring as medically appropriate through audio, video and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting; and
    - Mental health and substance use disorder consultations and services, via secure telecommunications technologies that shall include video capability, telephone and internet, when such consultations and services are delivered by a behavioral provider and are similar to office visit services provided in a face-to-face setting.

Compliance Notices

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

All the medical coverage options cover certain breast reconstructive benefits in connection with a mastectomy. If you choose breast reconstruction in connection with a mastectomy, coverage is available in a manner determined in consultation with your physician for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications for all stages of mastectomy, including lymphedema.

Such coverage is subject to all the terms of the plan, including relevant deductibles and coinsurance provisions.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care, are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center or are transported by an out-of-network air ambulance, you are protected from balance billing. In these cases, you shouldn't be charged more than your applicable copayment, deductible and/or coinsurance.

What is balance billing (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, deductible and/or coinsurance. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your plan's network.

Out-of-network means providers and facilities that haven't signed a contract with the plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what the plan pays and the full amount charged for a service. This is called balance billing. This amount is likely more than in-network costs for the same service and might not count toward your deductible or annual out-of-pocket maximum.

Surprise billing is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

- **Emergency Services:** If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (copayment, deductible and/or coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

  California Participants: California law protects you from surprise medical bills when you receive emergency services from a doctor or hospital that is not contracted with your plan. In this situation, under California law, the providers cannot bill you more than your in-network cost sharing under the plan.

- **Certain In-Network Hospital or Ambulatory Surgical Center Services:** When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

  California Participants: California law protects you from surprise medical bills when you receive scheduled care at an in-network facility, such as a hospital, lab or imaging center, but services are delivered by an out-of-network provider. When state law applies, providers cannot bill you more than your in-network cost sharing.

- **Certain Air Ambulance Transportation:** If you get certain transportation services from an air ambulance provider, the most those providers may bill you is your plan's in-network cost-sharing amount (copayment, deductible and/or coinsurance). You cannot be balance billed for these transportation services.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (copayment, deductible and/or coinsurance that you would pay if the provider or facility was in-network). The plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, the health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as prior authorization);
    - Cover emergency services by out-of-network providers;
    - Base what you owe the provider or facility (cost-sharing) on what the plan would pay an in-network provider or facility and show that amount in your explanation of benefits; and
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket maximum, as applicable.

If you think you've been wrongly billed, contact the BAE Systems Benefit Center at 1-888-900-4223.

You may also contact the federal No Surprises Help Desk for information and complaints at 1-800-985-3059 or visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Exclusions and Limitations

This list is not comprehensive. Simply because a service or procedure is not listed below does not mean it is covered by the plan. If you have any questions regarding covered expenses, contact member services.

In addition to any benefits listed as not covered in the ***Your Summary of Benefits*** or ***Covered Expenses*** sections, no payment will be made for expenses incurred for you or any dependent for:

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to this treatment and facilities are reasonably available.
- Treatment of an injury or sickness due to war, declared or undeclared.
- Charges you are not obligated to pay and/or for which you are not billed; this includes, but is not limited to:
    - Any instance where the Claims Administrator determines that a provider or pharmacy did not bill you for or has waived, reduced or forgiven any portion of its charges and/or any portion of any copayment, deductible and/or coinsurance amount(s) you are required to pay for an otherwise covered expense without 'the Claims Administrator's express consent.
    - Charges of a non-participating provider who has agreed to charge you at an in-network level or some other level not otherwise applicable to the services received.

    If the Claims Administrator determines that this exclusion applies, then the Claims Administrator, in its sole discretion, has the right to:

    - Require you and/or any provider or pharmacy submitting claims on your behalf to provide proof sufficient to the Claims Administrator that you have made your required cost-share payment(s) before payment of any benefits by the Claims Administrator;
    - Deny payment of benefits in connection with the covered expense regardless of whether the provider or the pharmacy represents that you remain responsible for any amounts that the plan does not cover; or
    - Reduce the benefits in proportion to the amount of the copayment, deductible and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or pharmacy represents that you remain responsible for any amounts that the plan does not cover.

- Charges or payment for healthcare-related services that violate state or federal law.

- Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

- Charges for or in connection with experimental, investigational or unproven services; experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or biologic therapies or devices that are determined by the utilization review physician to be:

    - Not approved by the FDA or other appropriate regulatory agency to be lawfully marketed;

    - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;

    - The subject of review or approval by an institutional review board for the proposed use except as provided in plan's clinical trials coverage; or

    - The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as covered under the plan's clinical trials coverage.

    In determining if any such technologies, supplies, treatments, drug or biologic therapies or devices are experimental, investigational and/or unproven, the utilization review physician may rely on the clinical coverage policies maintained by the Claims Administrator or the review organization; clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to FDA-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- Cosmetic surgery and therapies; cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.

- Regardless of clinical indications, acupressure, dance therapy, movement therapy, applied kinesiology, rolfing and Extracorporeal Shock Wave Lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.

- Medical and surgical services intended primarily for the treatment or control of obesity; however, treatment of clinically severe obesity, as defined by the Body Mass Index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.

- Reports, evaluations, physical examinations or hospitalization not required for health reasons, including, but not limited to, employment, insurance or government licenses and court-ordered, forensic or custodial evaluations unless otherwise covered under by the plan.

- Court-ordered treatment or hospitalization unless treatment is prescribed by a physician and is a covered service or supply under the plan.

- Treatment of erectile dysfunction; however, penile implants are covered when an established medical condition is the cause of erectile dysfunction, anorgasmy and premature ejaculation.

- Medical and hospital care and costs for the child of a dependent child unless the child is otherwise eligible under the plan.

- Non-medical counseling and/or ancillary services, including, but not limited to, custodial services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.

- Therapy or treatment intended primarily to improve or maintain general physical condition or to enhance job, school, athletic or recreational performance, including, but not limited to, routine, long term or maintenance care that is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

- Consumable medical supplies other than ostomy supplies and urinary catheters; excluded supplies include, but are not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as covered under the Plan's home health care services or breast reconstruction and breast prostheses coverage.

- Private hospital rooms and/or private duty nursing except covered under the Plan's home health care services coverage.

- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements and other articles that are not for the specific treatment of an injury or sickness.

- Artificial aids, including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.

- Aids or devices that assist with non-verbal communications, including, but not limited to, communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.

- Eyeglass lenses and frames, contact lenses and associated services (exams and fittings); except for the initial set after treatment of keratoconus or following cataract surgery.

- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

- All non-injectable prescription drugs, unless physician administration or oversight is required, injectable prescription drugs to the extent they do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs and investigational and experimental drugs, except as provided as covered by the plan.

- Routine foot care, including the paring and removing of corns and calluses and toenail maintenance; however, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when medically necessary.

- Membership costs and fees associated with health clubs, weight loss programs or smoking cessation programs.

- Genetic screening or pre-implantations genetic screening; general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

- Dental implants for any condition.

- Fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

- Blood administration for general improvement in physical condition.

- Cost of biologicals that are immunizations or medications for travel or to protect against occupational hazards and risks.

- Health and beauty aids, cosmetics and dietary supplements.

- All nutritional supplements, formulae, enteral feedings, supplies and specially formulated medical foods, whether prescribed or not except for infant formula needed for the treatment of inborn errors of metabolism.

- Charges for or in connection with an injury or sickness arising out of or in the course of any employment for wage or profit.

- Charges related to an injury or sickness payable under worker's compensation or similar laws.
- Massage therapy.
- Charges by a hospital owned or operated by or that provides care or performs services for, the U.S. Government if such charges are directly related to a military service-connected injury or sickness.
- Any charges related to care provided through a public program, other than Medicaid.
- Charges that would not have been made if the person did not have coverage.
- To the extent that they are more than maximum reimbursable charges applicable to care if any received out-of-network (for example, emergency care).
- To the extent resulting from not meeting the plan's pre-authorization requirements.
- Expenses for services, supplies, care, treatment, drugs or surgery that are not medically necessary.
- Charges by any physician or other health professional who is a member of your family or your dependent's family.
- Expenses incurred outside the U.S. other than expenses for medically necessary emergency or urgent care while temporarily traveling abroad.

Prescription Drug Program

Prescription drug coverage is automatic when you enroll in a medical plan option under a BAE Plan.

This program has a four-tier drug formulary system:

- Generic drugs;
- Preferred or formulary drugs;
- Non-preferred or non-formulary drugs; and
- Specialty drugs.

The plan pays a benefit for eligible generic, preferred/formulary and non-preferred/non-formulary and specialty medications. For specific information about the program and what you pay, see the ***Your Summary of Benefits*** section.

Below are some terms that may help you understand this coverage better.

- **Primary/Preferred (or Formulary) Drug List:** A list of safe, effective and FDA-approved prescription drugs. The list may include both generic and preferred brand-name drugs. The list is updated quarterly. For example, a brand-name drug for which a generic becomes available may be designated as a non-preferred drug. You can request the current list from CVS Caremark by phone at 1-866-236-8236 or online at www.caremark.com.
- **Generic Drugs:** Medications that have the same active ingredients, and are subject to the same FDA standards, as their brand-name counterparts. Generics are often manufactured by the same or other drug companies when the original manufacturer's patent expires. This makes the cost of the drug much less. Generic prescriptions typically cost you the least amount of money.
- **Generic Step Therapy:** Certain brand-name drugs require you to try one or two generic medication(s) before they are covered. For more information on of brand medications requiring use of generic(s) first, call 1-866-236-8236 or visit www.caremark.com.
- **Preferred or Formulary Drugs:** Commonly prescribed drugs that are preferred based on their clinical effectiveness. Drugs on the preferred drug list offer you cost savings over non-preferred drugs. Usually, a preferred drug has no generic equivalent.

- **Non-Preferred or Non-Formulary Drugs:** Drugs not included on the Primary/Preferred Drug List. Often, a non-preferred drug has a preferred or generic alternative. For information on preferred alternatives call 1-866-236-8236 or visit www.caremark.com.

- **Specialty Drugs:** Certain chronic and/or genetic conditions require special pharmacy products, often in the form of injected or infused medicines. These drugs are exclusively managed by the CVS Specialty Pharmacy, which is a comprehensive pharmacy program that provides these products directly to covered individuals along with the needed supplies, equipment and care coordination.

Retail Pharmacies

In-Network

Use an in-network retail pharmacy when you need to fill a prescription on a short-term basis (for example, an antibiotic to treat an infection). Your out-of-pocket cost is lower when you use an in-network pharmacy and fill the prescription with a generic medication.

The pharmacy network is extensive and includes many recognized pharmacy chains across the country; for a listing of participating pharmacies call 1-866-236-8236 or visit www.caremark.com. Always check to be sure your pharmacy still participates in the network before you fill a prescription.

ID Card

After you enroll in the medical plan, you will receive a separate identification (ID) card from CVS Caremark and additional information that outlines your prescription coverage. Show your ID card at an in-network pharmacy when filling your prescription. The card allows the pharmacy to confirm your coverage and file claims for you so you pay the appropriate amount.

If you have a prescription filled at an in-network pharmacy and you do not show your ID card, you will need to pay the full cost of the prescription when you have it filled and then submit a paper claim (along with the original prescription receipt) for reimbursement. You will be reimbursed based on the submitted amount. You can download and print a claim from when you log on to log on to www.caremark.com or call 1-866-236-8236.

Note: *If you fill a prescription that you take on a long-term, maintenance basis more than three times at a retail pharmacy, you must transition to a 90-day supply through a CVS pharmacy or through the mail order program. If you fill the prescription anywhere else or in 30-day supply increments, the prescription will no longer be covered and you will pay 100% of the cost.*

Out-of-Network

If you use an out-of-network pharmacy, you pay the full, retail (undiscounted) cost of the drug. You must then submit a paper claim (along with the original prescription receipt) to the Prescription Drug Claims Administrator for reimbursement. To submit a paper claim, send to:

CVS Caremark Claims Department
P.O. Box 52136
Phoenix, AZ 85072-2136

Mail Order Program

The mail order program is set up specifically for maintenance drugs used on an ongoing basis for chronic conditions, such as high blood pressure, asthma, allergies or birth control. Through the mail order program, you can receive a 90-day supply of your maintenance prescription each time you request an initial fill or refill.

Through this program, you get:

- Convenient delivery to the location of your choice, with free standard shipping;
- Access to an on-call pharmacist 24 hours a day, seven days a week; and
- Order refills online or by phone at any time.

Here's how it works:

- The first time you use the mail order program, ask your physician to write two prescriptions:
    - One for up to a 30-day supply to be filled at an in-network pharmacy (for the period before your first home delivery prescription arrives); and
    - One for up to a 90-day supply, plus any appropriate refills, to be filled through the mail order pharmacy.

    Note: *You pay for each prescription separately.*
- Mail your original prescription (photocopies are not accepted), along with your payment, to the Prescription Drug Claims Administrator (as noted in the ***Your Summary of Benefits*** section). Order forms are available on the Prescription Drug Claims Administrator's website or you may call and request the forms.
- Your medications should arrive within 10 days of when your order is placed. The package will include information about the drug, such as its use, correct dosage and other important details.

Note: *Home delivery alternatives other than the mail order program* ***are not covered.***

As an alternative to the above process, you also have the option to contact the mail order program to obtain a 90-day supply of your prescription by:

- Calling the phone number on the back of your ID Card 1-866-236-8236.
- Going online and logging on to www.caremark.com/RxDelivery (you will need to register and sign in, as necessary).

Have your ID card, the names of your medications, your doctor's information and your payment information ready.

Mail Order Refills

After the first time you request a new prescription through the mail order program, you may use the automated refill service. The information included with your last order will show the date you can request a refill and the number of refills you have left. With the automated refill service, you can order refills:

- Online by registering at and logging into www.caremark.com (you need to register to access this service);
- By calling the number provided with your last refill (have your ID number ready); or
- By mail, using the slip and following the instructions provided with your last refill. Simply fill in the ovals for the prescriptions you want to refill. If you need to refill a medication that is not listed, write the prescription number(s) in the space provided. Enclose your payment with your order.

Payment Options

You can pay for your mail order prescription by check, money order, electronic check or credit card. For credit card payments, include your credit card number and expiration date in the space provided on the mail service order form.

Drug Utilization Review

Prescriptions are examined for potential drug interactions based on your personal medication profile. A drug interaction occurs when drugs acting together cause an adverse effect in your body. The pharmacist may contact your physician before it is dispensed if there is a question about your prescription. You will receive only medications authorized by your physician.

Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products, often in the form of injected or infused medicines. The plan uses the CVS Specialty Pharmacy, which is a comprehensive pharmacy program that provides these products directly to covered individuals along with the needed supplies, equipment and care coordination.

Examples of conditions that may require special pharmacy products include, but are not limited to, allergic asthma, macular degeneration, Crohn's Disease, multiple sclerosis, growth hormone and related disorders, oncology, hematopoetics, osteoarthritis, hemophilia, von Willebrand Disease, osteoporosis and related bleeding disorders, psoriasis, hepatitis C, pulmonary arterial hypertension, hormonal therapies, pulmonary disease, infertility, renal disease, immune deficiencies and respiratory syncytial related disorders, rheumatoid arthritis, lysosomal storage disorders and virus prevention. To learn more about the specialty pharmacy, you can call CVS/Caremark Specialty toll-free at 1-800-237-2767. For billing and payments, call 1-800-250-9631 (TTY 711), Monday-Friday, 8 a.m. – 8 p.m., ET.

Note: *Some specialty medications may qualify for third-party copayment assistance programs that could lower your out-of-pocket costs for the products. For any such specialty medication where third-party copayment assistance is used, you will not receive credit toward your deductible or out-of-pocket maximum for any copayment or coinsurance amount that is applied to a manufacturer coupon or rebate.*

PrudentRx Copay Program for Specialty Medications

To provide a comprehensive and cost-effective prescription drug program for you and your family, BAE Systems has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx Copay Program assists members by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to 30% coinsurance. However, enrolled members who get a copay card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications, in particular for specialty medications. The PrudentRx Copay Program assists you in obtaining copay assistance from drug manufacturers to reduce your cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of the copay assistance program, but be assured that this is done in compliance with HIPAA.

If you currently take one or more medications included on the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. Eligible members will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call PrudentRx at 1-800-578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications; in this case, you must speak to someone at PrudentRx to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program or if you do not affirmatively enroll in any copay assistance as required by a manufacturer, you will be responsible for the full 30% coinsurance amount on specialty medications that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking, but start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program.

The PrudentRx Program Drug List may be updated periodically by the plan.

Copayments for these medications, whether made by you, the plan or a manufacturer's copay assistance program, will not count toward your deductible.

Because certain specialty medications do not qualify as essential health benefits under the Affordable Care Act, cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the plan's out-of-pocket maximum. A list of specialty medications that are not considered to be essential health benefits is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

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

Covered Prescriptions

If you or any one of your dependents incurs expenses for charges made by a pharmacy for medically necessary prescription drugs or related supplies ordered by a physician, the plan will provide coverage for those expenses as shown in the ***Your Summary of Benefits*** section.

Coverage also includes medically necessary prescription drugs and related supplies dispensed for a prescription issued to you or your dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

Medically necessary drugs, devices, treatments, supplies or procedures are covered, if they:

- Are required as treatment of a particular injury or illness and without which your condition or care would be adversely affected;
- Are prescribed consistently to treat the injury or illness;
- Are commonly accepted throughout the medical field as proper to treat the diagnosed injury or illness;
- Are the most appropriate drug or medicine that can safely be given to you;
- Have FDA approval and specific indications for your disease state;
- Are not being used for cosmetic or off-label use; and
- Are not available over-the-counter.

A medicine, service, supply or treatment prescribed for an injury or illness is not medically necessary if prescribed solely for your (or your provider's) convenience, nor is a treatment plan that is experimental, investigational, unproven or related to a research protocol. The fact that a physician prescribes a drug or treatment does not mean that it is medically necessary. The Prescription Drug Claims Administrator reserves the right to make the final determination regarding the medical necessity of a drug, device, treatment, supply or procedure.

Note: *Some drugs may require pre-authorization.*

Diabetes Coverage

Diabetes supplies are available at no cost to you when ordered through the mail order program. Examples of diabetes supplies are test strips, lancets, lancet devices, syringes and alcohol wipes. In addition, a blood glucose meter is provided at no charge annually. Call the CVS Caremark Member Diabetic Meter Team at 1-800-588-4456 (option 2). Have your ID number from your CVS Caremark card and doctor's name and phone number ready when you call.

Transform Diabetes Care (TDC) Program

TDC is a better way to manage your diabetes and overall health—available at no cost to you. The health information you share helps CVS personalize your health coaching. You will get help with diet and lifestyle habits, reminders about screenings and more. If you take diabetes medications or are already enrolled in a diabetes program, you are automatically enrolled in TDC. CVS will be in touch with you about next steps. If you have any questions, call Transform Diabetes Care l-800-348-5238.

Note: *Your copayment/coinsurance applies for prescription medications such as insulin, non-insulin injectables and oral anti-diabetes medications.*

Dispense as Written

Use of a generic or preferred/formulary medication is voluntary; however, your prescription cost will likely be higher if your physician does not prescribe a generic or preferred/formulary medication. Sometimes your doctor may prescribe a medication for which either a generic alternative or preferred/formulary brand-name is available. In these cases, your doctor may specify that a prescription be "Dispensed as Written" (DAW). The pharmacist may ask your doctor if a generic or preferred/formulary alternative might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative medication. A confirmation letter will be sent to you and your doctor explaining the change. Ask your doctor if you have questions about a change in prescription. Your doctor always makes the final decision on your medication, and you can always choose to obtain the original medication. Pharmacies will dispense only the medication authorized by your doctor.

Keep in mind that if a brand is dispensed for any reason, when a generic medication is available, you will pay the cost difference between the brand and generic medication, plus the brand cost share.

Medications Not Covered

Although there are many covered prescription drugs, there are also many prescription drugs that are not covered by the program.

Exclusions include, but are not limited to, certain drugs that have limited clinical value and that have clinically-appropriate, lower-cost alternatives (e.g., brand name drugs that are combinations of existing generic or over-the-counter drugs, new formulations of existing drugs).

Contact CVS Caremark or go online to see the most up-to-date information.

Continuing Coverage Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, as regulated by federal law, allows you and your eligible dependents (as defined in the BAE Systems, Inc. eligibility provisions) to temporarily continue health coverage beyond the time when it would otherwise end under the plan.

Under COBRA, you may elect to temporarily continue your group health coverage for yourself and any eligible dependents covered by the medical, dental, vision and/or Health Care Flexible Spending Account (HCFSA) plans ("group health plans") from the day your group health plan participation ceased because of a COBRA qualifying event (as defined in this section). You and your eligible dependents can elect COBRA continuation coverage even if you have health coverage under another group health plan.

Other Coverage Options Besides COBRA Continuation Coverage

You may have other options available to you when you lose group health coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a special enrollment period. Some of these options may cost less than COBRA continuation coverage.

When you lose job-based health coverage, it is important that you choose carefully between COBRA continuation coverage and other coverage options, because once you make your choice, it can be difficult or impossible to switch to another coverage option.

The Health Insurance Marketplace

The Marketplace offers one-stop shopping to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions right away, and you can see what your premium and cost-sharing costs will be before you make a decision to enroll. Through the Marketplace you will also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).

Coverage through the Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage does not limit your eligibility for coverage or for a tax credit through the Marketplace.

You have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a special enrollment event. After 60 days, your special enrollment period ends and you may not be able to enroll, so you should take action right away. In addition, during the Marketplace open enrollment period, anyone can enroll in Marketplace coverage.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event, such as marriage or birth of a child through a special enrollment period. However, if you terminate your COBRA continuation coverage early without another qualifying event, you have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

What to Consider

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. When considering your options for health coverage, you may want to think about:

- **Premiums:** COBRA coverage can cost up to 102% of total plan premiums. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

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

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

- **Severance payments:** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

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

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

This section, in addition to the initial COBRA continuation coverage notice that you received upon enrolling in the plan, provides a brief overview of your rights and obligations under the continuation coverage provisions of COBRA. Generally, this section should not be construed to provide greater COBRA rights than what the law requires. This section explains COBRA continuation coverage, when it may be available to you and your eligible dependents and what you need to do to protect your right to receive it. For more information about your COBRA continuation coverage rights and obligations, please contact the Benefit Center.

Retired Employees and COBRA

COBRA continuation coverage is available when you retire from BAE Systems. However, COBRA is only available to employees newly terminating from active employment; COBRA does **not** apply to former employees currently enrolled in retiree coverage, except if the employer declares Chapter 11 bankruptcy and the retiree loses coverage during the two-year period beginning one year before the bankruptcy filing and ending one year after the bankruptcy filing.

When you become eligible for retiree coverage, you can elect COBRA instead of retiree coverage or a combination of COBRA and retiree coverage (for example, you could elect COBRA for dental coverage and retiree coverage for medical benefits, if eligible). You would pay the full cost of COBRA coverage, as described in this section, but when COBRA coverage ends (ordinarily after 18 months), you cannot elect retiree coverage at that time. If you want to have retiree coverage, you must elect that instead of COBRA coverage when you retire from BAE Systems.

If you or your covered family members lose eligibility for retiree coverage, you or they may be eligible to elect to continue coverage through COBRA, as described in this section.

Definition of COBRA Continuation Coverage

COBRA continuation coverage is the same coverage that a plan gives to similarly situated participants or eligible dependents who are not receiving COBRA continuation coverage. Each eligible person that elects COBRA continuation coverage under a plan generally will have the same rights as other similarly situated participants covered under the plan, including annual enrollment and special enrollment rights (as applicable). In addition, plan changes that affect plan participants can also apply to COBRA participants.

After a COBRA qualifying event (as defined below). COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." An employee, his or her spouse or domestic partner and his or her dependent child(ren) (including a child covered due to a QMCSO) can be qualified beneficiaries if coverage under a plan is lost because of the COBRA qualifying event. Any child born to or placed for adoption with a qualified beneficiary who was a covered employee during a period of COBRA continuation coverage is also a "qualified beneficiary" for whom continuation coverage may be elected. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

COBRA qualified beneficiaries may add dependents that are acquired after they have elected COBRA continuation coverage in the same manner as an employee. These dependents are generally not qualified beneficiaries and therefore are not entitled to make separate continuation coverage elections. Coverage for these dependents will terminate no later than the date the qualified beneficiary's coverage terminates. Generally, a domestic partner is not a qualified beneficiary under COBRA; however, domestic partners may elect COBRA in the same manner as spouses. Contact the Benefits Administrator for details.

COBRA Qualifying Events

COBRA continuation coverage under the medical, dental and vision care plans can be elected as follows:

- **If you are an active employee covered by the plan**, you may elect COBRA continuation coverage if your coverage under the plan is lost because:
    - Your hours of employment are reduced; or
    - Your employment terminates (other than for gross misconduct).
- **If you are a retiree covered by the plan,** you may elect COBRA continuation coverage if your coverage under the plan is lost because your employer declares Chapter 11 bankruptcy and you lose coverage anytime during the two-year period beginning one year before the bankruptcy filing and ending one year after the bankruptcy filing.
- **If you are a covered spouse/domestic partner of an active or former employee**, you may elect COBRA continuation coverage for yourself if your coverage under the plan through your spouse/domestic partner is lost for any of these reasons:
    - Your spouse/domestic partner dies;
    - Your spouse's/domestic partner's hours of employment are reduced or employment terminates (other than due to gross misconduct);
    - You get divorced or legally separated from your spouse/domestic partner; or
    - Your spouse/domestic partner becomes entitled to (i.e., enrolled in) coverage under Medicare (under Part A, Part B or both).
- **If you are a covered dependent child of an active or former employee**, you may elect COBRA continuation coverage if coverage under the plan is lost for any of these reasons:
    - The covered employee dies;
    - The covered employee's hours of employment are reduced or employment terminates (other than due to gross misconduct);
    - Your parents divorce or legally separate;

- You cease to be an eligible dependent child (as defined in the BAE Systems, Inc. eligibility provisions); or

- The covered employee becomes entitled to (i.e., enrolled in) coverage under Medicare (under Part A, Part B or both).

A special rule applies if you drop coverage for your spouse/domestic partner and/or dependent children because you are planning to divorce, legally separate or dissolve your domestic partnership. In such a case, your spouse/domestic partner and/or dependent children who had previously been covered would be entitled to choose COBRA coverage for up to 36 months from the date that the divorce, legal separation or dissolution of your domestic partnership is final, but only if the Benefit Center is notified of the divorce, legal separation or dissolution within 60 days after the qualifying event occurs. No retroactive coverage before the date of divorce, legal separation or dissolution is available. Failure to notify the Benefit Center within 60 days will result in a loss of the right to COBRA continuation coverage and this right will not be reinstated.

When COBRA Coverage Is Available

If you have a change in employment status, such as termination of employment and are no longer eligible for benefits, your employer enters the change in status into PeopleSoft, which results in notification to the Benefit Center within 30 days of the event. The Benefit Center then mails you and your eligible dependents a notice of your COBRA rights and obligations to your home address, as well as a COBRA Enrollment Form. Notice to you is considered notice to your spouse/domestic partner with the same address. Notice provided to a parent is considered notice to your eligible dependent children with the same address. Eligible dependents residing at a different address will receive a separate notice at the address on file with the Benefit Center. It is important to keep the Benefit Center updated on your current address and the current address of your eligible dependents.

For some qualifying events (such as divorce or legal separation of the employee and spouse/domestic partner or a dependent child ceasing to be an eligible dependent child), you must notify the Benefit Center within 60 days of the qualifying event. The Benefit Center will mail a COBRA notice to that dependent (as the qualified beneficiary) to your home address or to the address you provide. Information on contacting the Benefit Center is in the ***Your Summary of Benefits*** section.

In either case, you must notify the Benefit Center if you do not receive a COBRA notice after the qualifying event or after you have notified the Benefit Center of a qualifying event.

COBRA deadlines are strictly enforced. If you fail to meet the 60-day deadline for notification, your notice will be rejected as untimely and you will lose your right to COBRA continuation coverage.

Giving Notice of a Qualifying Event

If you or a covered dependent experiences a qualifying event (due to divorce, legal separation or a dependent child losing eligibility for coverage as a dependent), it is your responsibility to notify the Benefit Center within 60 days of that event to be eligible to elect COBRA continuation coverage. You may provide notice via mail (including delivery and e-mail), telephone (including fax) or through Benefits Navigator. See the ***Your Summary of Benefits*** section for contact information. If you mail your notice, it must be postmarked no later than the last day of the required notice period. Any other method of notice (delivery, fax or e-mail) must be made and received by the Benefit Center no later than 7 p.m. CST on the last day of the notice period. If your notice fails to meet this deadline, your notice will be rejected as untimely. If your notice fails to include all of the required information, the Benefit Center will attempt to contact you to request the missing information, but only if there is still time before the notice is due. If you fail to provide any missing information as soon as reasonably possible following such a request, your notice will be rejected as insufficient.

Any notice that you provide to the Benefit Center must follow the plan's notice procedures. The Benefit Center is the designated recipient for all COBRA continuation coverage notices. If you mail a written notice or have it hand-delivered, you must mail or deliver it to the Benefit Center at the following address:

BAE Systems Benefit Center
P.O. Box 1495
Lincolnshire, IL 60069-1495

Qualifying Beneficiary Notice Requirements

The following table provides information regarding how and by when the Benefit Center must receive your information. Failure to properly notify the Benefit Center of the event will result in loss of your right to COBRA continuation coverage. This right and the related coverages cannot be reinstated.

Event	Form of Notice	Deadline	Required Information (as relevant)
Divorce, Legal Separation or Dissolution of Domestic Partnership	Internet or phone	Within 60 days from date of final court judgment for divorce or final agreement for legal separation (for dissolution of domestic partnership, within 60 days of decision to dissolve domestic partnership)	• Date • Employer's Name • Spouse/domestic partner or dependent name, address, telephone number, date of birth, gender, relationship to employee • Employee's, spouse's/domestic partner's or dependent's Social Security number • Date and reason for loss of coverage ***Note:*** *If notice is due to divorce or legal separation, a copy of the divorce or separation order must be provided.*
Dependent Child Becomes Ineligible	Internet or phone	Within 60 days of date of ineligibility	
Medicare Entitlement	Internet or phone	Within 60 days from date of entitlement (i.e., enrollment)	
Non-Disability Status Determination	Internet or phone	Within 30 days of the Social Security Administration's determination of non-disability	
Disability Determination	Internet or phone	Within 60 days of the later of Social Security Administration's disability determination or when COBRA continuation coverage began, and before the end of the maximum 18-month COBRA continuation period	
Marriage*	Internet or phone	Within 31 days from the date of marriage	

Event	Form of Notice	Deadline	Required Information (as relevant)
Birth, Adoption or Placement for Adoption*	Internet or phone	Within 60 days from the date of the event	

* *If you are covered by COBRA continuation coverage during one of these qualifying events, you may add dependents to your COBRA coverage within the timeframes mentioned in the table. These new dependents will be eligible to participate in coverage for the remainder of your COBRA continuation coverage period.*

Length of COBRA Coverage

The following are the maximum COBRA continuation coverage periods for each COBRA qualifying event.

A Covered Individual Who Has This Qualifying Event…	Can Continue Coverage for a Maximum of This Time Period…
If the Covered Individual Is the Employee:	
Reduced work hours resulting in loss of coverage	Up to 18 months
Termination of employment (except for gross misconduct)	Up to 18 months
If the Covered Individual Is an Employee's Covered Dependent:	
Reduced work hours for the employee resulting in loss of coverage for dependents	Up to 18 months
Termination of employee's employment (except for gross misconduct)	Up to 18 months
Death of employee	Up to 36 months
Divorce, legal separation or dissolution of domestic partnership from employee	Up to 36 months
Dependent child is no longer eligible	Up to 36 months
Employee becomes entitled to (i.e., enrolled in) Medicare	Up to 36 months

If a second "subsequent" qualifying event, other than your termination of employment or reduction in work hours affecting your eligibility for participation in the plan, occurs during an initial 18-month period of COBRA continuation coverage, the dependent's COBRA continuation coverage may be extended for up to a maximum period of 36 months *measured from the date of the first qualifying event*. An event will not be a subsequent qualifying event unless that event would cause a loss of coverage under the plan independent of the initial qualifying event. For example, the employee's entitlement to Medicare during the initial 18-month COBRA continuation coverage period is generally not a subsequent qualifying event because it does not cause a loss of coverage under the plan independent of the initial qualifying event. Notice of a subsequent qualifying event must be given to the Benefit Center within 60 days to extend the initial period of coverage and must be given in accordance with the plan's procedures for proper notice. If you fail to properly notify the Benefit Center within the 60-day period, you will lose your right to extended COBRA continuation coverage and that right will not be reinstated.

Disability Extension for COBRA Continuation Benefits

If you (and any other qualified beneficiary) are receiving 18 months of COBRA continuation coverage due to a qualifying event that is either your termination of employment or a reduction of hours, your maximum COBRA continuation coverage period may be extended by up to an additional 11 months, up to a maximum of 29 months, provided the following requirements are met:

- The Social Security Administration determines that you (or your covered dependent who is a qualified beneficiary) are disabled within the meaning of the Social Security Act;
- This disability is determined to exist as of the date of the qualifying event or at any time during the first 60 days of COBRA continuation coverage following the qualifying event; and
- The disability must last at least until the end of the 18-month maximum coverage period of COBRA continuation coverage.

Notice of the determination of disability under the Social Security Act must be provided to the Benefit Center within the initial 18-month maximum COBRA continuation coverage period and within 60 days of the latest of the following to occur:

- The date of the Social Security Administration determination;
- The date on which the qualifying event occurs;
- The date on which the qualified beneficiary loses coverage; or
- The date on which the qualified beneficiary is informed of the obligation to provide the disability notice.

If you fail to properly notify the Benefit Center within the deadlines above, you will lose your right to the extension of COBRA continuation coverage and this right will not be reinstated.

If the person entitled to the disability extension has a non-disabled eligible dependent qualified beneficiary who is entitled to COBRA continuation coverage, the non-disabled qualified beneficiary is also entitled to the disability extension.

If the Social Security Administration later determines that the qualified beneficiary is no longer disabled, the Benefit Center must be properly notified within 30 days of the Social Security Administration's determination that the disability no longer exists and the extended coverage will end.

If and when the disabled qualified beneficiary becomes eligible for Medicare (generally 29 months following the Social Security Administration determined date of disability), the Benefit Center must be properly notified to end the extended coverage for the disabled qualified beneficiary.

Medicare Extension for COBRA Continuation Coverage

A qualified beneficiary, who is entitled to (i.e., enrolled in) Medicare before electing COBRA, has the right to elect COBRA continuation coverage.

If you experience a qualifying event, specifically a termination of employment (for reasons other than gross misconduct) or a reduction of hours *within* the 18 month period after you become entitled to (i.e., enrolled in) Medicare, your qualified beneficiary(ies) (but not you) will become eligible for an extension of COBRA continuation coverage effective on the date your employment terminates and continuing for 18 months or, if later, the date that is 36 months following the date you originally became entitled to (i.e., enrolled in) Medicare. However, your COBRA continuation coverage will not be extended and you will remain eligible for only a maximum of 18 months of COBRA continuation coverage.

If you experience a qualifying event, specifically a termination of employment (for reasons other than gross misconduct) or a reduction of hours ***more than*** 18 months after you become entitled to (i.e., enrolled in) Medicare, you and your qualified beneficiary(ies) will become eligible for COBRA continuation coverage for a maximum period of 18 months from the date of your qualifying event.

Continuing Your Participation in the Health Care Flexible Spending Account

If your, your spouse's, or your dependent's participation in the general purpose or limited purpose HCFSA terminates due to a qualifying event and the maximum benefit available under the HCFSA for the year as of the date of the qualifying event equals or exceeds the COBRA premium that applies for coverage for the remainder of the Plan Year, you and/or they may elect to continue participating through COBRA continuation coverage in the general purpose or limited purpose HCFSA *only for the remainder of the Plan Year (including any grace period) in which the coverage otherwise terminates*. You will continue paying your contribution, but on an after-tax basis.

If you do not choose to continue your HCFSA participation under COBRA, only claims incurred up to your benefits termination date, as described in the BAE Systems, Inc. eligibility provisions, can be submitted for reimbursement. If your account is credited with contributions that exceed claims incurred before the end of the month in which you terminated employment, the "use it or lose it" rule will apply and you will forfeit any surplus in your account.

Considerations for Electing COBRA Continuation Coverage

You should take into account that you may have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's/domestic partner's employer) within 30 days after your group health coverage ends because of the qualifying events listed above. You also have the same special enrollment right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

If you reject COBRA continuation coverage before the election deadline, you may change your mind as long as you contact the Benefit Center and enroll before the deadline. Once enrolled in COBRA, if you notify the Benefit Center that you want to discontinue your COBRA coverage, your decision is irrevocable. Your coverage will not be reinstated even if you submit a payment after voluntarily dropping COBRA.

When the Benefit Center is notified that a COBRA qualifying event has happened, the Benefit Center will send you a Notice of COBRA Continuation Coverage Election and an enrollment packet that you can use to choose COBRA continuation coverage. You have 60 days from the date you would lose coverage (or the date of the Benefit Center's notification, if later) to elect the COBRA continuation coverage and to provide all information needed to meet BAE Systems' obligation of providing the actual coverage. If you or your covered family member fails to elect continuation coverage within the 60-day election period, you will lose your right to continue coverage and the right will not be reinstated.

Once you have paid your initial COBRA continuation coverage premium, your COBRA coverage will be effective retroactively to the date of the qualifying event. Until you choose COBRA coverage and make the required payment, COBRA coverage will not be effective. However, if a question about your COBRA coverage is asked during the COBRA continuation election period by a hospital or other health care provider, the inquiring party will be told that enrollment can still be made to receive retroactive coverage.

Cost of COBRA Coverage

If you or your covered dependent elect to continue coverage under the plan, you or your dependent must pay the full cost of that coverage (the company cost + employee cost), plus a 2% administration charge. The cost will be 102% of the full cost of providing the same coverage to a similarly situated active employee for the applicable level of coverage (for example, the employee only rate for single coverage or the family rate for family coverage). If you and your qualified beneficiary(ies) receive an additional 11 months of extended coverage due to disability, the cost of coverage will increase to 150% of the plan's cost during the additional 11 months of COBRA continuation coverage if the disabled qualified beneficiary is covered during the additional 11 months.

Rates are established annually by the company. Rates are provided on the COBRA election form and in materials distributed during each annual enrollment period. The rates that will apply will be the same rates that apply to a similarly situated active participant in the plan (not just employees of the business in which the employee is or was employed at the time of the qualifying event, but a rate based on the plan's average costs).

Payment for COBRA Coverage

If you elect COBRA continuation coverage, you do not have to send any payment with the COBRA Enrollment Form. However, the first payment is due within 45 days of the date the qualified beneficiary's election notice is received by the Benefit Center. The first payment is for coverage retroactive to the date of the qualifying event.

Subsequent payments for COBRA continuation coverage are due on the first of each month for that month. For example, the monthly payment for COBRA continuation coverage for the month of December is due on December 1. If you make a monthly payment on or before the first day of the month to which it applies, your coverage under the plan will continue for that month without any break. A check that has been returned unpaid from the bank for any reason may result in untimely payment and can result in cancellation of coverage.

Partial payments are not accepted. If you make only a partial payment of a monthly payment owed for COBRA continuation coverage, it will normally result in cancellation of coverage. However, if you make a partial payment and the Benefit Center determines the underpayment amount is insignificant (in accordance with IRS regulations), you will be provided notice and an opportunity to pay the remaining amount due before the cancellation of coverage.

Claims will not be honored for services incurred during a period for which payment has not been received. **Coverage is permanently cancelled without advance notice if payment is not received within the initial 45-day period or within 30 days of the first-of-the-month due date. This timing is strictly enforced.** Remember, even if no payment reminder notice is sent by the Benefit Center, it is the qualified beneficiary's responsibility to ensure that proper payment is timely received by the Benefit Center.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will not be provided beyond whichever of the following dates is first to occur:

- The date the maximum coverage period expires based upon the qualifying event that entitled you to receive COBRA continuation coverage;
- The date the group health plan is terminated and no other group health plan is provided to active employees;
- The last day of the month preceding the month for which the covered person fails to pay the COBRA continuation coverage premium by the last day of the grace period;
- The date that initial payment is not received within a maximum of 45 days after the election is made;
- The date the covered person first becomes covered under another group health plan (for children, coverage under the other parents' plan) and is no longer subject to, due to changes in the law or otherwise, a pre-existing condition exclusion or limitation under the other or new group benefit plan, after the date the person chooses COBRA continuation coverage;
- The date the covered person becomes entitled to Medicare after electing COBRA; or
- For a disabled qualified beneficiary receiving COBRA continuation coverage during the 11-month disability extension period (and their covered family members), the date the disabled person receives a final determination by the Social Security Administration that he or she is no longer "disabled." This final determination will end COBRA continuation coverage for all qualified beneficiaries as of the later of either the first day of the month following 30 days from the final determination date or the end of the COBRA continuation coverage period without regard to a disability extension.

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

In the event that your COBRA continuation coverage is terminated before the end of the maximum coverage period, the Benefit Center will notify you of such termination of coverage as soon as administratively possible. This Notice will explain why and when COBRA continuation coverage has ended.

For More Information

This COBRA section of the SPD does not fully describe all of the details of COBRA continuation coverage or other rights under the plans. Questions about a plan or your COBRA continuation coverage rights should be addressed to:

BAE Systems Benefit Center
P.O. Box 1495
Lincolnshire, IL 60069-1495
https://benefitsnavigator.baesystems.com
1-888-900-4223

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/agencies/ebsa or call their toll-free number at 1-866-444-3272. Addresses and phone numbers of Regional and District EBSA Offices in your area are available through EBSA's website.

For more information about health insurance options available through the Health Insurance Marketplace, enrolling in the Marketplace (including when the next open enrollment period will be and what you need to know about qualifying events and special enrollments periods) and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Coordination of Benefits

Coordination of benefits applies when you or your covered dependent(s) have coverage under this plan and one or more other plans. In this case, one of the plans will pay benefits first, making that plan primary. The other plan(s) will pay benefits next, making those secondary or even tertiary. The rules below determine which plan pays first, second, etc.

Insured coverage options under a BAE Plan may be subject to different coordination of benefits rules. Contact your insurer for coordination of benefits rules governing your insured coverage option under the plan.

For this section, "coverage under another plan" relates to any of the following providing benefits or services for medical treatment:

- Group insurance, or any other arrangement of coverage for individuals in a health maintenance organization (HMO) or other group on an insured or uninsured basis sponsored by an employer, or state or federal programs providing health coverage;
- Group coverage sponsored through a school or other educational institution, for a student;
- Group coverage under franchise organizations; or
- No-fault insurance required under any law of a government and provided on other than a group basis, but only to the extent the benefits are required under such no-fault law.

The applicable BAE Plan will not pay duplicate benefits for employees and/or retirees who are married to one another and who choose dependent coverage. Only one employee or retiree can cover the eligible dependents of two married BAE Systems employees or retirees. In certain limited instances, domestic partners may be eligible for coverage. Contact the Benefits Administrator for details.

How Coordination Works

If the BAE Plan is **primary**, it will pay benefits first. Benefits under the BAE Plan will not be reduced due to benefits payable under the other plan, but will not exceed 100% of the covered expenses (subject to plan limits).

If the BAE Plan is **secondary**, benefits under the BAE Plan will be reduced by benefits payable under other plan(s). The secondary plan will not pay more than the maximum benefit allowed by the BAE Plan. When the BAE Plan is secondary, the sum of its benefit and the primary plan's benefit will not exceed 100% of the total covered expenses (subject to plan limits).

Your bills and receipts must first be filed with the primary plan before being filed with the secondary plan. A copy of the primary plan's Explanation of Benefits (EOB) should be included with the secondary plan claim.

Which Plan Pays First

When two or more plans provide benefits for the same covered person, the benefit payment will follow the rules below in this order, subject to the other plan's provisions for coordination of benefits.

A plan that does not have a coordination of benefits rule consistent with this section is the primary plan. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- A plan that does not provide for coordination of benefits is the primary plan and pays first.
- A plan that covers you as an enrollee or employee is the primary plan; a plan that covers you as a dependent is secondary.
- If you are a dependent child whose parents are not divorced or legally separated, the plan that covers the parent whose birthday falls first in the calendar year as an enrollee or employee is the primary plan.
- If you are the dependent of divorced or separated parents, benefits are determined in the following:
    - First, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order (but only from the time of actual knowledge).
    - Then, the plan of the parent with custody of the child.
    - Then, the plan of the spouse of the parent with custody of the child.
    - Then, the plan of the parent not having custody of the child.
    - Then, the plan of the spouse of the parent not having custody of the child.
- The plan that covers you as an active employee (or as that employee's dependent) is the primary plan over a plan that covers you as laid-off or retired employee (or as that employee's dependent). If the other plan does not have a similar provision and, as a result, the plans do not agree on the order of benefit determination, this rule does not apply.
- The plan that covers you as an active employee or retiree (or as that employee's dependent) is the primary plan over a plan that covers you under a right of continuation provided by federal or state law. If the other plan does not have a similar provision and, as a result, the plans do not agree on the order of benefit determination, this rule does not apply.

- If one of the plans that covers you is issued out of a state whose laws govern this plan, and determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rules determines the order of benefits.

- If none of the above rules determines the order of benefits, the plan that has covered you for the longer period is the primary plan.

When coordinating benefits with Medicare, this plan is secondary and determines benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one plan is secondary to Medicare, the above benefit determination rules are used to determine how benefits are coordinated.

Limitations on Payments

In no event will the covered person recover more than the total allowable expenses offered by the plan. Nothing in this section will entitle the covered person to benefits in excess of the total maximum benefits of the plan during the claim determination period. The covered person or employee must refund any excess he or she may have been paid (or paid on his or her behalf) to the plan.

Coordination with Medicare

If you have earned the required number of quarters to qualify for Social Security benefits within the specified time frame, you are eligible for Medicare Part A at no cost. Your participation begins on the earlier of the first day of the month in which you reach age 65 or you qualify for Medicare as a result of disability or End Stage Renal Disease (ESRD). Participation in Medicare Part B is available at the same time if you apply and pay the full cost of coverage.

The following provisions apply to determine your primary coverage when participants are covered under the plan and are eligible to be covered under Medicare Part A and Part B. ***Note:*** *The Medicare provisions outlined below apply from when the covered employee or covered family member is* ***first eligible to enroll*** *in Medicare, even if that person is not enrolled for Medicare.* Covered employees should contact the Benefit Center at least 30 days before the date they or their covered family members will become eligible for Medicare. If a covered person is eligible for Medicare but does not enroll for Part B and Medicare is the primary plan, the BAE Plan will still pay benefits only up to the level it would have paid if the person was covered by Medicare Part A and Part B.

Unless determined otherwise, the BAE Plan is primary for:

- Participants who are in current employment status (as defined below), age 65 or older and eligible for Medicare;

- Spouses age 65 or older of employees who are still in current employment status;

- Participants younger than "attained age" 65 with End Stage Renal Disease (ESRD); the plan will be primary for 30 months beginning on the earlier of the month the participant becomes entitled to Medicare Part A due to ESRD or the month the participant would have become entitled to Medicare Part A due to ESRD if the participant had filed an application for coverage; and

- Disabled active employees and disabled dependents of active employees.

For this section and subject to regulations under the Centers for Medicare and Medicaid Services:

- Attained age means the age, in years, of a person as of the last anniversary of his or her date of birth.

- Active employee means an individual who is covered under the plan by virtue of the individual's "current employment status."

- Current employment status means an individual who is either actively working or who is not actively working and meets all these conditions:

    - Has not been terminated from employment with BAE Systems;

    - Retains employment rights with BAE Systems (e.g., individuals who are furloughed, temporarily laid off or on an approved leave of absence in compliance with BAE Systems policy); and

    - Is not receiving disability payments through BAE Systems' disability plan for more than 30 months.

Choice of Primary Coverage by Employee and Employee's Spouse

If you or your spouse is Medicare eligible, you may:

- Keep your healthcare plan coverage as well as your Medicare coverage; or

- Discontinue coverage in the BAE Plan and enroll in Medicare coverage.

If you chose to continue your BAE Plan coverage and enroll in Medicare, then the plan will be primary, as outlined above, consistent with applicable Medicare Secondary Payor rules.

If you and/or your spouse discontinue BAE Plan coverage and enroll in Medicare, no benefits will be paid from the BAE Plan; Medicare will be the only payor.

COBRA and Medicare

The following provisions apply to determine your primary coverage when a former plan participant is covered under the plan through COBRA continuation coverage and is eligible to be covered under Medicare Part A and Part B.

If COBRA Continuant…	Then, the Order of Payment Is…
Is entitled to Medicare based on attained age	1. Medicare 2. COBRA plan
Is entitled to Medicare based on disability	1. Medicare 2. COBRA plan
Is entitled to Medicare based on ESRD and COBRA timeframe is during the 30-month coordination period	1. COBRA plan 2. Medicare
Is entitled to Medicare based on ESRD and COBRA timeframe is after the 30-month coordination period	1. Medicare 2. COBRA plan

Claims Payment and Appeals Process

Note: *For this section, any reference to "you" refers to the claimant, whether a covered employee, covered retiree or covered dependent and also refers to a representative designated by you to act on your behalf, unless otherwise noted. An out-of-network provider will in no event be permitted to file a claim or bring an appeal of an adverse benefit determination unless expressly required by law.*

Start With Customer Service

You should be completely satisfied with the care you receive, which is why the Claims Administrator has process in place to address your concerns and solve problems.

If you have a concern about a person, service, quality of care, contractual benefit or rescission of coverage, you may call the toll-free number on your ID card, explanation of benefits or claim form and explain your concern to a Customer Service representative. You may also express that concern in writing.

Customer Service representatives will do their best to resolve the matter during your initial contact. If more time to review or investigate your concern is needed, Customer Service will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Claims and Appeals for Insured Plans and HMOs

For determination of benefits provided by insured plan options, the insurer or Health Maintenance Organization (HMO) is the named fiduciary, with the full power to interpret and apply the terms of the plan as they relate to the benefits provided under the applicable insurance or HMO contract. To obtain benefits from an insurer or HMO, you must follow the claims procedures under the applicable insurer or HMO contract, which may require you to complete, sign and submit a written claim on the insurer's or HMO's form. The insurer or HMO will decide a claim in accordance with its reasonable claims procedures, as required by ERISA, if applicable. If the insurer or HMO denies a claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial. If a claim is denied, you may appeal to the insurer or HMO for a review of the denied claim. The insurer or HMO will also decide the appeal in accordance with its ERISA claims procedures. BAE Systems is not responsible for any claim decisions made by an insurer or HMO nor is there any right of appeal to BAE Systems for benefits provided or denied under an insured plan option by an insurer or HMO.

You may have special appeal rights under insured and HMO plan options in addition to those outlined in this Summary Plan Description, such as the right to arbitrate your appeal. Consult your insurer or HMO for further information or contact your insurer or HMO at the numbers provided in the ***Administrative Information*** section of this document.

Other Claims and Appeals

For this section, procedures regarding other claims will apply to any claim for a benefit under the plan that is unrelated to a claim for a health care, such as a claim for Dependent Care Flexible Spending Account (DCFSA) benefits. In general, you can expect a decision within 90 days from the time the Decision Maker receives your claim. The Decision Maker may extend this period by 90 days if special circumstances exist that are beyond the control of the Decision Maker. If an extension is required, the Decision Maker will notify you before the end of the initial 90-day time period, explain the reason for the extension and give an approximate decision date. Either way, the Decision Maker will notify you of the claim decision. If the claim is denied, the notification will contain the required information outlined below. A "Decision Maker" is the Plan Administer or Claims Administrator that has authority to make a claim decision.

Claims and Appeals for Self-Insured Medical (Including Prescription Drug) and Dental Plans

If you want your inquiry to constitute a claim or an appeal, you must follow the procedures included in this SPD. Casual or general inquiries about eligibility or a particular benefit that may be provided under a plan do not constitute claims or appeals under this plan.

To initiate an appeal, you must submit a request for an appeal in writing to the Claims Administrator within 180 days of receipt of a denial notice.

The prompt filing of any required claim form will result in faster payment of your claim. If you are seeing an in-network provider, you may not be responsible for filing your claim; however, you are responsible for making sure your provider is doing this for you. If you are seeing an out-of-network provider, you may be required to file your own claims. Claims must be submitted within 180 days after services are provided or they will be denied as untimely.

Your Claims Administrator will provide you the required claim forms. All fully completed claim forms and bills should be sent directly to the Claims Administrator, as indicated on the claim form.

Claim Determination Timeframes

Your claim for benefits will be decided within the following timeframes:

- For urgent care claims, the Claims Administrator will notify you of the benefit determination within 72 hours after receipt. A decision can be provided to you orally, as long as written or electronic notification is provided to you within three days after the oral notification. If you do not provide the Claims Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan, the Claims Administrator will notify you within 24 hours of receiving your urgent care claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of the:

    - Claims Administrator's receipt of the requested information; or

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

    If an ongoing course of treatment was previously approved for a specific period or number of treatments, any reduction or termination by the plan for the course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. You will be notified of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

    If your request to extend the course of treatment beyond the period of time or number of treatments is a claim involving urgent care, your request will be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after it receives your claim, provided the claim is made to the plan at least 24 hours before the expiration of the prescribed period of time or number of treatments. If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care time frames previously described.

    If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the plan does not involve urgent care, your request will be considered a new claim and will be decided according to pre-service or post-service time frames, whichever applies. Appeals will be governed according to the applicable timeframes (urgent care, pre-service or post-service) listed in the "Appeals Determination Timeframes" section below.

- **For pre-service claims,** the Claims Administrator will notify you of the benefit determination within 15 days after receipt of the claim.

- **For post-service claims (claims that are submitted for payment after you receive care),** the Claims Administrator will notify you of an adverse benefit determination within 30 days after receipt of the claim.

For pre-service and post-service claims, the Claims Administrator may be allowed a 15-day extension to make a determination, provided the Plan Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Claims Administrator will notify you before the end of the applicable first 15- or 30-day period of the reason(s) for the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information needed to decide the claim, the notice of extension will also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for pre-and post-service claims due to your failure to submit necessary information, the plan's timeframe for making a benefit determination is tolled from the date of the notification until the earlier of:

- The date on which you respond to the request for additional information; or
- 45 days.

Appeal Determination Timeframes

To initiate an appeal, you must submit a request for an appeal in writing to the Claims Administrator within 180 days of receipt of a denial notice.

When appealing a claim, you should state the reason why you feel your appeal should be approved and include any information supporting your appeal. Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving medical necessity or clinical appropriateness will be reviewed by a health care professional.

The timeframe for a decision on your health care appeal depends on the type of appeal you are submitting, whether you submit a complete appeal and whether an extension is required to make a decision on your appeal.

There are four types of health claim appeals; each with different periods for making a determination of claims for benefits. A "Decision Maker" is the Plan Administrator or Claims Administrator that has authority to make a claim decision.

The types of appeals and periods are as follows:

- **Urgent Care Claim Appeal:** An urgent care appeal is an appeal pertaining to a claim for medical treatment where the time required to make a non-urgent determination could seriously jeopardize your life or health, ability to function at maximum level or would subject you to severe pain that cannot be adequately managed without the care or treatment claimed. If your health care provider with knowledge of your medical condition deems your medical care or treatment to be urgent, then the appeal is an urgent care claim appeal. The Decision Maker will respond to an urgent care appeal no later than 72 hours of receiving the appeal.

- **Pre-Service Claim Appeal:** A pre-service claim appeal is an appeal of a claim for a benefit that depends on receipt of prior approval under the terms of the plan (for example, preauthorization for surgery). The Decision Maker will notify you of its determination on a pre-service claim appeal within 15 days of receipt of the appeal. If more time or information is needed to make the determination, the Decision Maker will notify you in writing to request an extension of up to 15 days and specify any additional information needed to complete the review.

- **Post-Service Claim Appeal:** A post-service claim appeal is an appeal of a claim that is not conditioned upon receipt of advance approval and is claimed following the service. The Decision Maker will notify you of its determination on a post-service appeal within 30 days of receipt of the claim. If more time or information is needed to make the determination, the Decision Maker will notify you in writing to request an extension of up to 15 days and specify any additional information needed to complete the review.

CVS Caremark Claims Process

First-Level Clinical Appeal

First-level appeals are reviewed against predetermined medical criteria relevant to the drug or benefit being requested. This includes the consideration of relevant and supporting documentation you or your authorized representative submit. Supporting documentation may include:

- A letter written by the practitioner in support of the appeal;

- A copy of the denial letter sent by CVS Caremark; or

- A copy of your payment receipt, medical records, etc.

The appeal will be reviewed by an appropriately qualified reviewer. If the denial is upheld on appeal, a denial notification will be sent to you with instructions on how to request a second-level medical necessity review. If your appeal is urgent, CVS Caremark will perform both the first-level and second-level review as a combined appeal review within the designated timeframes. If the first-level request is approved, no further review is required and a notice of approval will be sent to you. If the first-level review cannot be approved, a second-level medical necessity review will be initiated automatically. You will receive notice of the determination at the conclusion of the medical necessity review. The two levels are combined to meet the designated urgent appeal timeframe.

Second-Level Medical Necessity Appeals

If the first-level appeal denial is upheld, you or your authorized representative may choose to pursue a second-level appeal. The second-level appeal consists of a review to determine if the requested drug or benefit is medically necessary. These requests are reviewed either by an appropriately qualified reviewer or a sub-delegated Medical Necessity Review Organization (MNRO). If your appeal is urgent, CVS Caremark will perform the second-level review within the designated urgent appeal timeframe.

For appeals reviewed by the MNRO, the following will occur:

- CVS Caremark will forward applicable medical records, prior authorization and appeals documentation, plan language and specific criteria to the MNRO.

- The independent physician reviewer selected by the MNRO to conduct the review will evaluate the provided documentation received with the case. If the physician reviewer determines additional information is necessary or potentially useful in the review, the physician reviewer may contact the member's physician to request such information.

- The independent physician reviewer will review current medical literature and available medical records and any additional information obtained from the prescribing physician. The independent physician reviewer will write an independent rationale in support of his or her final decision.

- The letter containing the rationale will be forwarded to CVS Caremark for communication to you or your representative.

Notification of Claims and Appeals Decision

The Claims or Plan Administrator will provide you with written or electronic notice of the plan's claims or appeals decision. If your claim is denied, the notice will include, subject to applicable law, the following information:

- The specific reasons for the denial;

- Reference to the specific plan or SPD provisions on which the decision is based;

- For an initial claim only, a description of additional material or information if needed to perfect the claim and the reason(s) the material or information is necessary;

- For a medical or prescription drug claim, information about the claim, including the date of service, health care provider, claim amount and any diagnosis and treatment code and its corresponding meaning (or a statement describing the availability upon request of the diagnosis and treatment code and its corresponding meaning) to the extent the information is available;

- The denial code and corresponding meaning;

- A description of any external review process as applicable;

- A statement about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes;

- For an appeal only, a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other relevant information as defined below;

- For an appeal only, a description of any voluntary appeal procedures offered by the plan and your right to obtain information about the procedures;

- For an initial claim only, a description of the plan's appeal procedures and the time limits applicable to those procedures;

- A statement of your right to bring a civil action under ERISA if relevant;

- If the denial was based on a standard internal rule, guideline, protocol or other criterion, either a copy of the standard rule, guideline, protocol or other criteria, or a statement that a copy of the rule, guideline, protocol or other criteria will be provided free of charge to you upon request;

- If the denial was based on a determination of medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the plan to your medical circumstances) or a statement that the explanation will be provided free of charge upon request; and

- For a denial involving an urgent care claim, a description of the expedited appeal process applicable to the claims.

In addition to the above, the following statement will be included: You and the plan may have other voluntary alternative dispute resolutions options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of labor Office and/or your state insurance regulatory agency.

For an urgent care claim denial, the information may be provided to you orally within the period prescribed (i.e., 24 hours) and you will be given written or electronic notice within three days after receiving the oral notice. In addition, if the denial relates to an urgent care claim, you may request an expedited external review, as outlined in the ***Expedited External Appeal*** section.

Relevant Information

Relevant information means information:

- Relied upon in the benefit determination;
- Submitted, considered or generated in the course of benefit or eligibility determination;
- Demonstrates compliance with plan administrative procedures; and
- Constitutes a policy statement or guidance concerning the denial, regardless of whether it was relied upon.

External Appeal Procedures

If you are not satisfied with the Decision Maker's determination on your internal appeal and the appeal involves medical judgment, a rescission of coverage or an adverse determination that involves consideration of whether the plan is complying with the surprise billing and cost-sharing protections of ERISA Sections 716 and 717, you may request that your appeal be referred for an external appeal, following the procedures listed in this section.

Standard External Appeal

This section describes the standard external review for self-insured medical and prescription drug claim procedures. A standard external review is an external review that is not considered expedited (as described in the ***Expedited External Appeal*** section).

Request for External Review. To request an external review, you must file a request on the document or form provided to you with your final benefit claim denial. You must file this request within four months after the date of receipt of the benefit denial notice. There is no charge for you to initiate an external review.

Preliminary Review. Within five business days following the date of receipt of the external review request (or by such other date as required by law), the plan will complete a preliminary review of the request to determine if:

- You are or were covered under the plan at the time the health care item or service was requested or, for a retrospective review, were covered under the plan at the time the health care item or service was provided;
- The benefit denial determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);

- You have exhausted the plan's internal appeal process, unless you are not required to exhaust the internal appeals process (i.e., urgent care claim); and

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

Within one business day after completion of the preliminary review, the plan will issue you a written notification. If the request is not complete, the notification will describe the information or materials needed to make the request complete. Upon receipt of this notice, you must perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization (IRO). Under the external review process, the plan will have an Independent Review Organization (IRO) that is accredited by Utilization Review Accreditation Commission (URAC) or another similar nationally recognized accrediting organization conduct the external review. The IRO will be randomly selected.

The IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit, in writing, to the assigned IRO within 10 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 after 10 business days.

Within five business days after the date of assignment of the IRO, the plan will provide to the IRO the documents and any information considered in making the benefit claim denial or final internal benefit claim determination. If the plan does not timely provide the documents and information, this will not delay the conduct of the external review. However, if the plan does not timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination.

Within one business day after making the decision, the IRO will notify you and the plan.

Upon receipt of any information submitted by you, the IRO, within one business day, will forward the information to the plan. Upon receipt of any information, the plan may reconsider its benefit claim denial that is the subject of the external review. However, reconsideration by the plan will not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its benefit denial and provide coverage or payment. If the benefit denial is reconsidered and payment of a claim approved, the plan, within one business day after making the decision, will provide written notice of its decision to you and the IRO. Upon receipt of this notice, the IRO will terminate the external review.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process. In addition to the documents and information provided, the IRO will consider the following in reaching a decision:

- Your medical records;

- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the plan, you or your treatment provider;
- The terms of the plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which will include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law;
- The opinion of the IRO's clinical reviewer or reviewers after considering information described above to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO will deliver the notice of final external review decision to you and the plan.

The IRO's decision notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim including the date or dates of service, the health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning and the reason for the previous denial;
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage and evidence-based standards, considered in reaching a decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making a decision;
- A statement that the determination is binding except to the extent that other remedies may be available under applicable law to either the plan or to you;
- A statement that judicial review may be available to you; and
- Current contact information for any applicable office of health insurance consumer assistance or ombudsman.

Reversal of Plan's Decision. Upon receipt of a notice of a final external review decision reversing the benefit claim denial, the plan will provide coverage or payment for the claim as soon as possible.

Expedited External Appeal

Request for Expedited External Review. You may make a request for an expedited external review of a medical claim at the time you receive:

- An adverse benefit determination, if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services, but have not been discharged from a facility.

Preliminary Review. Immediately upon receipt of the request for expedited external review, the plan will determine if the request meets the reviewability requirements, as described in the previous section for standard external review. The plan will send a notice that meets the requirements for a standard external appeal.

Referral to IRO. Upon a determination that a request is eligible for an expedited external review following the preliminary review, the plan will assign the claim to an IRO, as described in the ***Standard External Appeal*** section. The plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the IRO will review the claim de novo and is not bound by any decisions reached during the plan's internal claims and appeals process.

Notice of Final Expedited External Review Decision. The IRO will provide notice of the final expedited external review decision, in accordance with the requirements described in the ***Standard External Appeal*** section, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to you and the plan.

For assistance or questions about your appeal rights, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA.

Voluntary Internal Level of Claim Appeal to BAE Systems Appeal Committee

This section applies only to appeals for self-insured medical, prescription drug and dental benefits where the Claims Administrator (third party administrator, such as Cigna or CVS/Caremark) has been the Decision Maker for the claim and prior appeal(s) and your claim and appeal were wholly or partially denied. It also applies to appeals regarding health care FSA and eligibility enrollment determinations made by the Claims and Appeals Management Team. It does not apply to appeals of denials for insured dental or vision benefit claims or short-term disability claims. Voluntary internal appeals also do not apply to insured medical or other plan options.

If, after exhausting all of the claims review steps provided by your Decision Maker, you still feel that your claim has been denied in error, you may voluntarily request an internal appeal of the denied claim from the BAE Systems Appeals Committee (Appeals Committee) directly.

Note that if your claim involves medical judgment and is entitled to external appeal, then you may only bring a voluntary internal appeal if you have filed an external appeal and that appeal has been denied. You must exhaust all prior appeal rights (including external appeal, if applicable) before submitting your voluntary internal appeal. External appeals are described in greater detail above.

In general, your voluntary internal appeal must be made in writing (except urgent care appeals), contain all required information and must be submitted within the applicable timeframes. If you want to file a voluntary appeal of a self-insured medical, prescription drug, vision or dental claim decision, you must file your request within 60 days of receiving a **final** denial by the Decision Maker (in the case of a claim entitled to external appeal, 60 days from the date you receive an external appeal denial).

Every voluntary internal claim appeal under the plan will be given full and fair review by the Appeals Committee. The Appeals Committee will review all of the materials used to reach the claim decision by the plan, in addition to any additional comments, documents, records and/or other materials that you submit with the appeal. If the Appeals Committee relies on or considers new or additional evidence generated by the plan or another party in connection with a claim or prior appeal, or any new or additional rationale for a denial, the Appeals Committee will provide you, free of charge, with any evidence and allow you a reasonable opportunity to respond to the new evidence or rationale. The Appeals Committee will make an independent determination and will not give deference to the decision reached by any previous Decision Maker. The Appeals Committee will provide reasonable access to copies of all documents, records and other information relevant to the claim decision upon request.

If a medical expert was consulted in connection with your initial claim or appeal, then the Appeals Committee will disclose the name of the expert, upon request, regardless of whether the expert's opinion was used to make the initial claim or appeal decision. On a voluntary internal appeal, the Appeals Committee will consult a different medical expert than the expert consulted in the initial decision. The expert consulted on a voluntary internal appeal will not be a subordinate of the expert consulted in the prior appeal.

To receive a form on which to file your voluntary internal appeal, you must contact the Benefit Center.

Upon timely receipt of your written voluntary internal appeal, the Appeals Committee will evaluate your claim appeal and will generally make a determination within the following times:

- 72 hours of receipt of your appeal for an urgent care claim;
- 30 days of receipt of your appeal for a pre-service claim; or
- 60 days of receipt of your appeal for a post-service claim.

Note: *Because this is a voluntary level of appeal, the timeliness for decisions are not binding; however, your appeal will be handled as expeditiously as possible. The Appeals Committee will notify you in writing of the decision on your voluntary internal claim appeal.*

Maintaining Records

It is important that you keep accurate records and receipts of the expenses associated with your benefit plan. The records will be required when you submit requests for claims to be paid under the plan or if you decide to file an appeal on a claim.

Assignment of Benefits

Your benefits under the plan cannot be used as collateral for loans or be assigned in any other way, except as required by federal law. The plan will not—in any manner—be liable for or subject to debts, contracts, liabilities, or torts of any person entitled to benefits under the plan. To the extent permitted by law, neither the benefits nor payments under the plan will be subject to the claim of creditors or to any legal process.

Except as otherwise provided in the Plan Documents or as otherwise required by law, you may not assign health benefits directly to a health care provider or facility. Benefits will be paid according to the terms of the specific benefit programs under the plan. If you or your covered family member uses a network provider, the benefit plan will pay benefits, if any, to the provider of the service and the use of the network provider will be considered an automatic assignment, subject to consent of the Plan Administrator. Payment in accordance with such assignments will act as a complete discharge of liability on the part of the plan.

Benefits for non-network providers will be subject to all plan terms and conditions, including usual and customary charge limitations.

Notwithstanding anything to the contrary, an out-of-network provider will not, in any event, be permitted to file a claim or bring appeal of an adverse benefit determination unless expressly required by law.

Misrepresentation

It is a crime to knowingly, and with intent to injure, defraud or deceive the plan or the employer or provide any false information, including filing a claim that contains any false, incomplete or misleading information. These actions will result in denial of your claims, and you may be subject to criminal and/or civil prosecution and punishment under state and/or federal law. The plan reserves the right to pursue all appropriate legal remedies in the event of misrepresentation. Any material misrepresentation on the part of you and/or your dependents in making application for coverage or benefits will render the coverage under this plan null and void. Misrepresentation (intentional or unintentional) and fraud could result in cancellation of coverage, as permitted by law.

Necessary Information

Certain facts are needed to administer the plan. The Plan Administrator and its designated Claims Administrators and insurers have the authority to decide what facts are necessary. Necessary facts can be obtained from or given to any other organization or persons permitted by law, including any Independent Review Organization (IRO) upon an external appeal, if applicable. The Plan Administrator and its delegates need not tell, or get the consent of, any person to do this except as required by law. Each person claiming benefits under the plan must give the Plan Administrator and its delegates, any facts the Plan Administrator needs to administer the claim and execute documents authorizing the release by any third party of such facts, if necessary.

Refund of Overpayments

If the Plan Administrator or Claims Administrator pays benefits for expenses incurred by you or your dependent, you (or any other person or organization that was paid) must make a refund to the Plan Administrator or Claims Administrator if either of the following applies:

- All or some of the expenses were not paid by you or did not legally have to be paid by you; or
- All or some of the payment the Plan Administrator or Claims Administrator made exceeded the allowable benefits under the plan.

The refund equals the amount the Plan Administrator or Claims Administrator paid in excess of the amount they should have paid under the plan. If the refund is due from another person or organization, you agree to help the Plan Administrator or Claims Administrator obtain the refund when requested.

If you or your dependents do not promptly refund the full amount, the Plan Administrator or Claims Administrator may reduce the amount of any future benefits payable under the plan to offset the amount owed. The reductions will equal the amount of the required refund. The Plan Administrator or Claims Administrator may have other rights of recoupment in addition to the right to reduce future benefits.

Action for Recovery

You may not bring an action at law or in equity (i.e., a lawsuit) for benefits under the plan before exhaustion of all administrative remedies available under the plan. Under no circumstances may you bring a lawsuit for benefits under the plan after one year from the time a claim is incurred or, if later, 60 days following exhaustion of all administrative remedies under the plan. Any statute of limitations or other defense based on timeliness is tolled during the time that a voluntary appeal is pending.

Subrogation and Reimbursement

If you and/or a dependent are injured or become ill due to the actions of any third party and become entitled to receive any benefits covered or paid under the medical, dental, or vision plans, you must assist the plan in recovering any benefits paid by the plan from the responsible third party (or third party insurer). For example, if you are injured in a car accident and a third party is or may be responsible for the accident, you will need to pursue a claim against that person and/or his or her insurance company if the plan pays benefits to you because of the accident.

Any money recovered from the responsible person or insurance company must be used first to reimburse the plan for benefits paid to you for claims because of the responsible person, and the plan will be entitled to reimbursement from any recovery from the responsible party on a first-dollar, priority basis, without regard to whether you are fully compensated for your damages and without reduction for attorney's fees or other costs and expenses incurred by you in making the recovery.

This right to reimbursement is regardless of the manner in which the recovery is structured or worded, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for reimbursement will include, but are not limited to, any and all amounts earmarked as non-economic damage settlement or judgment.

The plan's share of the recovery will not be reduced because the full damages or expenses claimed have not been reimbursed unless the plan agrees in writing to such reduction. Further, the plan's right to subrogation or reimbursement will not be affected by the "make whole" doctrine, "fund" doctrine, "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the plan's right to subrogation or reimbursement.

The plan will recover the full amount of moneys and the value of the benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of a covered person, whether under comparative negligence or otherwise.

By filing a claim for payment under a benefit option of the plan or by receiving benefit payments (to you or on your behalf) from the plan for an injury or illness that a third party has caused, you and/or your covered dependent give the plan and the company any rights that you have to recover from the third party (or insurer) to the extent of the benefits paid or owed by the plan caused by the third party or insurer; this is called the right of subrogation. The Plan Administrator and the company have the right to sue, compromise, or settle with any responsible third party (or insurer, if applicable) on behalf of you or your covered dependent. The Plan Administrator and the company can recover from any responsible third party or any insurer covering the third party, including your or your covered dependent's own uninsured/underinsured motorist coverage, medical, or no-fault benefits that are paid or payable due to the third party's liability.

When a third party is (or may be) responsible, the plan can either:

- Pay all or part of the benefits covered by the specific benefit under the plan and be reimbursed from a settlement or judgment against the responsible third party; or

- Delay payment of all or part of the benefits covered under the plan and require the third party to pay the benefits as part of a settlement or judgment.

You and/or any covered dependent must cooperate with the Plan Administrator and the company to exercise the plan's right of subrogation and to help recover the amount of any subrogation or reimbursement of plan payments for claims that the third party caused. In addition, you and/or any covered dependent may be required by the Plan Administrator to sign a subrogation/reimbursement agreement before payment of any benefits by the plan. However, if any benefits are paid before a signed agreement is obtained, the company and the plan still have the right to require you or any covered dependent to sign it. The plan's right of subrogation is binding on you or any covered dependent (or legal representative, including a legal representative of a minor or incompetent participant and/or dependent), regardless of whether:

- The payment received from the third party (or third party insurer) is the result of a legal judgment, arbitration award, compromise settlement or any other arrangement;

- The third party has admitted liability for the payment;

- Any medical expenses are itemized in the payment by the third party (or insurer); or

- The settlement, judgment or award is described or designated to cover losses, expenses or damages other than those paid by the plan.

If you or your dependent make or file a claim, demand, lawsuit or other proceeding against a third party who may be liable for benefits paid by the plan related to claims against the third party, you or any covered dependent must seek payment or reimbursement on behalf of the plan for the amount of benefits covered by the plan (whether or not paid by the plan). You or any covered dependent must notify the insurer (if applicable) and/or the Plan Administrator before making or filing a claim against a potentially liable third party. Any compromise or settlement you or any covered dependent agrees to that attempts to reduce or limit the amount of the payment for medical or any other expenses covered by the plan (whether or not paid) to an amount that is less than the benefits covered by the plan (whether or not paid) is not effective unless the Plan Administrator and/or the insurer (if applicable) consents to the compromise or settlement in writing.

If you receive a settlement, judgment or recovery from a responsible third party (or insurer) and you fail to reimburse the plan according to the subrogation/reimbursement agreement, the company may take disciplinary action against you, up to and including immediate termination of employment, and/or may file a civil action against you for any benefits paid by the plan.

If you receive a settlement, judgment or recovery that does not cover all of your damages (including plan benefits), the plan may accept less than the full amount of benefits paid, such as a fixed percentage of the amount recovered. However, this is within the company's and the Plan Administrator's sole discretion, and the plan reserves the right to collect the full amount paid by the plan even if you are not fully compensated for your injuries or damages. You should notify the insurer and the Plan Administrator and/or insurer before accepting any settlement or upon receipt of any partial judgment.

For this section, the term "you" includes any covered person, as well as his or her estate or legal guardian and any legal representative appointed for him or her by a court or governmental agency. If you have any questions concerning this section, contact the Benefit Center.

Note: *If you are covered under an insured program under the plan, the above provisions generally describe the plan's subrogation and reimbursement rights pertaining to your coverage; however, the specific insurance policy governing your coverage may have more specific provisions governing subrogation and reimbursement rights with respect to the insured benefits insured. Contact your insurer for additional information.*

Subrogation/Reimbursement Agreement

A subrogation/reimbursement agreement is a document that states that you will reimburse the plan for any benefit payments the plan makes for the injury or illness if you recover money from someone else, including the uninsured motorist coverage provision in your own automobile policy.

Administrative Information

Plan Names, Plan Numbers and Type of Plans

The BAE Plans for active employees are the following ERISA plans:

- The BAE Systems Unfunded Welfare Benefit Plan (Plan No. 501) is an unfunded welfare benefit plan that includes these benefits:
  - General Purpose Health Care Flexible Spending Account;
  - Limited Purpose Health Care Flexible Spending Account;
  - Dependent Care Flexible Spending Account (not subject to ERISA);
  - Insured Medical and Prescription Drug (including HMOs);
  - Long-Term Disability;
  - Insured Dental;
  - Insured Vision;
  - Life;
  - TRICARE Supplemental;
  - Accidental Death and Dismemberment;
  - Employee Assistance Program; and
  - Business Travel Accident.
- The BAE Systems Funded Welfare Benefit Plan (Plan No. 503) is a funded health and welfare benefit plan that includes these benefits:
  - Self-Insured Medical and Prescription Drug;
  - Self-Insured Dental; and
  - Short-Term Disability.

Plan Sponsor and Administrator

BAE Systems, Inc., the Plan Sponsor, established and maintains the BAE Plans that provides the benefits described in this booklet. BAE Systems, Inc. has also designated the BAE Systems Administrative Committee as the Plan Administrator.

The BAE Systems Administrative Committee, which acts as the Plan Administrator, has discretionary authority to interpret plan provisions, construe plan terms, determine eligibility for benefits and otherwise make all decisions and determinations regarding plan administration. By participating in the plan, you (and your dependents or beneficiaries, if any) agree to accept the Plan Administrator's authority. You can contact the Plan Administrator and the Plan Sponsor as follows:

- **Plan Sponsor:**
  BAE Systems, Inc.
  c/o Benefits COE
  2941 Fairview Park Drive
  Falls Church, VA 22042
  Phone: 1-888-900-4223

- **Plan Administrator:**
  BAE Systems Administrative Committee
  c/o Benefits COE
  2941 Fairview Park Drive
  Falls Church, VA 22042
  Phone: 1-888-900-4223

Claims Administrator

For some of the plan benefits, the Plan Sponsor or the Plan Administrator has delegated authority to third party administrators to administer benefit claims. In addition, third and final appeal authority for self-funded medical, prescription drug, vision and dental claims have been delegated to the BAE Systems Appeals Committee by the Plan Administrator. The Claims Administrator (and contact information) for your benefit is stated in the ***Your Summary of Benefits***.

Employer Identification Number

BAE Systems, Inc.'s employer identification number, assigned by the IRS, is **22-3537950**.

Plan Year

The plan year, which is the 12-month period by which the plan's fiscal records are kept, is the calendar year.

Type of Administration

The type of administration associated with this plan is as listed in the ***Your Summary of Benefits***.

Agent for Legal Process

If you want to file suit, legal papers may be served on the Plan Administrator at the address above, or to the following address:

General Counsel
BAE Systems, Inc.
2941 Fairview Park Drive
Falls Church, VA 22042
Phone: 1-888-900-4223

Note: Service of legal process may also be made on the Plan Administrator.

Plan Funding and Contributions

Plan benefits and insurance premiums for employees and their eligible family members are paid in full or in part by the company out of its general assets or through amounts funded through a trust and, in some cases, in full or in part by employees' payroll deductions. The Plan Administrator provides a schedule of applicable employee contributions during the new hire enrollment and subsequent annual enrollment periods, and on request for each of the component benefit programs, as applicable. Contributions for the self-funded component benefit programs are also made in part by the employer's and in part by the employees' payroll deductions. The employer will make contributions in an amount that is expected to be at least sufficient to fund the benefits that are not otherwise funded by employee contributions. The company will collect the employer and employee contributions and will use these contributions to pay premiums to insurers and HMOs, and, with respect to benefits that are self-funded, will use these contributions to pay benefits directly to or on behalf of you or your eligible family members from the company's general assets or from a trust established for funding the plan. Your contributions are deemed to be used in their entirety before any employer contributions are deemed to be used.

The following benefits under the Funded Plan are funded through a trust:

- Self-insured medical and prescription drug, including the Cigna medical plans and CVS/Caremark prescription drug program;
- Self-insured dental; and
- Short-term disability (only benefits based on compensation below the compensation limit in Internal Revenue Code Section 401(a)(17)(B)).

The following benefits under the Unfunded Plan are either provided through insurance or are paid from BAE Systems' general assets:

- General purpose health care flexible spending account;
- Limited purpose health care flexible spending account;
- Dependent care flexible spending account;
- Insured medical and prescription drug;
- Long-term disability;
- Insured vision;
- Insured dental;
- Life insurance;
- TRICARE supplemental;
- Accidental death & dismemberment;
- Employee assistance program; and
- Business travel accident plan

Trust Information

Note: The Trust only applies to the Funded Plan.

Welfare Benefit Trust	**BAE Systems Welfare Benefit Trust**
Employer Identification Number (EIN)	74-2624710
Trust Year	January 1 through December 31
Trustee	JP Morgan Worldwide Securities Services 4 New York Plaza, 17th Floor New York, NY 10004-2413

Insurer Information

Coverage	Insurer	Contact Information
Medical	HMSA Medical	1-800-776-4672
Medical	Kaiser California	1-800-464-4000
Medical	Kaiser Colorado	1-800-632-9700
Medical	Kaiser Hawaii	1-800-966-5955
Medical	Optima	1-800-741-9910
Medical (Global)	Cigna	1-800-441-2668
Medical/Dental	SIMNSA	1-800-424-4652
Dental	Western Dental	1-800-992-3366
Vision	Vision Service Plan (VSP)	1-800-877-7195
Short-Term Disability	New York Life	1-888-842-4462
Long-Term Disability	New York Life	1-888-842-4462
Life and AD&D Insurance	The Hartford	1-888-563-1124

Amendments to the Plan and Termination of Coverage

BAE Systems, Inc. (including its divisions or subsidiaries) intends to continue this plan, but it reserves to itself or its designee the right to change or terminate the plan or any of the plan benefits at any time to the extent permitted by law. This can occur without the consent of, and without prior notice to, any active or retired person, eligible dependent or beneficiary covered by these benefits. Any amendments or termination will be communicated in writing. In the event of an amendment, alteration, discontinuation or termination of the plans, the BAE Plans' only liability will be for claims acquired before the change or termination of the plans. BAE Systems reserves the right to merge or consolidate the plans at any time.

In the event of a termination of the plan, any plan assets will be transferred to a successor plan. In the event that there is no successor plan, the plan assets (if any) will be disposed of in accordance with the laws and regulations that govern the disposal of plan assets.

Plan Administrator Rights

The Administrative Committee, as it relates to any plan matter including a claim for benefits, eligibility of a participant or any other matter, will have complete and final discretionary authority to interpret, apply and amend these plans and maintain control over the operation and administration of these plans, including interpretation of all plan documents, decisions as to who is eligible for reimbursement, what benefits are payable, and all other related questions that arise under these plans. The Plan Administrator's (or appropriate Claims Administrator's or insurer's) decision relating to matters arising under these plans will be final and conclusive, and there will be no de novo review unless such decisions are determined to be an abuse of discretion.

The Plan Administrator has the right to pay any plan expenses out of existing plan funds that, in the Plan Administrator's discretion, are allowable expenses under the Employee Retirement Income Security Act (ERISA). Some administrative expenses related to benefits described herein are paid out of the trusts that hold plan assets.

Collective Bargaining Agreements

If applicable, this plan is administered in consideration of the terms of multiple collective bargaining agreements. If you are a member of a collective bargaining agreement, a copy of the agreement may be obtained upon written request to the Plan Administrator and is available for examination by participants and their beneficiaries.

Keeping Your Information Private

The plan complies with the privacy and security regulations put into effect under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The plan will not use or disclose your protected health information for purposes other than treatment, payment, and plan administrative functions without your written authorization or as required by law. The plan routinely discloses protected health information to insurance companies, Claims Administrators, and others for contracted health operations services such as paying claims, verifying benefits or conducting audits. All protected health information used, requested or disclosed is limited to the minimum amount necessary to accomplish the intended purposes of the plan and its administration.

You have the right to inspect and copy, request amendment or correction, restrict the use or disclosure and request an accounting of the uses and disclosures or your protected health information. A Notice of HIPAA Privacy Practices containing a description of these uses and disclosures of protected health information, your rights, the plan's duties and complaint procedures is available upon request from the Plan Administrator and is also outlined in this section.

Notice of HIPAA Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Protected Health Information Rights

HIPAA provides certain protections and rights for that portion of your health information, which is "protected health information" or "PHI." HIPAA defines protected health information in the Code of Federal Regulations, Title 45, Section 160.103 as any health information about an individual (including demographic information) that:

- Identifies or can be used to identify the individual;
- Is created or received by a health care provider, health plan or employer; and
- Relates to:
    - Past, present or future physical or mental health or condition of an individual;
    - The provision of health care to the individual; or
    - The past, present or future payment for the provision of health care to the individual.

You have certain rights with respect to your PHI, including to:

- Request a restriction on certain uses and disclosures of your protected health information. The plan will carefully consider, although generally is not required to honor, your request for restrictions, except in limited circumstances;

- Obtain a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically;

- Inspect and obtain a copy, including an electronic copy, of the protected health information in your health record in a designated record set. The plan may charge a reasonable, cost-based fee for such copies;

- Request amendment or correction of your protected health information that the plan maintains in a designated record set. The plan may deny your request for an amendment if it believes your information is accurate and complete, or if the information was created by a party other than the plan;

- Obtain an accounting of disclosures by the plan of your health information for six years before your request, except for disclosures you have authorized or disclosures for routine treatment, payment or health care operations of the plan;

- Request communication of your protected health information by alternative means or at alternative locations if you state in writing that disclosing through normal means could endanger you; and

- Revoke your authorization for the plan to use or disclose health information except to the extent that action has already been taken.

You can exercise these rights by submitting a written request to:

BAE Systems, Inc.
Attn: HIPAA Privacy Officer
2941 Fairview Park Drive
Falls Church, VA 22042

If you want to access or amend protected health information held by a provider or business associate, you should go to the health care provider (doctor, dentist, pharmacy, hospital or other caregiver) or business associate that generated the original records, which may be more complete than any records maintained by the plan. If you are not sure, contact the BAE Privacy Officer.

The Plan's Responsibilities

This plan is required to:

- Maintain the privacy of your health information in all forms including written, oral and electronically maintained, stored and transmitted information;

- Provide you with a notice of the plan's legal duties and privacy practices with respect to information collected and maintained about you;

- Notify you if there has been a breach of unsecured protected health information; and

- Abide by the terms of this Notice.

The plan will obtain your written authorization for uses or disclosures of your protected health information that are not described in this Notice.

Permitted Disclosures for Treatment, Payment and Health Operations

Under HIPAA, the plan is permitted to make use of and disclose your protected health information, without your authorization, for treatment, payment and health care operations purposes. For example, the plan may disclose protected health information to your health care provider so that your provider may treat you or use your protected health information for management activities related to the plan, including auditing, fraud and abuse detection and customer service. The plan also may use or disclose your protected health information to pay your claims for benefits. For example, the plan may use your information to make eligibility determinations and for billing and claims management purposes. Note that the Genetic Information Nondiscrimination Act (GINA) prohibits using protected health information that is genetic information for underwriting purposes. In addition, the plan may disclose your protected health information to BAE Systems, Inc., as Plan Sponsor, so that BAE Systems, Inc. can perform administrative functions on behalf of the plan, such as facilitating claims or appeals.

Disclosures Other than Treatment, Payment or Health Care Operations

In addition to disclosures for treatment, payment and health care operations, the plan may use or disclose your PHI without your authorization under the conditions specified by HIPAA, including:

- Where required by law;
- For public health activities;
- To report child or domestic abuse;
- For governmental oversight activities;
- Pursuant to judicial or administrative proceedings;
- For certain law enforcement purposes;
- For a coroner, medical examiner or funeral director to obtain information about a deceased individual;
- For organ, eye or tissue donation purposes;
- For certain government-approved research activities;
- To avert a serious threat to an individual’s or the public’s health or safety;
- For certain government functions, such as related to military service or national security;
- To comply with workers’ compensation laws;

- As permitted by state law, which may be more stringent than HIPAA;
- To a family member or a close friend that you have identified and who is directly involved in your care or payment for your care; or
- To notify a family member or other individual involved in your care of your location, general condition or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.

Any other uses and disclosures not described in this Notice will be made only with your written authorization. By enrolling in the plan, you authorize the plan to use and disclose protected health information consistent with the description in this Notice.

Written Authorization

The plan may disclose your protected health information according to the terms of a written authorization to the plan from you. The plan may also disclose your information to any legal representative who is authorized to receive your protected health information under applicable law (in some cases, such as minors, a written authorization may not be required) or whom you have authorized in writing to receive your protected health information. Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of protected health information for marketing purposes and disclosures that constitute a sale of protected health information require authorization. If you give the plan an authorization to disclose protected health information, you can revoke that authorization at any time as long as you do so in writing. (However, the plan will not be responsible for any actions taken in reliance upon the authorization prior to receiving the revocation.)

Limitations on Disclosure

Generally, except for disclosures associated with treatment, the plan may only disclose the minimum amount of your protected health information necessary to accomplish the allowed purpose.

Right to Amend

The plan reserves the right to change the terms of this Notice and to make the new provisions effective for all protected health information maintained. If there is a material change to this Notice, the Plan will distribute a revised Notice.

For More Information

If you have questions and would like additional information on any of the information in this Notice of Privacy Practices or to exercise any of your privacy rights, you may contact the Benefit Center at 1-888-900-4223 and if necessary, they can refer you to the plan's Privacy or Security Officer.

To File a Complaint

If you believe your privacy rights have been violated, you can file a complaint in writing with the plan or the Office of Civil Rights of the Secretary of Health and Human Services. There will be no retaliation against you for filing a complaint.

You may file a complaint with the plan at the following address:

BAE Systems, Inc.
Attn: HIPAA Privacy Officer
2941 Fairview Park Drive
Falls Church, VA 22042

This Notice is revised effective as of January 1, 2024.

Your Rights Under ERISA

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that plan participants are entitled to the rights described in this section.

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls, if applicable) all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue Health Care Coverage

- Continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage.

Prudent Actions by Plan Fiduciaries

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

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right, all within certain time schedules, to:

- Know why this was done;
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, and you have properly followed and exhausted the plan's reasonable claims procedures, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

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

Assistance with Your Questions

For questions regarding eligibility, enrollment or contribution rates for this plan, contact the Benefit Center. For questions regarding benefit coverage or claims under this plan, please contact the Claims Administrator at the number given on the back of your ID card (if applicable). If you are not satisfied with the answers to your questions, if you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in the telephone directory or at the following address:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-800-998-7542 or by visiting www.dol.gov/agencies/ebsa.

Additional Provisions

Governing Law/Jurisdiction and Venue

The plans, the Summary Plan Descriptions and all matters arising from these plans will be construed and enforced according to the laws of the Commonwealth of Virginia, to the extent such state law is not preempted by ERISA or federal law, which otherwise controls. Exclusive jurisdiction and venue of all disputes arising out of or relating to the plans and the Summary Plan Descriptions will be in any court of appropriate jurisdiction in Fairfax County, Virginia.

Insured Benefits

Insurers or HMOs provide some benefits under this plan according to the terms of insurance policies or similar contracts. Any benefits specified in those insurance policies will be provided solely by the insurers that issued the policies. Under no circumstances will BAE Systems, any employer or any plan be liable to pay any benefits specified in these insurance policies or contracts.

Authority of Plan Administrator

The BAE Systems Administrative Committee is the Plan Administrator for this plan and has complete and final discretionary authority regarding certain eligibility decisions, including who is eligible and related eligibility questions that arise under the plan. Plan Administrator decisions will be final and conclusive unless the decisions are determined to be an abuse of direction.

No Employment Guarantee

This SPD is intended only to summarize the plan health and welfare benefits. The plan and this SPD are not intended to constitute a contract between you and your employer, and they in no way guarantee your continued employment with your employer. If you leave the employment of your employer, or if you are discharged, the plans do not give you any rights to any benefits, plan assets or company assets, except as specifically provided in the benefit plans.

Responsibility for Goods and Services

BAE Systems and the plan do not guarantee (and are not responsible for) the nature or quality of the goods and services provided through any health care providers or programs. This includes, but is not limited to, physicians, utilization review organizations, Claims Administrators and hospitals. The selection of health care providers, hospitals or health care programs is solely the responsibility of you and your attending physician(s).

Health care coverage under the plan will comply with the Mental Health Parity Act of 1996, Newborns' and Mothers' Health Protection Act of 1996, Women's Health and Cancer Rights Act of 1998 and the Patient Protection and Affordable Care Act, all as amended, and with the regulations described, to the extent applicable.

Terms to Know

Ambulance—Licensed ambulance transportation services involve the use of specially designed and equipped vehicles for transporting ill or injured patients. It includes ground, air or sea transportation when medically necessary and clinically appropriate.

Biologic—A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide) or analogous product or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound) used for the prevention, treatment or cure of a disease or condition of human beings, as defined in Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, Title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), as may be amended).

Biosimilar—A biologic that is highly similar to the reference biologic product notwithstanding minor differences in clinically inactive components that has no clinically meaningful differences from the reference biologic in terms of its safety, purity and potency as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, Title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), as may be amended).

Business Decision Team—A committee comprised of voting and non-voting representatives across various claims administrator business units, such as clinical, medical and business leadership that is duly authorized by the Claims Administrator to effect changes regarding coverage treatment of medical pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, changes regarding tier placement and application of utilization management to medical pharmaceuticals.

Charges—The actual billed charges except when the Claims Administrator has contracted directly or indirectly for a different amount including where the Claims Administrator has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of the services and/or supplies.

Chiropractic Care—The conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Claims Administrator—The entity or person appointed by the company that is responsible for handling plan claims, reimbursements and appeals.

Company—BAE Systems, Inc., and its affiliated companies that have adopted this plan.

COBRA—The Consolidated Omnibus Budget Reconciliation Act of 1985 or COBRA, as amended, which is an Act that allows some people who are no longer eligible for health coverage to extend health coverage for a specified period.

COBRA Administrator—Administers the COBRA rights of each employee to receive coverage under certain conditions.

Coinsurance—The amount that you pay after you meet your deductible but before you reach your out-of-pocket maximum, as applicable.

Copay or Copayment—A flat amount you pay for health services.

Convenience Care Clinics—Clinics staffed by nurse practitioners and physician assistants and offer customers convenient, professional walk-in care for common ailments and routine services. Convenience Care Clinics have extended hours and are located in or near easy-to-access, popular locations (pharmacies, grocery and free-standing locations) with or without appointment.

Custodial Services—Any services that are of a sheltering, protective or safeguarding nature. These services may include a stay in an institutional setting, at-home care or nursing services to care for someone due to age or mental or physical condition. These services primarily help the person in daily living. Custodial care can also provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial services include, but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods or taking medications that can be self-administered; and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Deductible—The amount of covered expenses that you incur and pay, out-of-pocket, in a plan year before the plan begins to pay for certain benefits, where applicable. For family coverage, it means the amount of covered expenses that two or more family members together must incur out-of-pocket in a plan year before the plan begins to pay. Once you meet the family limit, individual deductibles are waived.

Emergency Medical Condition—A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, for a pregnant individual, the health of the individual or their unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Emergency Services—For an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

Enrollment Date—The first date of coverage or, if there is a waiting period, the first day of the waiting period.

ERISA—The Employee Retirement Income Security Act of 1974 or ERISA, as amended, which is the federal law that governs most employee and retired employee benefit plans. ERISA outlines the specific responsibilities of employers and guarantees specific rights to all plan participants.

Essential Health Benefits—To the extent covered under this plan, expenses incurred for to covered services for at least the following categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services;
- Chronic disease management services; and
- Pediatric services, including oral and vision care.

Expense Incurred—An expense is incurred when the service or the supply for which it is incurred is provided.

Freestanding Surgical Facility—An institution that:

- Has a medical staff of physicians, nurses and licensed anesthesiologists;
- Maintains at least two operating rooms and one recovery room;

- Maintains diagnostic laboratory and X-ray facilities;
- Has equipment for emergency care;
- Has a blood supply;
- Maintains medical records;
- Has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis; and
- Is licensed according to the laws of the appropriate legally authorized agency.

Unless specifically stated otherwise, a free-standing surgical facility is covered the same as an outpatient facility.

Hospice Care Program—A:

- Coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- Program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness; and
- Program for persons who have a terminal illness and for the families of those persons.

Hospice Care Services—Any services provided by a hospital, skilled nursing facility or similar institution, home health care agency, hospice facility or any other licensed facility or agency under a hospice care program.

Hospice Facility—An institution or part of an institution that:

- Primarily provides care for terminally ill patients;
- Is accredited by the National Hospice Organization;
- Meets standards established by the Claims Administrator; and
- Fulfills any licensing requirements of the state or locality in which it operates.

Hospital—An institution:

- Licensed as a hospital that:
    - Maintains, on the premises, all facilities necessary for medical and surgical treatment;

- Provides treatment on an inpatient basis for compensation under the supervision of physicians; and

- Provides 24-hour service by registered graduate nurses;

- That qualifies as a hospital, psychiatric hospital or tuberculosis hospital, and a provider of services under Medicare, if the institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or

- That:

  - Specializes in treatment of mental health and substance use disorder or other related illness;

  - Provides residential treatment programs; and

  - Licensed according to the laws of the appropriate legally authorized agency.

A hospital does not include an institution that is primarily a place for rest, a place for the aged or a nursing home.

Hospital Confinement or Confined in a Hospital—You are considered confined in a hospital if you are:

- A registered bed patient in a hospital on the recommendation of a physician;

- Receiving treatment for mental health and substance use disorder services in a partial hospitalization program; or

- Receiving treatment for mental health and substance use disorder services in a mental health or substance use disorder residential treatment center.

Illness or Sickness—A physical or mental illness, including pregnancy.

Injury—An accidental bodily injury.

In-Network or Participating Provider—A hospital, physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with the Claims Administrator to provide covered services for this plan.

Maintenance Treatment—Treatment provided to keep or maintain your current status.

Maximum Reimbursable Charge—For covered services from an Open Access Plus in-network provider, the maximum reimbursable charge is determined based on a policyholder-selected percentile of a schedule developed by the Claims Administrator that is based on a methodology similar to a methodology used by Medicare to determine the allowable fee for the same or similar service within the geographic market. The percentage used to determine the maximum reimbursable charge is listed in the schedule.

In some cases, a Medicare based schedule is not used and the maximum reimbursable charge for covered services is determined based on the lesser of:

- The provider's normal charge for a similar service or supply; or
- The 80th percentile of charges made by providers of the service or supply in the geographic area where it is received as compiled in a database selected by the Claims Administrator.

The maximum reimbursable charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by the Claims Administrator. Additional information about how the Claims Administrator determines the maximum reimbursable charge or for help determining the maximum reimbursable charge for a specified service is available upon request by calling the toll-free number shown on your ID card.

Medicaid—A state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965, as amended.

Medical Pharmaceutical—Pharmaceuticals used for treatment of complex chronic conditions, which are administered and handled in a specialized manner and may be high cost. Because of their characteristics, they require a qualified physician to administer or directly supervise administration. Some medical pharmaceuticals may initially or typically require physician oversight but subsequently may be self-administered under certain conditions specified in the product's FDA labeling.

Medically Necessary or Medical Necessity—Health care services, supplies and medications provided to prevent, evaluate, diagnose or treat sickness, injury, condition, disease or its symptoms, that are, as determined by a medical director or review organization:

- Required to diagnose or treat an illness, injury, disease or its symptoms;
- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Not primarily for the convenience of the patient, physician or other health care provider;
- Not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of the sickness, injury, condition, disease or its symptoms; and
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies; where applicable, the medical director may compare the cost effectiveness of alternative services, settings or supplies when determining least intensive setting.

In determining whether health care services, supplies or medications are medically necessary, the medical director or review organization may rely on the clinical coverage policies maintained by the Claims Administrator or review organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to FDA-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

Medicare—The programs established by Title XVIII of the Social Security Act of 1965, as amended, known as the Health Insurance for the Aged Act (HIAA).

Necessary Services and Supplies—Any charges, except charges for room and board, made by a hospital for medical services and supplies actually used during hospital confinement. This does not include any charges for special nursing fees, dental fees or medical fees.

New Prescription Drug Product—A **p**rescription drug product or new use or dosage form of a previously FDA-approved prescription drug product for the period starting on the date the prescription drug product or newly-approved use or dosage form becomes available on the market following approval by the FDA and ending on the date the Claims Administrator makes a prescription drug list coverage status decision.

Nurse—A graduate Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN).

Other Health Care Facility—A facility other than a hospital or hospice facility. Examples include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and subacute facilities.

Other Health Professional—An individual other than a physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other health professionals include, but are not limited to, physical therapists, registered nurses and licensed practical nurses. Other health professionals do not include providers such as certified first assistants, certified operating room technicians, certified surgical assistants/technicians, licensed certified surgical assistants/technicians, licensed surgical assistants, orthopedic physician assistants or surgical first assistants.

Out-of-Network Provider—A provider not under contract with the Claims Administrator.

Out-of-Pocket Maximum—The maximum amount of money you must for most covered expenses before the Plan begins to pay your covered expenses at 100%, subject to any limits under the plan. If you reach any specific benefit or lifetime maximums, you must pay amounts that exceed the out-of-pocket limit.

Participating Provider—A person or entity that has a direct or indirect contractual arrangement with the Claims Administrator to provide covered services and/or supplies, the charges for which are covered expenses. This includes an entity that has directly or indirectly contracted with the Claims Administrator to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the charges that covered expenses.

Patient Protection and Affordable Care Act of 2010 (PPACA)—The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Pharmacy & Therapeutics (P&T) Committee—A committee comprised of physicians and an independent pharmacist that represent a range of clinical specialties. The committee regularly reviews medical pharmaceuticals for safety and efficacy, the findings of which clinical reviews inform coverage determinations made by the business decision team. The P&T committee's review may be based on consideration of, without limitation, FDA-approved labeling, standard medical reference compendia or scientific studies published in peer-reviewed English-language bio-medical journals.

Physician—A licensed medical practitioner practicing within the scope of his or her license and who is licensed to prescribe and administer drugs or to perform surgery. This also includes any other licensed medical practitioner whose services are required to be covered by law in the locality where the plan is located if he or she is:

- Operating within the scope of his or her license; and
- Performing a service for which benefits are provided under this plan when performed by the physician.

Plan Administrator—The Administrative Committee of BAE Systems, Inc., unless another person or entity is appointed by the company according to the terms of the plan.

Plan Sponsor—BAE Systems, Inc.

Prescription Drug List—A list that categorizes drugs, biologics (including biosimilars) or other products covered under the plan's prescription drug benefits that have been approved by the FDA. This list is adopted by the Company as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan.

Prescription Drug Product—A drug, biologic (including a biosimilar) or other product that has been approved by the FDA, certain products approved under the drug efficacy study implementation review or products marketed before 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. For this plan, this definition may also include products in the following categories if specifically identified in the prescription drug list:

- Certain durable products and supplies that support drug therapy;
- Certain diagnostic testing and screening services that support drug therapy;

- Certain medication consultation and other medication administration services that support drug therapy; and

- Certain digital products, applications, electronic devices, software and cloud based service solutions used to predict, detect and monitor health conditions in support of drug therapy.

Prescription Order or Refill—The lawful directive to dispense a prescription drug product issued by a physician whose scope of practice permits issuing such a directive.

Preventive Treatment—Treatment provided to prevent disease or its recurrence.

Primary Care Physician (PCP)—A physician who:

- Qualifies as a participating provider in general practice, internal medicine, family practice, OB/GYN or pediatrics; and

- Has been voluntarily selected by you and is contracted as a primary care physician with, and as authorized by, the Claims Administrator to provide or arrange for medical care for you or any of your covered dependents.

Psychologist—A person licensed or certified as a clinical psychologist. Where no licensure or certification exists, a psychologist is a person who is considered qualified as a clinical psychologist by a recognized psychological association. It also includes any other licensed counseling practitioner whose services are required to be covered by law in the locality where the plan operates if he or she is:

- Operating within the scope of his or her license; and

- Performing a service for which benefits are provided under this plan when performed by the psychologist.

Review Organization—An affiliate of the Claims Administrator or another entity to which the Claims Administrator has delegated responsibility for performing utilization review services. The review organization is an organization with a staff of clinicians that may include physicians, registered graduate nurses, licensed mental health and substance use disorder professionals and other trained staff members who perform utilization review services.

Room and Board—Charges made by a hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Sickness—A physical or mental illness, including pregnancy. Expenses incurred for routine hospital and pediatric care of a newborn child prior to discharge from the hospital nursery will be considered to be incurred as a result of sickness.

Skilled Nursing Facility—A licensed institution, other than a hospital, that specializes in physical rehabilitation on an inpatient basis or skilled nursing and medical care on an inpatient basis if that institution:

- Maintains on the premises all facilities necessary for medical treatment;
- Provides treatment for compensation under the supervision of physicians; and
- Provides nurse services.

Specialist—A physician who provides specialized services and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

Specialty Prescription Drug Product—A medical pharmaceutical considered to be a specialty prescription drug product based on consideration of, subject to applicable law, whether the medical pharmaceutical:

- Is prescribed and used for the treatment of a complex, chronic or rare condition;
- Has a high acquisition cost; and
- Is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight.

A specialty prescription drug product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a medical pharmaceutical will be considered a specialty prescription drug product. Specialty prescription drug products may vary by plan benefit assignment based on factors such as method or site of clinical administration or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a specialty prescription drug product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

Stabilize—For an emergency medical condition, to provide medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Substance Use Disorder Residential Treatment Center—An institution that:

- Specializes in the treatment of psychological and social disturbances from substance use disorder;
- Provides a subacute, structured, psychotherapeutic treatment program under the supervision of physicians;

- Provides 24-hour care in which a person lives in an open setting; and
- Is licensed according to the laws of the appropriate legally authorized agency as a residential treatment center.

Terminal Illness—A prognosis of six months or less to live as diagnosed by a physician.

Therapeutic Alternative—A medical pharmaceutical that is of the same therapeutic or pharmacological class and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as another medical pharmaceutical or over-the-counter medication.

Therapeutic Equivalent—A medical pharmaceutical that is a pharmaceutical equivalent to another medical pharmaceutical or over-the-counter medication.

Urgent Care—Medical, surgical, hospital or related health care services and testing that are not emergency services but that are determined by the Claims Administrator, according to generally accepted medical standards, to be necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. This care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a physician's recommendation that you should not travel due to any medical condition.