

Discover Welfare Benefits Plan Summary Plan Description

January 1, 2023

INTRODUCTION

This booklet is the Summary Plan Description (SPD) for the medical, prescription drug, dental, vision, critical illness insurance, accident insurance, hospital indemnity insurance, flexible spending accounts, life insurance, accidental death and dismemberment insurance, business travel accident insurance, long-term disability, long-term care, commuter benefits, legal assistance, employee assistance and pre-tax benefits offered under the Discover Financial Services Welfare Benefits Plan (plan) as in effect on January 1, 2023. This SPD explains in easy-to-understand language the applicable terms of the plan. Certain plan terms are described in additional detail in materials prepared and updated as needed by our benefit plan providers, including, the current materials for the following benefits:

- Medical Coverage
- Health Savings Account
- Flexible Spending Accounts
- Dental Coverage
- Vision Coverage
- Life Insurance
- Long-Term Disability Insurance
- Critical Illness Insurance
- Long-Term Care Insurance
- Accidental Death and Dismemberment Insurance
- Business Travel Accident Insurance
- Commuter Benefit Program
- Hospital Indemnity Insurance
- Accident Insurance
- On-Site Medical Clinic
- Legal Assistance Program
- Employee Assistance Program

Other plan benefits, if available, are described under separate SPDs, including the Severance Policy Summary Plan Description (updated January 1, 2017, June 1, 2018, and November 1, 2019) and the Discover Financial Services Change in Control Severance Policy Summary Plan Description (amended and restated October 15, 2014). You should read the current materials and SPDs for these benefits carefully and keep them with your other important papers for future reference.

Discover Financial Services (Discover) sponsors the plan and reserves the right to amend the plan or discontinue the plan at any time in its sole discretion. The terms outlined in this SPD may change at any time but you will be provided with written notice of any material change and generally such changes will occur during annual enrollment held in the fall of each year.

We hope you find this information helpful to you and your family. If you have questions, you should contact myHR:

- Online at MyDiscoverBenefits.com, generally available 24 hours a day, 7 days a week
- Phone: 844-DFS-myHR (844-337-6947)

  You may contact a myHR Service Center Representative by phone or chat from 8 a.m. to 6 p.m. Central Time, Monday through Friday, except certain holidays.

Plan information is available to you by logging into your account on the MyDiscoverBenefits.com website. Once you become eligible to participate in the plan, visit MyDiscoverBenefits.com or call a myHR Service Center Representative to enroll, name a beneficiary and make or change

benefit elections. After you have begun participating, refer back regularly to MyDiscoverBenefits.com for updated information, including annual enrollment materials and other summaries of material modification and other important notices regarding the plan and administration. If you do not have access to the Internet, you may obtain access to all this information by calling a myHR Service Center Representative.

The plan provides eligible employees of Discover and its participating affiliates and, in certain cases, their eligible dependents with welfare benefits under several different programs offered from time to time (programs). This SPD summarizes some of the benefits provided under the plan, as noted above. Other benefits provided under the plan are summarized in other SPDs. This booklet and certain other documents, including such other SPDs and other applicable documents related to the plan are made part of this SPD. If there is a conflict between the information in the official plan document and any other materials, including any verbal representation, the official plan document controls. Additionally, in the event there is a conflict between the SPD and any materials (other than the official plan document and documents incorporated by reference in the plan document), including any verbal representation, the SPD controls.

BENEFIT PROVIDER CONTACTS

Each benefit under the Plan is highlighted in the applicable section of this SPD. You can contact myHR with questions about any general benefits information. Please contact providers directly with detailed coverage questions.

myHR 1-844-DFS-myHR (844-337-6947) **MyDiscoverBenefits.com**

Plan	Administrator	Group Number	Website	Phone
Medical				
BlueCross Blue Shield Medical Plans	BCBS of Illinois	PPO: 256916 EPO: 282263 HSA: 256922 Saver HSA: 266208	bcbsil.com/member	877-217-7985
Prescription Drugs for BCBS Medical Plans	CVS Caremark	RX1381	caremark.com	888-739-7987
SelectHealth Medical Plans (Utah only)	SelectHealth	G1007059	selecthealth.org	800-538-5038
HMSA Medical Plan (Hawaii only)	Hawaii Medical Service Association	11487-1-7	hmsa.com	808-948-6111
Supplemental Benefits				
Accident, Critical Illness, and Hospital Indemnity Insurance	MetLife	N/A	metlife.com/mybenefits	800-GET-MET8 (800-438-6388)
Dental				
MetLife Dental Plans	MetLife	139358	metlife.com/mybenefits	800-942-0854
Vision				
VSP Vision Plans	VSP	12309573	vsp.com	800-877-7195
Work/Life Management				
Live and Work Well Program	Optum / United Behavioral Health	N/A	liveandworkwell.com (access code: Discover)	800-622-7276
Health Evaluation	Alight Well	N/A	alightwell.com	844-DFS-myHR (844-337-6947)
Quit For Life®	Optum / United Behavioral Health	N/A	quitnow.net	866-784-8454
Health Savings Account (HSA) & Flexible Spending Accounts (FSAs)				
HSA & Health Care / Dependent Day Care FSA	Optum Financial	N/A	optumfinancial.com	888-285-9499

Plan	Administrator	Group Number	Website	Phone
Life Insurance				
Basic & Supplemental and Retiree Life Insurance	The Hartford	805593	N/A	Claims: 800-563-1124 Convert & Port: 877-320-0484
Disability Insurance				
Long-Term Disability (LTD)	The Hartford	805593	abilityadvantage.thehartford.com	888-437-8660
Accidental Death and Dismemberment and Business Travel Accident Insurance				
Basic and Supplemental AD&D	LINA	ABL980064	N/A	844-DFS-myHR (844-337-6947)
Business Travel Accident	LINA	ABL980064	N/A	844-DFS-myHR (844-337-6947)
Other				
Legal Assistance	MetLife Legal Plans	N/A	metlife.com/mybenefits	800-821-6400
Commuter Benefits	WageWorks	N/A	wageworks.com	877-924-3967

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ELIGIBILITY

You and your eligible dependents may participate in the plan if you are a U.S. benefits-eligible employee of Discover and are classified by Discover and its affiliates as:

- A full-time employee,
- A flex part-time employee,
- A regular part-time employee, or
- An employee working in Hawaii 20 hours or more per week for four consecutive weeks earning at least 86.67 percent of the current minimum wage a month, subject to Hawaii Department of Labor regulations.

A U.S. benefits-eligible employee means an employee of Discover or a participating U.S. subsidiary who is eligible to participate in the plan and who either:

- Lives in the U.S. or
- Is a U.S. expatriate or U.S. benefits-eligible international employee who in either case receives pay from a U.S. dollar-based payroll.

A listing of participating companies as of January 1, 2023, is found in the "Other Important Information" section of this SPD. An updated listing may be obtained from the plan administrator.

The determination of whether an individual is a U.S. benefits-eligible employee shall be made by the plan administrator in its sole discretion; provided such individuals who are employees of Discover or its participating affiliates are eligible to participate in the wellness and the employee assistance benefits under the Live and Work Well Program.

Employees who are classified by Discover and its affiliates as part-time or temporary employees are not eligible to participate in the plan. Discover classifies employees under the Discover Financial Services Employee Classification Policy.

Additionally, individuals who are (a) classified by Discover and its affiliates as non-U.S. benefits-eligible workers, including, but not limited to, interns, summer associates, contingent workers, leased workers, independent contractors or consultants, regardless of whether or not such classification is subsequently upheld for any purpose by a court or federal, state or local administrative authority; (b) covered by a collective bargaining agreement with respect to which Discover or an affiliate is a party, unless such agreement provides for participation in the plan; or (c) hired in connection with an acquisition agreement entered into on or after January 1, 2008, unless such agreement provides for participation in the plan, are not eligible to participate in the plan.

Dependent Eligibility

Eligible dependents generally include:

- Your spouse or your domestic partner (see the "Domestic Partnership Eligibility" section for information about domestic partner benefits)

- Your or your spouse's/domestic partner's eligible dependent children, up to the end of the month in which they become age 26, regardless of marital status, eligibility for other coverage, or financial dependence on the parent
- Your or your spouse's/domestic partner's fully disabled children
- For the Accidental Death and Dismemberment plan, an eligible dependent child is an employee's unmarried child who meets the following requirements:
    1. A child from live birth to 21 years old;
    2. A child who is 21 or more years old but less than 26 years old, enrolled in school as a full-time student and primarily supported by the Employee;
    3. A child who is 21 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical disability.
- For the Business Travel Accident plan, an eligible dependent child is an employee's unmarried child who meets the following requirements:
    4. A child from live birth to 19 years old;
    5. A child who is 19 or more years old but less than 25 years old, enrolled in school as a full-time student and primarily supported by the Employee;
    6. A child who is 19 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical disability.

Your children include your biological children, stepchildren, domestic partner's children, legally adopted children, children placed for adoption, foster children, children for whom you are the legal guardian, children you have legal custody of, children whom you may claim as a tax exemption as a non-custodial parent or children you have an obligation to cover under a Qualified Medical Child Support Order (QMCSO).

Children born to your eligible dependent children are not eligible dependents unless you have legal custody. Parents, grandparents and siblings are not eligible dependents.

Certain participating programs have different eligibility terms for dependents from what is described in this SPD. Any applicable certificates or policies, including but not limited to official documents describing flexible spending accounts, health savings accounts, Accidental Death and Dismemberment and Business Travel Accident, and any applicable IRS regulations control.

Qualified Medical Child Support Orders

A Medical Child Support Order (MCSO) is any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or an administrative agency pursuant to a state domestic relations law that:

- Provides for child support or health benefit coverage (medical, dental and vision) for the child of an eligible participant in a group health plan relating to benefits under the group health plan, or
- Enforces a law concerning medical child support under a group health plan (medical, dental and vision) as provided by state Medicaid laws

A MCSO can only apply to an employee's children. The plan administrator, in its sole discretion, determines whether an MCSO meets the requirements of a Qualified Medical Child Support Order (QMCSO) pursuant to the plan's QMCSO procedures. The plan administrator may retain the services of a third party to administer QMCSOs on behalf of the plan.

Discover's procedures for obtaining a QMCSO and a sample QMCSO are available on Discover's benefits website. Paper copies will be provided without charge to employees and dependents upon request to myHR.

A QMCSO can require health coverage (medical, dental and vision) even if the eligible employee does not have legal custody of the child. A child who receives benefits under a QMCSO is known as an alternate recipient. Children eligible for benefits under a QMCSO include any children who would be eligible dependents under the terms of the medical program as if the employee had legal custody. A QMCSO may not be used to provide coverage for former spouses, domestic partners, or the dependents of domestic partners.

If the plan receives a valid QMCSO, the employee and all relevant parties will be notified by the plan administrator or its delegate. An employee who is responsible for providing benefits to a child under the terms of a QMCSO may change his/her coverage election as necessary to comply with the requirements of the QMCSO (see the "Qualified Life Events" section).

Definition of Fully Disabled

For purposes of medical, dental, vision, flexible spending accounts, legal assistance, accident, critical illness, hospital indemnity and supplemental life insurance, a child is fully disabled if:

- He/she is not able to earn his/her own living because of a mental or physical disability which started prior to the date he/she reached the maximum age for eligibility as a dependent (age 26), and
- He/she depends primarily on you or another care provider for support

Another care provider means the child requires a community integrated living arrangement, group home, supervised apartment or other residential services licensed or certified by a state department of health. Proof that your child is fully disabled must be submitted to the plan administrator (or designated third party which currently is the medical plan provider) within 31 days after the child reaches the plan's maximum age. Each program has the right to require proof of the continuation of the disability from time to time. At that time, the program is required to obtain verification of the disabled status.

Coverage will cease on the first to occur:

- Cessation of the disability or dependency
- 60-days after proof of the continuation of the disability or dependency has been requested but not provided, or
- Termination of dependent coverage for any reason other than reaching maximum age.

The plan administrator (or designated third parties, which currently are the medical plan providers) has the sole discretionary authority for determining whether your child qualifies as a disabled dependent.

Domestic Partnership Eligibility

All references to domestic partner or civil union partner in this document are defined as follows:

A domestic partner (of either gender) or civil union partner is considered eligible if you and your partner are engaged in a spouse-like relationship and your relationship meets one of the following criteria:

- You and your domestic partner or civil union partner are registered as domestic partners through a governmental domestic partnership or civil union partnership registry, or
- You and your domestic partner or civil union partner are registered through myHR

For your domestic partner or civil union partner to be registered through myHR, your relationship must meet the following criteria:

- You have shared a primary residence for at least six months and are responsible to each other for the direction and management of your household
- You are both legally entitled to reside in your household under applicable immigration laws
- You have a committed relationship of mutual caring which has existed for at least six months prior to enrollment in Discover's benefit plans
- Your relationship is expected to be long-term
- You are both 18 years of age or older and mentally competent
- Neither you nor your domestic partner or civil union partner is married or has another domestic partner or civil union partner
- You have not been married to each other at any time within the past 12 months.

If your domestic partner and his/her eligible dependents qualify as your dependents under federal tax law, you pay for their coverage under the medical, dental and vision programs with pre-tax dollars. See IRS Publication 502 to determine whether your domestic partner and their children may qualify as your dependents under federal income tax rules. You must return the Tax Certification Form for Domestic Partners or Civil Union Partners Form to myHR, indicating their federal and/or state tax dependent status to avoid imputed income. You may request a registration form on the Discover benefits website or by calling myHR.

If your domestic partner or civil union partner and their eligible dependents are not your tax dependents under federal tax law, the full cost of medical, dental and/or vision coverage for these dependents is taxable to you under federal tax law, and, therefore, added to your taxable income and reported on your Form W-2 as imputed income. Imputed income is added to your income on each pay date and you are responsible for the resulting tax on the imputed income. You are responsible for determining the tax dependent status of your dependents under federal tax law.

If your domestic partner or civil union partner relationship status changes (for example, marriage, divorce, or termination of partnership or civil union), you must contact myHR within 31 days of the change in status to update your dependents on file and to avoid imputed income (if applicable).

If your domestic partner or civil union partner (and his/her eligible dependents) is your dependent under state tax law, contact myHR.

Other Important Dependent Eligibility Information

A person is determined to be a spouse or surviving spouse if the individual is lawfully married to an eligible employee under the laws of any domestic or foreign jurisdiction where such individual and employee were married.

Other than under the life and accident insurance programs, no person may be covered both as an employee and a dependent; no person may be covered as a dependent of more than one employee.

Discover audits on a regular and/or periodic basis the coverage of dependents, including spouses, domestic partners, civil union partners and children to ensure compliance with plan rules. This is known as the dependent verification process. Any person who fails to cooperate or who provides false or misleading information to Discover or the plan for the purpose of obtaining benefits may lose any or all benefits coverage and may be required to repay any benefits improperly received. Employees may be subject to further corrective action, up to and including termination of employment and forfeiture of executive compensation.

ENROLLMENT

As a new or newly benefits-eligible active employee, you may elect coverage under the plan within 31 days of the date your personalized enrollment materials are produced and sent to you (but not after November 1 for the FSA).

Enrollment is available on the Discover benefits website when newly eligible, with a qualified life event that allows enrollment, or during annual enrollment typically held in the fall of each year.

The elections you make as a new or newly benefits-eligible active employee are generally effective from your first day of employment, or the first day of benefits eligibility, whichever is later. Life insurance coverage not subject to evidence of insurability (EOI) is generally effective the date of enrollment. The insured must be living at the time of enrollment. You must enroll your eligible dependents within this same 31-day time frame for them to be covered. Once enrolled, the corresponding payroll deduction change is effective as of your new hire date or newly eligible date, whichever is later, and you will be responsible for any missed payroll deductions.

You will be required to provide eligible dependent(s)' social security numbers when adding them to coverage.

You will be enrolled in the following coverage automatically if you do not make elections or opt out of coverage during your initial eligibility enrollment period:

- Medical coverage for yourself only in the BCBS HSA Plan
- Long-Term Disability (LTD)
- Basic life insurance (1 times your HWEE, see the "Health and Welfare Eligible Earnings" section for more information, up to $500,000)

- Basic Accidental Death and Dismemberment (AD&D) Insurance (1 times your HWEE, up to $500,000)
- Business Travel Accident (BTA) insurance

You may change your coverage elections, including your dependents, during annual enrollment for coverage in the following calendar year or within 31 days of a Qualified Life Event (QLE) - see the "Qualified Life Events" section for more information.

Evidence of Insurability (EOI) may be required for some elections. Coverage requiring EOI will become effective the later of the date the EOI is found satisfactory, or the general effective date for the enrollment period (for example, annual enrollment elections become effective January 1, or the date the required EOI is approved, if later).

Your coverage, except for the FSA, will continue as in effect from year to year if you do not make changes during annual enrollment. To continue to participate in the FSA, you must re-enroll annually during annual enrollment. To drop coverage, other than FSA, you must elect no coverage during annual enrollment.

Additional LTD Enrollment Information

Non-exempt employees are eligible to make LTD elections as part of the new hire or newly eligible enrollment event. However, non-exempt employees are only eligible for LTD benefits after six continuous months of benefits-eligible employment with Discover and/or its participating subsidiaries.

If you waive LTD insurance coverage during your initial enrollment period and later elect LTD coverage, you will be required to provide EOI, also known as medical evidence of good health (see the "Long-Term Disability Insurance" section). Coverage that requires EOI generally will become effective the later of the date the EOI is found satisfactory or after 6 months of continuous benefits-eligible employment for non-exempt employees. The "active at work" rule applies under the LTD program. If you are ill or injured and away from work on the day your coverage would become effective, the effective date of coverage and any premium will be deferred to the date you return to work for one full day.

Additional FSA and HSA Enrollment Information

If you were hired on or after November 1, you cannot enroll in a Health Care FSA or Dependent Care FSA for the remainder of that year. However, you can enroll in either or both FSAs for the following year during annual enrollment. See the "Flexible Spending Accounts" section for details.

You can only incur expenses for reimbursement from the Health Care FSA or Dependent Care FSA through the date your employment ends or the date you become ineligible for the plan. You can elect to continue the Health Care FSA through COBRA. See the "Continuation Coverage Rights Under COBRA and Other Health Coverage Alternatives" section for details.

If you were hired on or after December 1, you can enroll in an HSA; however your account will not be opened until January 1 of the following year. If you leave Discover, your contributions to the HSA will end; however, you own your HSA and will not forfeit any remaining balance.

Supplemental Life, Accidental Death & Dismemberment (AD&D), and Business Travel Accident (BTA) Insurance Enrollment Information

You must elect supplemental life insurance coverage for yourself to elect supplemental life insurance coverage for your spouse or domestic partner. The amount of supplemental life insurance coverage for your spouse or domestic partner cannot exceed the supplemental life insurance coverage for yourself. You do not need to elect supplemental life insurance to elect child life insurance.

You must elect supplemental AD&D insurance coverage for yourself to elect supplemental AD&D insurance coverage for your spouse, domestic partner, or child(ren).

Dual coverage is allowed under the life and accident insurance programs, a person may be covered both as an employee and a dependent; a child may be covered as a dependent of more than one employee.

The “active at work” rule applies under the life, AD&D, and BTA insurance programs. If you are ill or injured and away from work on the day your coverage (or any increase in coverage) would become effective, the effective date of coverage (or increase) and any increase in premium will be deferred (for yourself and eligible dependents) to the date you return to work for one full day. As an exception for dependent life insurance, coverage provided under the 31-day child automatic coverage from live birth provision applicable to an employee’s eligible newborn child is not subject to the “active at work” rule.

Dependent life coverage is also subject to a “non-confinement” rule. If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement (this does not apply to a newborn child).

Coverage Levels

You may choose one of the following coverage levels. If you cover eligible dependents, you must identify each dependent you wish to cover for each benefit during the enrollment process.

Medical, Dental, Vision, Accident, Critical Illness, and Hospital Indemnity:

- No Coverage
- You Only
- You + Spouse/DP (domestic partner)
- You + Child(ren)
- You + Family

LTD and Legal Assistance:

- You may elect “no coverage” or “coverage.” If you elect “coverage” under the legal assistance program, all eligible family members (spouse/ domestic partner, dependents) will be eligible to access the program.

Supplemental Life:

- You may elect “no coverage” or choose your coverage level (based on available plan coverage options and EOI, if applicable)

Supplemental AD&D:

- You may elect “no coverage” or choose your coverage level and indicate who is covered (You Only, You + Spouse/DP, You + Child(ren), or You + Family)

Basic Life, Basic AD&D, and BTA Insurance:

- Coverage is automatic and you may not make an election

QUALIFIED LIFE EVENTS

As a general rule, elections concerning coverage under the plan’s various benefit programs are irrevocable for the entire calendar year. However, you may change your elections in limited circumstances, known as Qualified Life Events (QLEs) if you contact myHR and complete the change within 31 days of the QLE. You may learn more about QLEs and your opportunity to make coverage changes by contacting myHR.

In general, QLEs are events that affect you or your spouse’s legal marital status, number of dependents, employment status, and certain plan cost or coverage changes (determined by the plan administrator). Examples of QLEs include, but are not limited to:

- Marriage or entering a domestic partnership
- Addition of a dependent through birth or adoption
- Divorce, legal separation, annulment, or end of a domestic partnership
- Death of spouse or dependent
- Spouse or dependent’s employment status change that causes gain or loss of benefits
- Dependent loses eligibility (turns age 26; turns age 13 for ending DDCFSA contributions)
- Commence a paid or unpaid leave of absence
- Return from a paid or unpaid leave of absence
- Address change that impacts eligibility (to/from Utah or Hawaii or in/out of BlueCross BlueShield EPO network area)
- Start/end qualified medical child support order
- Lose other health coverage
- Move from part time to regular part time, flex part time or full time status (gain eligibility)
- Move from full time to regular part time or flex part time status
- Move from regular part time or flex part time to full time status

- Significant change in childcare costs (only allows changes on a go-forward basis to DDCFSA)
- Gain or lose eligibility under Medicaid or State Children's Health Insurance Program (SCHIP)

Consistency Rule: You may only change your elections in a manner consistent with your QLE. For instance, if your dependent no longer qualifies for coverage, you may drop the dependent.

Domestic Partners: You may enroll your domestic partner in the plan within 31 days of the date you first meet the criteria listed in the Domestic Partnership Eligibility section (except for the FSA). Under IRS rules, the health care or dependent day care expenses of your domestic partner or your domestic partner's dependents generally cannot be reimbursed under the FSA or HSA programs, unless they are your dependent as determined under federal tax law. You are responsible for determining whether your dependents are dependents under applicable tax law. Contact Optum Financial and see the "Flexible Spending Accounts" section for details.

Child(ren): If you have a child born or adopt a child, the child will be presumed to be covered for the medical, dental and vision programs if you are already enrolled in You + Family or You + Child(ren) coverage and you add the child as a covered dependent within ninety (90) days of birth or adoption by contacting myHR.

For any other coverage category, you must enroll a child in coverage by notifying myHR and adding the child within 31 days of the birth or adoption. If you fail to add the child by notifying myHR within 31 days, you may still be able to add the child as a covered dependent if you file a claim requesting such coverage to the claims committee within 90 days of the birth or adoption.

Gain/Lose Eligibility Under Medicaid or State Children's Health Insurance Program (SCHIP): If you or your dependent loses eligibility for Medicaid or coverage under SCHIP, or if you or your dependent becomes eligible for a state premium assistance subsidy under the plan through Medicaid or SCHIP, you must request and complete a special enrollment with myHR within 60 days after the termination of coverage or the determination of eligibility for a state premium assistance subsidy, as applicable.

EOI: If you drop or decline LTD coverage and later elect to be covered, the EOI requirements will apply to your later coverage election.

If you drop, decrease, or decline life insurance coverage and later elect to be covered, increase your coverage level more than one level, or choose a coverage amount that results in a supplemental insurance amount of $1,000,000 for yourself or over $30,000 for your spouse/domestic partner, the EOI requirements will apply to your later coverage election.

Contact myHR to make any changes in coverage elections due to QLEs, new dependents or requests for special enrollment or to obtain more information.

Important Information About Dependent Coverage

If your dependent becomes ineligible for coverage, you must notify myHR of the dependent's loss of eligibility within 31 days of the event (for example, date of divorce). Your dependent's coverage will end retroactive to the effective date of the event in which the dependent ceased to meet the dependent eligibility requirements. In addition, if your dependent is eligible for COBRA continuation coverage, you must notify myHR, typically within 60 days of the date of the qualifying event.

There are a few situations in which your dependent's coverage will end retroactive to the last day of the month in which your dependent ceased to meet the dependent eligibility requirements:

- Your dependent child loses eligibility due to turning age 26
- Your dependent is deemed ineligible as a result of the dependent verification process, either due to your lack of providing sufficient documentation to verify your dependent's eligibility or due to you voluntarily opting-out your dependent from coverage during the dependent verification process

IMPACT OF WORK OR LIFE EVENTS ON COVERAGE

If you or a covered dependent experience a specific work or life event, the continuation of your benefits may be affected. The following pages describe the impact of different life events on your welfare benefits.

Note: IRS rules dictate what changes are allowable due to certain qualified life events. See the "Qualified Life Events" section for details.

Rehire

Impact on Your Medical, Dental, Vision, HSA, Accident, Critical Illness, Hospital Indemnity, Life, AD&D, BTA, LTD, and Legal Assistance Benefits

If your rehire date is within 31 days of your termination date and in the same calendar year, your coverage elections in effect prior to your termination will be reinstated as of your rehire date (no EOI will be required for LTD or life insurance).

If your rehire date is more than 31 days after your termination date or in a new calendar year, you will need to make new elections within 31 days of your rehire date. If you do not make timely elections, your coverage will default automatically to: You Only coverage in the BlueCross BlueShield HSA medical plan option or HMSA medical plan option (if you reside in Hawaii), LTD coverage, Basic Life Insurance coverage, Basic AD&D coverage, EAP coverage and no coverage under other benefits.

Impact on Your Flexible Spending Account (FSA) Benefits

If your rehire date is within 31 days of your termination date, in the same calendar year and prior to November 1, the annual contribution amount you elected to be contributed to your FSA prior to your termination will be reinstated as of your rehire date.

If your rehire date is more than 31 days after your termination date or in a new calendar year, you may make new elections within 31 days of your rehire date, provided you make your election prior to November 1.

You may only receive reimbursement from your Health Care FSA (HCFSA) for eligible expenses incurred while you were actively employed by Discover and were contributing to your account through December 31, unless you elected to continue HCFSA coverage through COBRA during your break in service.

If you were rehired on or after November 1, you cannot enroll in a HCFSA or Dependent Day Care FSA (DDCFSA) for the remainder of that year. However, during annual enrollment you can enroll in either or both FSAs for the following year. See the "Flexible Spending Accounts" section for details.

Impact on your Commuter Benefits

You must re-enroll in commuter benefits if you would like to participate.

Terminate or Become Ineligible for Benefits

Impact on Your Medical, Dental, Vision, HSA, Accident, Critical Illness, Hospital Indemnity and Legal Assistance Benefits

Coverage under the active medical, dental, vision, accident, critical illness, hospital indemnity and legal assistance programs ceases at the end of the month of your termination or loss of eligibility date.

You may continue your medical, dental and vision coverage in effect at the time you terminated or became ineligible for benefits at your own expense, generally for up to 18 months through COBRA. See the "Continuation Coverage Rights Under COBRA and Other Health Coverage Alternatives" section for details. You will be directly billed by myHR, the benefits administrator, for the cost of coverage under COBRA.

If you were contributing to an HSA, your contributions will end. Since you own your HSA, you will not forfeit any remaining balance. You may leave your HSA with ConnectYourCare (a subsidiary of Optum Financial) or transfer your balance to another HSA custodian. You may be responsible for administrative fees with ConnectYourCare, or your HSA custodian if you transfer your balance.

The legal assistance program will cover eligible legal fees for covered services that were open and pending prior to your termination or loss of eligibility date. You may be eligible to continue coverage at your own expense for up to 30 months. See the "Legal Assistance Program" section.

Impact on Your Life Insurance Benefits

Your active Basic and Supplemental Life Insurance coverage ends as of your termination or loss of eligibility date. Under the plan terms, you may be eligible to port or convert part or all of your life insurance (including any spouse/domestic partner and/or child life insurance) that is in force at the time your employment terminated directly with The Hartford without providing evidence of insurability. You must complete, and The Hartford must receive, the necessary application forms within 60 days following the date your coverage ends. Call The Hartford for

information about portability and/or conversion, rates, plan terms and limitations, and to request the appropriate application form. Rates will differ from those paid as an active employee.

Impact on Your Flexible Spending Account (FSA) Benefits

FSA coverage ends as of your termination or loss of eligibility date. If you have a balance remaining in your HCFSA, you can only submit claims for reimbursement that were incurred prior to your termination or loss of eligibility date. Eligible expenses may be submitted up to March 31 of the following year. You may continue your HCFSA coverage through COBRA on an after-tax basis until the end of the calendar year and submit expenses incurred after your termination or loss of eligibility for reimbursement.

If you have a balance remaining in your Dependent Day Care FSA (DDCFSA), you may request reimbursement for eligible expenses up to March 31 of the following year for expenses incurred through the end of the calendar year. COBRA continuation is not available for the DDCFSA.

Impact on Your LTD Benefits

Coverage ends as of your termination or loss of eligibility date unless you have already been approved for LTD benefits by The Hartford as of your termination date.

Impact on your Commuter Benefits

You have 180 days to submit claims for reimbursement of expenses incurred through your termination date. Any unclaimed balance after 180 days will be forfeited.

Basic and Supplemental AD&D and BTA Insurance

Coverage ends as of your termination or loss of eligibility date.

Paid Leave of Absence

Note: Beginning and returning from a paid leave generally constitutes a qualified life event. See the “Qualified Life Event” section for more information.

Impact on Your Medical, Dental, Vision, HSA, FSA, Accident, Critical Illness, Hospital Indemnity, Life, LTD and Legal Assistance Benefits

Coverage continues through payroll deductions. Upon your return from leave, you may participate in the plans on the same terms as prior to your leave, if eligible.

If you incur claims under the medical, dental or vision programs while you are on a paid military leave and you are covered under both Discover’s plan and the U.S. Defense Department plan, the Discover plan is considered primary.

Upon your return from paid leave of absence, you may participate in the plans on the same terms as prior to your leave if eligible.

Impact on Your Commuter Benefits

Coverage ends upon your leave of absence. You must re-enroll in the program upon your return from leave.

Impact on Your Basic and Supplemental AD&D and BTA Insurance Benefits

Coverage continues for basic and supplemental AD&D. Coverage for BTA ends upon your leave of absence, but automatically resumes upon your return from leave.

Unpaid Leave of Absence

During an unpaid leave of absence, myHR will bill you monthly for your coverage on an after-tax basis. Your coverage will be cancelled retroactive to your paid-through date if you do not make timely payments to myHR.

If you are on an unpaid personal leave of absence, you will be billed 100% of the cost of coverage, which may be higher than the rates you pay as an active employee.

Beginning and returning from an unpaid leave generally constitutes a qualified life event. See the "Qualified Life Event" section for more information.

Impact on Your Medical, Dental, Vision, Accident, Critical Illness, Hospital Indemnity, Life, Supplemental AD&D and Legal Assistance Benefits

Coverage continues and myHR will bill you monthly for your coverage on an after-tax basis. If you don't make timely payments, your coverage will be cancelled retroactive to your paid-through date and will be automatically reinstated when you return from leave.

Upon your return from leave, you may participate in the plans on the same terms as prior to your leave, if eligible, and subject to EOI rules.

Impact on your Commuter Benefits

Commuter benefits coverage ends upon your leave of absence. You must re-enroll in commuter benefits upon your return from leave.

Impact on your Health Savings Account (HSA)

HSA pre-tax payroll contributions are suspended while you are on an unpaid leave of absence. Upon your return from leave, your bi-weekly payroll deductions will be adjusted so you can meet your annual HSA elected goal amount.

Impact on Your Flexible Spending Account (FSA) Benefits

You may continue HCFSA coverage. myHR will bill you monthly on an after-tax basis.

If you do not continue HCFSA coverage, expenses incurred while on leave (when you were not contributing to the HCFSA) will not be eligible for reimbursement.

DDCFSA contributions are suspended while you are on an unpaid leave of absence. You may not submit for reimbursement expenses incurred while you are on an unpaid leave of absence and not contributing to the DDCFSA.

Impact on Your LTD Benefits

You may continue LTD coverage for up to six months if you continue to pay premiums and remain employed. After six months, coverage is dropped. However, coverage will continue if you remain on an approved Military Leave and continue to pay premiums.

Impact on Your Basic AD&D and BTA Insurance Benefits

Coverage ends upon the leave of absence, but automatically resumes upon your return from leave.

Death

Impact on Your Medical, Dental, Vision, Accident, Critical Illness, Hospital Indemnity and Legal Assistance Benefits

Medical, dental and vision coverage will automatically continue for one year through COBRA for your covered dependents at the same coverage level as prior to your death at Discover's expense if you were an active employee at the time of your death.

After one year of coverage at Discover's expense, your covered dependents may continue medical, dental and vision coverage at their own expense through the remainder of the COBRA period. See the "Continuation Coverage Rights Under COBRA and Other Health Coverage Alternatives" section for details.

Accident, critical illness and hospital indemnity coverage for you and your dependents will end on the date of your death.

Legal assistance program participation ends on the date of your death. The program will cover eligible legal fees for covered services that were open and pending prior to your death.

Impact on Your Health Savings Account (HSA)

Your HSA ends on your date of death and your account is then inherited by your designated beneficiary.

Impact on Your Flexible Spending Account (FSA) Benefits

Your contributions to an FSA end upon your death. Your eligible dependents may submit FSA claims for reimbursement up to March 31 of the following calendar year, for eligible expenses incurred prior to your death (for the HCFSA) and eligible expenses incurred through the end of the calendar year (for the DDCFSA). Keep in mind that eligible expenses for DDCFSA are those that allow you to work, be a full-time student, or if you are disabled, to care for your dependents.

Impact on Your LTD Benefits

If you die while receiving a monthly disability benefit at the time of your death, The Hartford will pay a survivor income benefit of three times the monthly benefit when they receive satisfactory proof of your death and proof that the person claiming the benefit is entitled to receive the benefit. The survivor income benefit will only be paid to your surviving spouse, or if no surviving spouse, in equal shares to your surviving children. However, The Hartford will first apply the survivor Income Benefit to any overpayment which may exist on your claim.

Impact on your Commuter Benefits

Claims for reimbursement of expenses incurred through your date of death must be submitted within 180 days. Any unclaimed balance after 180 days will be forfeited.

Impact on Your Life, AD&D and BTA Insurance Benefits

Coverage ends on the date of your death. Any covered dependents may convert their supplemental life insurance coverage to individual policies within 60 days from the date of your death. Contact The Hartford for more information.

Dependent Becomes Ineligible for Benefits

Impact on Your Medical, Dental, Vision, Accident, Critical Illness and Hospital Indemnity Benefits

Coverage for your dependent ends retroactive to the effective date of the event in which your dependent ceased to meet the dependent eligibility requirements. Your dependent may have the right to continue medical, dental and vision coverage at their own expense, generally for up to 36 months through COBRA. See the "Continuation Coverage Rights Under COBRA and Other Health Coverage Alternatives" section for information.

It is your responsibility to notify myHR within 60 days of the date that your dependent loses eligibility and ensure that myHR has the correct address on file for your dependent if your dependent elects COBRA coverage.

Note: if your dependent's eligibility ends due to your dependent turning age 26, your dependent's medical, dental and/or vision coverage will end on the last day of the month in which your dependent turns age 26.

Impact on Your Flexible Spending Account (FSA) Benefits

Coverage ceases on the day they reach the applicable age limit or when they no longer qualify as your eligible dependents for any other reason.

Impact on Your Supplemental Life, AD&D and Legal Assistance Benefits

Coverage for your dependents ends when they reach the applicable age limit or when they no longer qualify as your eligible dependents for any other reason. Your covered dependents may convert their supplemental life coverage to individual policies within 60 days from the date they lose coverage. Contact The Hartford for more information.

Conversion and portability policies are not available for AD&D insurance coverage.

If you are enrolled in You + Child(ren) or You + Family AD&D coverage and you no longer have any children eligible for AD&D coverage, you must contact myHR within 31 days to change your coverage tier. See the "Life, Accidental Death and Dismemberment and Business Travel Accident Insurance" section for more information.

Coverage for your dependents in the legal assistance program can be continued for up to 12 months through a portable plan. Contact MetLife Legal Plans for more information.

COST

Medical, Dental and Vision

Discover pays a portion of the cost of medical and dental coverage for active employees and employees on paid leave. You pay the cost of vision coverage. For medical coverage, your

share of the cost is determined by the coverage level you elect and your HWEE (see “Health and Welfare Eligible Earnings” section). Your share of the cost is automatically paid through pre-tax payroll deductions.

If you are on an unpaid leave of absence, you will be billed monthly by myHR for your share of the cost for coverage. If you are on an unpaid personal leave of absence, you will be billed monthly by myHR for 100% of the cost for coverage.

If your domestic partner and their eligible dependents are not your dependents under federal tax law, the full cost of medical, dental and vision coverage for your domestic partner (and his or her eligible dependents) is taxable to you and, therefore, added to your taxable income and reported on your Form W-2 as imputed income.

If your domestic partner and his or her dependents qualify as your dependents under federal and/or state tax law, you must return a Tax Certification Form for Domestic Partners or Civil Union Partners to myHR indicating their tax dependent status to avoid imputed income. Forms are available from myHR.

If you elect not to have medical, dental and/or vision coverage, you will be paid your compensation in cash each pay period over the plan year, subject to applicable federal, state, and local income taxes and other withholdings.

Accident, Critical Illness and Hospital Indemnity Insurance

You pay the full cost of any accident, critical illness or hospital indemnity insurance coverage through after-tax contributions.

Life and Accident Insurance

Discover pays the full cost of your basic life insurance, basic AD&D insurance and BTA insurance coverage. Under IRS rules, the value of your basic life insurance over $50,000 is considered taxable income to you. This taxable income will be reflected on your paycheck and W-2 Form as imputed income. You pay the full cost of supplemental life and supplemental AD&D insurance coverage for yourself and your eligible dependents through after-tax contributions.

Your cost for supplemental life insurance coverage for yourself depends upon your attained age at the beginning of the year, smoker status, and your elected coverage level. The cost of life insurance for your spouse/domestic partner depends on their age at the beginning of the year, smoker status and elected coverage level. The cost of supplemental life and AD&D insurance coverage for your eligible dependent children remains constant, regardless of age or the number of dependent children you cover. Your cost for supplemental AD&D insurance will depend upon the coverage level and amount of coverage elected (your “principal sum”).

Long-Term Disability

You pay the full cost of Long-Term Disability (LTD) coverage with after-tax contributions. This way, any LTD benefit is generally free from federal income tax. LTD contribution rates are based on a blended rate for all LTD participants so your LTD rates may not reflect the actual cost of your particular risk profile based on your age.

Legal Assistance Program

You pay the full cost of the legal assistance program coverage through after-tax contributions.

Flexible Spending Accounts

You pay the full cost of funding the Health Care Flexible Spending Account (HCFSA) and/or the Dependent Day Care Flexible Spending Account (DDCFSA) with pre-tax contributions.

In the event of a retroactive effective date, deductions begin with prospective pre-tax dollars even if coverage is retroactive to the date of eligibility or qualified life event date.

Paying for Benefits on Paid Leave of Absence

Discover will continue to take payroll deductions for your share of any applicable premiums during a paid leave of absence.

Paying for Benefits if You Are on Unpaid Leave or Participate in COBRA

You will be billed for your benefits coverage directly by myHR if you go on an unpaid leave or lose coverage for yourself or your dependent(s) and elect COBRA.

Coverage will be cancelled retroactively to your paid-through date if you do not pay for coverage in a timely manner.

Note: During an unpaid personal leave you will be billed 100% of the cost of your coverage. This means you are responsible for paying both your share of the cost and the Discover share of the cost of coverage.

Tobacco and/or Nicotine Use Surcharge

If you are a tobacco and/or nicotine user, you will pay a $30 per month surcharge in addition to your regular medical contributions and you will pay a higher employee rate for supplemental life insurance coverage to account for the increased cost of medical care and the lower life expectancy caused by tobacco and/or nicotine use.

Tobacco and/or nicotine use indicates that you are currently using or have used in the past twelve (12) months, tobacco products or other products containing nicotine, including but not limited to: cigarettes, electronic cigarettes, vape pens, cigars, pipes, chewing tobacco, snuff, the nicotine patch, nicotine gum or lozenges.

You may avoid the tobacco and/or nicotine use surcharge on your medical contributions by participating in the smoking cessation program provided to you at no cost by Discover. Once this smoking cessation program is completed, the tobacco surcharge will be removed for the plan year. Removal of the tobacco surcharge is available to all employees. If you think you may be unable to complete the smoking cessation program, you may qualify for an opportunity to have the surcharge removed by different means. Contact myHR and we will work with you (and, if you wish, with your doctor) to find a smoking cessation program that is right for you in light of your health status.

Wellness Credit

You are eligible to receive a $300 wellness credit towards the cost of the following plan year's medical coverage if you are benefits-eligible and complete all parts of the annual health evaluation and biometric screening by the administrative cut-off date designated as the end of the annual health evaluation period. The total wellness credit earned will be prorated over 26 pay periods and reduces the cost of your medical plan payroll contribution for the following plan year. The health evaluation is currently available through Alight Well. You will not receive the credit if you are not enrolled in a Discover medical plan, but you can still complete the health evaluation and biometric screening and access your results.

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Alight Well and they will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

HEALTH AND WELFARE ELIGIBLE EARNINGS (HWEE)

Throughout this SPD, there are references to HWEE. HWEE is used to determine the following:

- Your medical program contribution
- Your LTD contributions and benefit amounts
- Your basic and supplemental life insurance coverage amounts
- Your Business Travel Accident (BTA) coverage amount

HWEE is calculated annually, generally each September, for use the following year.

If you are a current employee with at least 12 months of continuous service at Discover, HWEE is generally the greater of:

- Annualized base salary in effect at the time HWEE is calculated or
- The most recent 12 months of eligible pay.

If you are a new hire or have been rehired more than 31 days after you terminate employment with Discover, HWEE is generally your annualized base salary as of your most recent hire date.

If you are rehired within 31 days following your date of termination of employment with Discover, your HWEE is generally your HWEE in effect as of your termination date.

If you are a newly U.S. benefits-eligible employee because you transferred from an international non-U.S. benefits-eligible position, your HWEE is generally your annualized US base salary at the time that you became a U.S. benefits-eligible employee.

Eligible Pay

Eligible pay is actual earnings, including regular pay, incentive (commissions), overtime, bonus payments, contributions to the company's 401(k) Plan and flex and commuter assistance plans,

and paid equity awards. Eligible pay does not include amounts payable as referral fees, expense allowances and imputed income.

WHEN COVERAGE ENDS

Your coverage as a participant in the plan will end on the earlier of:

- The last day of the month in which you are no longer an employee, for any reason
- The first day of the period for which required contributions have not been made
- The first day after you elect to no longer participate in a participating program
- The date of your death
- The date the plan is amended to consider you ineligible to participate
- The date the plan is terminated

An eligible dependent will no longer be a participant in the plan on the earlier of:

- The last day of the month in which the employee is no longer an eligible employee
- The last day of the month in which the dependent no longer meets the definition of an eligible dependent
- The first day of the period for which required contributions have not been made
- The date of the eligible employee's death A dependent may be eligible for continuation of existing medical, dental and vision coverage after an active employee's death. See the section "Impact of Work or Life Events on Coverage" for information on dependent continuation of coverage upon an active employee's death.

For a dependent who is a fully disabled child, the date as described in the section "Definition of Fully Disabled":

- The date a participant fails to provide the necessary information to determine an individual's status as an eligible dependent, within the specified timeframe
- The date the plan is amended to consider the dependent ineligible to participate
- The date the plan is terminated

A participant (you or your dependents) may have rights to COBRA continuation coverage. See the section "Continuation Coverage Rights Under COBRA and Other Health Coverage Alternatives" for eligibility and information.

Note: Certain coverage may end on a different date as described in the "Impact of Work or Life Events on Coverage" or applicable plan section. In the event of a conflict between this section and the specific plan section, the specific plan section and terms will apply.

MEDICAL PROGRAM

The Discover medical program is designed to help you and your family manage the financial impact of both expected and unexpected medical expenses:

- The medical program is comprised of several medical program options as described within this SPD.
- The options available to you will vary by your home state and/or zip code.
- Each option provides benefits for a broad range of medical services and supplies, in and out of the hospital, for illness, injury or pregnancy and includes prescription drug coverage.
- When you are no longer eligible to participate in the medical program, you and your eligible dependents may have an opportunity to continue coverage (at your own expense) under COBRA for a period of time. See the "Continuation Coverage Rights Under COBRA and Other Health Coverage Alternatives" section for details.

Your Medical Program Options

The Discover medical program offers a variety of coverage and network options, allowing you to choose the coverage that best meets your family's needs.

If you live in the U.S. (except Hawaii) and are benefits-eligible, you may choose from the following national medical program options. With the exception of the BlueCross BlueShield EPO, these plans offer both in- and out-of-network coverage:

- **BlueCross BlueShield (BCBS) HSA**
- **BlueCross BlueShield (BCBS) Saver HSA**
- **BlueCross BlueShield (BCBS) PPO**
- **BlueCross BlueShield (BCBS) EPO –** only available if you live in an area designated as being within BlueCross BlueShield's high-performance (narrow) network. The BCBS EPO has a narrow network of providers known as the Blue High Performance Network (Blue HPN). Coverage at non-Blue HPN providers is limited to emergent care within the Blue HPN service area and to urgent and emergent care outside of the Blue HPN service area.

The BCBS HRA medical plan is no longer offered as a medical program option effective January 1, 2022.

Based on your home state, you may be eligible for one or more of the following regional medical program options. Each of the following options only offer in-network coverage:

- **SelectHealth HSA - Utah**
- **SelectHealth HMO - Utah**
- **HMSA - Hawaii**

CVS Caremark is the managed prescription drug vendor for the BlueCross BlueShield medical program options. For all other options, prescription drug coverage is provided under the applicable regional medical program option (SelectHealth or HMSA). See the "Prescription Drug Coverage" section for details.

Listings of in-network providers are available without charge from the applicable medical program administrators. You can also get a list of in-network providers for the option you're enrolled in on MyDiscoverBenefits.com. See the "Benefit Provider Contacts" section of this SPD for all contact information. You should verify network participation with your health care provider(s) before receiving services.

Onsite Health Clinics

Discover offers onsite health clinics in designated locations, which provide health and wellness services to Discover benefits-eligible employees. The clinics are staffed and managed by Concentra, an independent contractor for medical on-site services. The types of services include:

- Injury and illness care, such as work-related injury care, emergency medical care, illness treatment, urgent care, prescriptions, and over-the-counter medication
- Travel health, such as travel prescriptions, exams, and vaccinations
- Preventive care, such as health promotion programs and screenings, blood pressure monitoring, cholesterol and blood sugar screening, flu immunizations, and health education and monitoring.

The clinics are provided at no cost to benefits-eligible employees not covered under an HSA medical plan. In accordance with IRS rules governing high deductible health plans, employees participating in an HSA medical program option are required to pay a $30 fee for medical visits until they meet their deductible, other than for wellness or preventive care visits, including first aid, which are provided at no cost to all benefits-eligible employees.

National Medical Program Options

The BCBS HSA, BCBS Saver HSA and BCBS PPO options allow you to visit any independent doctor and receive medical care at any hospital that you or your doctor choose. You don't need to name a Primary Care Physician (PCP) or get a referral to see a specialist. However, your share of the cost is lower when you visit an "in-network" provider.

The BCBS EPO option has a narrow network of providers known as the Blue High Performance Network (Blue HPN). Coverage at non-Blue HPN providers is limited to emergent care within the Blue HPN service area and to urgent and emergent care outside of the Blue HPN service area. You don't need to name a Primary Care Physician (PCP) or get a referral to see a specialist.

The following is a general summary of the plan features for the BlueCross BlueShield (BCBS) options. The following Benefit Booklets (found on MyDiscoverBenefits.com, on bcbsil.com/member, or by contacting BlueCross BlueShield directly) describe specific terms of the HSA, Saver HSA, PPO and EPO program options. For additional information contact BlueCross BlueShield directly at 877-217-7985.

- BlueCross BlueShield HSA Benefit Booklet
- BlueCross BlueShield Saver HSA Benefit Booklet
- BlueCross BlueShield PPO Benefit Booklet
- BlueCross BlueShield EPO Benefit Booklet

Important Notes

In-Network Services

- In-network services are services rendered by network providers and facilities, that is, by providers and facilities that participate in the medical program's network.

Out-of-Network Services

- Out-of-network services are rendered by out-of-network providers or facilities, that is, by providers and facilities that do not participate in the medical program's network.
- Out-of-network services, if covered, are subject to balance billing over the allowed amount. The allowed amount is 100% of the reimbursement allowed by Medicare.
- The member is responsible for any deductible, coinsurance and amount above the eligible charges allowed amount. This also applies to any claim that received the in-network reimbursement level for a non-participating provider, for example durable medical equipment.

Summary of Benefits

National (BlueCross BlueShield) Medical Program Options - What You Pay for Care		
	In-Network	**Out-of-Network**
Deductible and Maximums		
Annual Deductible (Individual/Family)		
HSA	$1,500/$3,000 (must meet family deductible if you cover dependents)	$3,000/$6,000 (must meet family deductible if you cover dependents)
Saver HSA	$4,000/$8,000 (must meet family deductible if you cover dependents)	$8,000/$16,000 (must meet family deductible if you cover dependents)
PPO	$500/$1,500	$1,000/$3,000
EPO	$600/$1,800	No out-of-network coverage except for emergencies
Annual Out-of-Pocket Maximum (Individual/Family)		
HSA	$3,500/$7,000 (must meet family out-of-pocket maximum if you cover dependents)	$7,000/$14,000 (must meet family out-of-pocket maximum if you cover dependents)
Saver HSA	$4,000/$8,000 (must meet family out-of-pocket maximum if you cover dependents)	$8,000/$16,000 (must meet family out-of-pocket maximum if you cover dependents)
PPO	$2,500/$4,500	$5,000/$9,000

National (BlueCross BlueShield) Medical Program Options - What You Pay for Care		
	In-Network	**Out-of-Network**
EPO	$3,000/$6,000	No out-of-network coverage except for emergencies
Office Visits		
Preventive & Well Baby Care Eligible Expenses		
HSA	You pay $0	40% of eligible charges after deductible
Saver HSA	You pay $0	0% of eligible charges after deductible
PPO	You pay $0	40% of eligible charges after deductible
EPO	You pay $0	No out-of-network coverage except for emergencies
Primary Care Physician Office Visit (for example, internist, family doctor, pediatrician)		
HSA	Deductible then you pay 20%	40% of eligible charges after deductible
Saver HSA	Deductible then you pay 0%	0% of eligible charges after deductible
PPO	Office visit: $30 copay Additional services: deductible then you pay 20%	40% of eligible charges after deductible
EPO	Office visit: $25 copay Additional services: deductible then you pay 20%	No out-of-network coverage except for emergencies
Specialist Office Visit		
HSA	Deductible then you pay 20%	40% of eligible charges after deductible
Saver HSA	Deductible then you pay 0%	0% of eligible charges after deductible
PPO	Office visit: $40 copay Additional services: deductible then you pay 20%	40% of eligible charges after deductible
EPO	Office visit: $35 copay Additional services: deductible then you pay 20%	No out-of-network coverage except for emergencies
Discover On-Site Clinic Medical Service Visit		
HSA	$30 fee per visit until deductible is met, then covered 100%	Not applicable
Saver HSA	$30 fee per visit until deductible is met, then covered 100%	Not applicable

National (BlueCross BlueShield) Medical Program Options - What You Pay for Care		
	In-Network	**Out-of-Network**
PPO	You pay $0	Not applicable
EPO	You pay $0	Not applicable
Emergency Room		
Facility Charges (copay waived if admitted)		
HSA	Deductible then you pay 20%	20% of eligible charges after deductible
Saver HSA	Deductible then you pay 0%	0% of eligible charges after deductible
PPO	$250 copay	$250 copay
EPO	$250 copay	$250 copay
Most Other Medical Services		
HSA	Deductible then you pay 20%	40% of eligible charges after deductible
Saver HSA	Deductible then you pay 0%	0% of eligible charges after deductible
PPO	Deductible then you pay 20%	40% of eligible charges after deductible
EPO	Deductible then you pay 20%	No out-of-network coverage except for emergencies

A separate out-of-pocket maximum applies for prescription drugs under the PPO and EPO plans. For the HSA plans, the out-of-pocket maximum for prescription drugs is integrated with the medical plan out-of-pocket maximum. There is no lifetime maximum except for infertility services.

Services Outside the U.S.

If you travel outside the United States, you may be able to take advantage of BlueCross BlueShield Global® Core when accessing covered services or for emergency services. For medical assistance services (including locating a doctor or hospital) or to obtain prior authorization for any non-emergent inpatient services, call Global Core at 800-810-2583. When you receive services outside the United States, you will typically need to pay the provider or the hospital directly and then submit a Global Core international claim form with the provider's itemized bill(s) in order to receive reimbursement. For more information, reference the "General Provisions" section of the appropriate BlueCross BlueShield Benefit Booklet.

Utilization Management and Review Program

BlueCross BlueShield has established the Utilization Management and Review Program to assist you in determining the course of treatment that will maximize your benefits.

The Utilization Management and Review Program requires a review of the following covered services before maximum benefits for such services are available:

- Skilled nursing facility services
- Services received in a coordinated home care program
- Private duty nursing services
- Certain outpatient procedures

The following information will be required when you notify BlueCross BlueShield for utilization management purposes:

- The name of the attending and/or admitting physician
- The name of the hospital where the admission has been scheduled and/or the location where the service has been scheduled
- The scheduled admission and/or service date
- A preliminary diagnosis or reason for the admission and/or services

For more information, reference the “Utilization Management and Review” section of the appropriate BlueCross BlueShield Benefit Booklet.

Regional Medical Program Options

The regional medical program options are offered to certain employees based on their home state. All options are fully insured and subject to state mandates. Each option includes prescription drug coverage.

These options do not require you to name a Primary Care Physician (PCP) or get a referral to see a specialist.

The SelectHealth HSA and HMO options are available to you if you are a U.S. benefits-eligible employee and live in Utah. These two options require you to visit doctors and receive medical care from hospitals in-network (SelectHealth Med network), except in the case of emergencies.

The HMSA option is the only option available to you if you are a U.S. benefits-eligible employee and live in Hawaii. This option allows you to visit any independent doctor and receive medical care at any hospital that you or your doctor choose. However, your share of the cost is lower when you visit an in-network provider.

The following is a general summary of the plan features for the regional medical program options. The following certificates (found on MyDiscoverBenefits.com or by contacting the program administrators directly) describe specific terms of the SelectHealth HSA, SelectHealth HMO and the HMSA program options. For additional information contact SelectHealth at 800-538-5038 or HMSA at 808-948-6111.

- SelectHealth HSA Certificate of Coverage
- SelectHealth HMO Certificate of Coverage
- HMSA Guide to Benefits

Important Notes

In-Network Services

- In-network services are services rendered by network providers and facilities, that is, by providers and facilities that participate in the medical program’s network.

Out-of-Network Services

- Out-of-network services are rendered by out-of-network providers or facilities, that is, by providers and facilities that do not participate in the medical program's network.
- Out-of-network services, if covered, are subject to balance billing over the allowed amount. The allowed amount is 100% of the reimbursement allowed by Medicare.
- The member is responsible for any deductible, coinsurance and amount above the eligible charges allowed amount. This also applies to any claim that received the in-network reimbursement level for a non-participating provider, for example durable medical equipment.

Summary of Benefits

Regional Medical Program Options - What You Pay for Care		
	In-Network	**Out-of-Network**
Deductible and Maximums		
Annual Deductible (Individual/Family)		
SelectHealth HSA	$1,500/$3,000 (must meet family deductible if you cover dependents)	No out-of-network coverage except for emergencies
SelectHealth HMO	$500/$1,000	No out-of-network coverage except for emergencies
HMSA	Not applicable	$100/$300
Annual Out-of-Pocket Maximum (Individual/Family)		
SelectHealth HSA	$3,500/$7,000 (must meet family out-of-pocket maximum if you cover dependents and the out-of-pocket maximum for prescription drugs is integrated with the medical out-of-pocket maximum)	No out-of-network coverage except for emergencies
SelectHealth HMO	$2,500/$5,000	No out-of-network coverage except for emergencies
HMSA	$2,500/$7,000	$2,500/$7,000
Office Visits		
Preventive & Well Baby Care Eligible Expenses		
SelectHealth HSA	You pay $0	No coverage
SelectHealth HMO	You pay $0	No coverage
HMSA	You pay $0	30% of eligible charges after deductible

Regional Medical Program Options - What You Pay for Care		
	In-Network	**Out-of-Network**
Primary Care Physician Office Visit (for example, internist, family doctor, pediatrician)		
SelectHealth HSA	Deductible then you pay 20%	No coverage
SelectHealth HMO	$30 copay	No coverage
HMSA	$12 copay	30% of eligible charges after deductible
Specialist Office Visit		
SelectHealth HSA	Deductible then you pay 20%	No coverage
SelectHealth HMO	$40 copay	No coverage
HMSA	$12 copay	30% of eligible charges after deductible
Discover On-Site Clinic Medical Service Visit		
SelectHealth HSA	$30 fee per visit until deductible is met, then covered 100%	Not applicable
SelectHealth HMO	You pay $0	Not applicable
HMSA	Not applicable	Not applicable
Emergency Room		
Facility Charges (copay waived if admitted)		
SelectHealth HSA	Deductible then you pay 20%	20% of eligible charges after deductible
SelectHealth HMO	$250 copay	$250 copay
HMSA	Deductible then you pay 20%	20% of eligible charges after deductible
Most Other Medical Services		
SelectHealth HSA	Deductible then you pay 20%	No coverage
SelectHealth HMO	Deductible then you pay 20% (all other copays may apply)	No coverage
HMSA	Inpatient: deductible then you pay 10% Outpatient: deductible then you pay 20%	30% of eligible charges after deductible

Travel Reimbursement for SelectHealth Plans

Effective April 1, 2023, covered persons in the SelectHealth medical plans will be reimbursed through a travel HRA (administered by HealthEquity, formerly known as WageWorks) for qualified travel expenses for transportation and lodging incurred for travel that is necessary to obtain medical or behavioral health services rendered if there is not a provider able to perform that service located within 100 miles of the covered person's home address.

Coverage is available for the covered person and up to one companion, or, if the covered person is under age 18, up to 2 companions. Reimbursement for lodging is limited to $50 per night for the covered person and an additional $50 per night for each permitted companion per IRS guidelines. Meals are not reimbursable.

Reimbursement requires sufficient supporting documentation. Travel benefits are limited to a maximum of $5,000 annually. Reimbursement is subject to the service, travel, and reimbursement being in accordance with all applicable laws or regulations and Plan terms.

Services Outside the U.S.

For the SelectHealth program options, if you are traveling outside of the U.S. and need urgent or emergency care, visit the nearest doctor or hospital. You may need to pay for the service and then seek reimbursement. If the service is covered, you will be reimbursed the allowed amount minus your copay/coinsurance and/or deductible. Some services received outside of the U.S. require preauthorization. For more information, contact SelectHealth at 800-538-5038.

For the HMSA program option, if you travel outside the United States, you may be able to take advantage of Blue Cross Blue Shield Global® Core when accessing covered services or for emergency services. For medical assistance services (including locating a doctor or hospital) or to obtain prior authorization for any non-emergent inpatient services, call Global Core at 800-810-2583. When you receive services outside the United States, you will typically need to pay the provider or the hospital directly and then submit a Global Core international claim form with the provider's itemized bill(s) in order to receive reimbursement. For more information, contact HMSA at 808-948-6111.

Utilization Management

SelectHealth requires preauthorization (prior approval) for certain services. Benefits may be reduced or denied if you do not obtain preauthorization of certain services. Your in-network provider or in-network facility/hospital is responsible for obtaining preauthorization on your behalf. You are responsible for obtaining preauthorization when using an out-of-network provider or facility/hospital.

If you need to request preauthorization, contact SelectHealth at 800-538-5038. Generally, preauthorization is valid for up to six months. You should call SelectHealth as soon as you know you will be using an out-of-network provider or facility for any service that requires preauthorization.

For a list of all services that require preauthorization, please refer to the "Healthcare Management" section of the appropriate SelectHealth Certificate of Coverage.

HMSA requires precertification, a special approval process to make sure that certain medical treatments, procedures, or devices meet payment determination criteria before the service is

rendered, for certain services. Benefits may be reduced or denied if you do not obtain precertification of certain services. Your in-network provider or in-network facility/hospital is responsible for obtaining precertification on your behalf. You are responsible for obtaining precertification when using an out-of-network provider or facility/hospital.

A few common examples of services you must obtain precertification for include:

- Lab, x-ray and other diagnostic tests such as genetic testing, polysomnography and sleep studies, computed tomography (CT) and functional MRI
- Surgeries such as organ and tissue transplants and varicose veins treatment.
- Treatment therapies such as applied behavioral analysis, physical, occupational and speech therapies, chiropractic services, in vitro fertilization, growth hormone therapy, home IV therapy, drugs such as oral chemotherapy agents, infusible and injectables, new drug to market (specialty market drugs) and off-label drug use
- Durable medical equipment and orthotics and prosthetic devices such as wheelchairs, positive airway pressure and oral devices to treat obstructive sleep apnea

For a list of all services that require preauthorization, please refer to www.hmsa.com/precert or call HMSA at 808-948-6464 for Oahu or 800-344-6122 for neighbor islands.

If you need to request precertification, contact HMSA by writing or faxing them at:

HMSA
P. O. Box 2001
Honolulu, HI 96805-2001
808-944-5611

Prescription Drug Coverage

Prescription drug benefits are part of your medical program coverage.

National Medical Program Options – Summary of Benefits

If you participate in a national BlueCross BlueShield medical program option, CVS Caremark administers your prescription drug coverage.

Additional information about the prescription drug program, including information regarding the preferred drugs, also referred to as “formulary,” to order refills or locate a retail pharmacy, is available at caremark.com or by calling CVS Caremark at 888-739-7987.

Your costs will vary based on your medical program option, as detailed below. Some medications may be subject to prior approval or you may be required to try a generic drug first. Contact CVS Caremark for more information.

Below are key points to note regarding your prescription drug coverage:

- ***Maintenance Medications***
  If you are enrolled in the BCBS PPO or the BCBS EPO medical program option, maintenance medications (taken on a regular basis prescribed for chronic, long-term conditions such as high blood pressure, high cholesterol, and diabetes) must be filled as a 90-day supply through a CVS Caremark pharmacy or through CVS Caremark mail

order. If you have more than three refills of a maintenance medication filled at a non-CVS pharmacy, you will be required to pay an additional $15 copay for each refill.

Deductible and Out-of-Pocket Maximum Integrated with the Medical Plan

For the BCBS HSA and BCBS Saver HSA medical program options, your deductible and out-of-pocket maximum for prescription drugs are integrated with the medical plan. That means both your medical and prescription drug expenses will go toward the same deductible and out-of-pocket maximum. You must first meet the deductible before the plan shares the cost with you.

- ***True Accumulation for Specialty Medications***
  If you pay for specialty medication(s) with manufacturer coupons or copay cards, you will only have your true out-of-pocket costs applied to the annual deductible and/or out-of-pocket maximum (known as "true accumulation"). The amount saved when using a coupon or copay card will not be applied to your annual deductible and/or out-of-pocket maximum.
- ***Prudent Rx Solution for Specialty Medications***
  Effective January 1, 2023, if you are enrolled in the BCBS PPO or the BCBS EPO medical plan, you are automatically opted-in to a specialty medications program known as the PrudentRx Solution. PrudentRx partners with CVS Specialty Pharmacy and will work with you to obtain copay cards for any of your specialty medications covered by the PrudentRx Solution. When copay cards are used for your specialty medication(s), you will pay $0 out-of-pocket and will not be subject to the standard 30% coinsurance. Note: there are a few medications which are excluded from the Prudent Rx Solution program including HIV, fertility and certain limited distribution drugs.
- ***Lifetime Maximum for Fertility Medications***
  In addition to other prescription drug exclusions and limitations that apply, fertility drugs are limited to a $10,000 lifetime maximum plan benefit per covered person.

National (BlueCross BlueShield) Medical Program Options **Prescription Drug Coverage - What You Pay for Care**		
	Retail (30-day supply)	**Mail Order (90-day supply)**
Generic		
BCBS HSA	20% coinsurance after deductible; deductible does not need to be met for preventive drugs as defined by CVS Caremark	20% coinsurance after deductible; deductible does not need to be met for preventive drugs as defined by CVS Caremark
BCBS Saver HSA	0% coinsurance after deductible; deductible does not need to be met for preventive drugs as defined by CVS Caremark	0% coinsurance after deductible; deductible does not need to be met for preventive drugs as defined by CVS Caremark
BCBS PPO	$10 copay	$10 copay

National (BlueCross BlueShield) Medical Program Options Prescription Drug Coverage - What You Pay for Care		
	Retail (30-day supply)	**Mail Order (90-day supply)**
BCBS EPO	$10 copay	$10 copay
Preferred Brand		
BCBS HSA	20% coinsurance after deductible	20% coinsurance after deductible
BCBS Saver HSA	0% coinsurance after deductible	0% coinsurance after deductible
BCBS PPO	25% coinsurance ($35 minimum/$100 maximum)	25% coinsurance ($70 minimum/$200 maximum)
BCBS EPO	25% coinsurance ($35 minimum/$100 maximum)	25% coinsurance ($70 minimum/$200 maximum)
Non-Preferred Brand		
BCBS HSA	25% coinsurance after deductible	25% coinsurance after deductible
BCBS Saver HSA	0% coinsurance after deductible	0% coinsurance after deductible
BCBS PPO	45% coinsurance ($50 minimum/$160 maximum)	45% coinsurance ($100 minimum/$320 maximum)
BCBS EPO	45% coinsurance ($50 minimum/$160 maximum)	45% coinsurance ($100 minimum/$320 maximum)
Specialty Drugs - Only covered through CVS Specialty Pharmacy and limited to a 30-day supply. May require approval, contact CVS Caremark.		
	30-day supply through CVS Specialty Pharmacy	**31+ day supply through CVS Specialty Pharmacy (only allowed for certain medications)**
BCBS HSA	20% coinsurance after deductible	20% coinsurance after deductible
BCBS Saver HSA	0% coinsurance after deductible	0% coinsurance after deductible

National (BlueCross BlueShield) Medical Program Options Prescription Drug Coverage - What You Pay for Care		
	Retail (30-day supply)	**Mail Order (90-day supply)**
BCBS PPO	If you remain opted-in to PrudentRx and complete necessary requirements: $0 out-of-pocket cost for eligible medications	If you remain opted-in to PrudentRx and complete necessary requirements: $0 out-of-pocket cost for eligible medications
	If your specialty medication is not eligible under PrudentRx: 30% coinsurance ($50 minimum; $160 maximum)	If your specialty medication is not eligible under PrudentRx: 30% coinsurance ($100 minimum; $320 maximum)
	If you opt-out of PrudentRx and your medication is eligible under the program: 30% coinsurance	If you opt-out of PrudentRx and your medication is eligible under the program: 30% coinsurance
BCBS EPO	If you remain opted-in to PrudentRx and complete necessary requirements: $0 out-of-pocket cost for eligible medications	If you remain opted-in to PrudentRx and complete necessary requirements: $0 out-of-pocket cost for eligible medications
	If your specialty medication is not eligible under PrudentRx: 30% coinsurance ($50 minimum; $160 maximum)	If your specialty medication is not eligible under PrudentRx: 30% coinsurance ($100 minimum; $320 maximum)
	If you opt-out of PrudentRx and your medication is eligible under the program: 30% coinsurance	If you opt-out of PrudentRx and your medication is eligible under the program: 30% coinsurance
Annual Deductible (Individual/Family)		
BCBS HSA	$1,500/$3,000 integrated with medical deductible	
BCBS Saver HSA	$4,000/$8,000 integrated with medical deductible	

National (BlueCross BlueShield) Medical Program Options Prescription Drug Coverage - What You Pay for Care		
	Retail (30-day supply)	**Mail Order (90-day supply)**
BCBS PPO	N/A	
BCBS EPO	N/A	
Annual Out-of-Pocket Maximum (Individual/Family)		
BCBS HSA	$3,500/$7,000 integrated with medical out-of-pocket maximum	
BCBS Saver HSA	$4,000/$8,000 integrated with medical out-of-pocket maximum	
BCBS PPO	$4,600/$9,200 separate from medical out-of-pocket maximum	
BCBS EPO	$4,600/$9,200 separate from medical out-of-pocket maximum	

Regional Medical Program Options – Summary of Benefits

If you participate in a regional medical program option, prescription drug coverage is included within the regional medical program option and may differ from the prescription drug coverage for the national program options.

Your costs will vary based on your medical program option, as detailed below. Some medications may be subject to prior approval or you may be required to try a generic drug first. Contact the administrators for additional information:

SelectHealth – call 800-538-5038 or visit selecthealth.org/pharmacy

HMSA – call 808-948-6111 or visit hmsa.com

Regional Medical Program Options Prescription Drug Coverage - What You Pay for Care		
	Retail (30-day supply)	**Mail Order (90-day supply)**
Generic		
SelectHealth HSA	20% coinsurance after deductible	20% coinsurance after deductible
SelectHealth HMO	$10 copay	$10 copay
HMSA	$7 copay	$11 copay
Preferred Brand		
SelectHealth HSA	20% coinsurance after deductible	20% coinsurance after deductible

Regional Medical Program Options Prescription Drug Coverage - What You Pay for Care		
	Retail (30-day supply)	**Mail Order (90-day supply)**
SelectHealth HMO	$20 copay	$40 copay
HMSA	$30 copay	$65 copay
Non-Preferred Brand		
SelectHealth HSA	20% coinsurance after deductible	20% coinsurance after deductible
SelectHealth HMO	$45 copay (generic required or must pay copay plus cost differential)	$90 copay (generic required or must pay copay plus cost differential)
HMSA	$30 copay	$65 copay
Specialty Drugs – may require prior approval		
SelectHealth HSA	20% coinsurance after deductible	
SelectHealth HMO	$100 copay	
HMSA	Preferred: $100 copay Non-Preferred: $200 copay	
Annual Deductible (Individual/Family)		
SelectHealth HSA	$1,500/$3,000 integrated with medical deductible	
SelectHealth HMO	N/A	
HMSA	N/A	
Annual Out-of-Pocket Maximum (Individual/Family)		
SelectHealth HSA	$3,500/$7,000 integrated with medical out-of-pocket maximum	
SelectHealth HMO	$2,500/$5,000 integrated with medical out-of-pocket maximum	
HMSA	$3,600/$4,200 separate from medical out-of-pocket maximum	

Health Savings Account (HSA)

A Health Savings Account (HSA) is an individual savings account that has FDIC protection. Optum Financial is the administrator and ConnectYourCare, a subsidiary of Optum Financial, is the non-bank trustee/custodian of the Discover HSA program. Your HSA can be used to directly pay or reimburse you for qualified out-of-pocket health care expenses including medical, prescription drug, dental and vision expenses.

The HSA is a triple tax advantaged account, which makes it an excellent way to save money for current health care needs or for expenses you may incur in the future and/or during retirement:

1. Your contributions are made on a pre-tax basis;
2. Your account could grow over time through tax-free interest and investment earnings (if you choose to invest your HSA funds); and
3. Withdrawals from your account are not subject to federal (or in most cases, state) taxes if used to pay for qualified expenses.

You can contact Optum Financial at 888-285-9499 or access your online account at optumfinancial.com or on the Optum Financial mobile app.

How the HSA Works

- If you enroll in one of the following Discover HSA medical program options, Discover will automatically set up an HSA account on your behalf:
    - BlueCross Blue Shield HSA
    - BlueCross BlueShield Saver HSA
    - SelectHealth HSA

- The HSA will be opened the first day of the month following your enrollment effective date in the eligible medical program. Discover expects that you will follow any applicable administrative requirements requested of you by Optum Financial to ensure your account is opened. You must have an open/active account to receive your HSA contributions and any Discover HSA contributions. If you fail to meet the requirements to open your account or your account is subsequently closed, you may not receive Discover's HSA contributions and any pre-tax HSA payroll deductions withheld from your pay will be returned to you.
- You can pay for qualified medical expenses with HSA funds. See IRS Publication 502 for a full list of qualified medical expenses. There's no "use it or lose it" rule for HSA money so any funds not spent in the current year will roll over to be used in the future.
- Once your account is opened, you will receive a Discover HSA healthcare payment card in the mail that will be linked to your HSA. The payment card is considered a debit card but it does not have a PIN associated with it. The card can be used to pay for eligible expenses directly, and when used, should be processed with the card type of "credit."
- If you instead wish to pay for your qualified expenses after your claims have been processed by the medical, prescription drug, dental and/or vision program administrators, you can do so by logging into your account at optumfinancial.com or by accessing the Optum Financial mobile app.

  For your convenience, eligible medical, prescription drug, dental and vision claims from BlueCross BlueShield, SelectHealth, CVS Caremark, MetLife and VSP are automatically fed to Optum Financial within one to two weeks from the date the respective program administrator processes your insurance claim. You can choose which claims you'd like to be reimbursed for or to pay your provider directly from your HSA on Optum Financial's website or mobile app – there's no need to submit an HSA claim form or any documentation.

You can also choose to set up auto-pay online so that you are either automatically reimbursed or your provider is automatically paid from your HSA any time BlueCross BlueShield, SelectHealth, CVS Caremark, MetLife or VSP feeds a claim of yours to Optum Financial. You may turn the auto-pay feature on or off any time, either online or by contacting Optum Financial.

- You can choose to invest your HSA funds once you have a minimum HSA account balance of $1,000. For more information, access your online account at optumfinancial.com and click on the Investments link.
- If you leave Discover, you can either leave your HSA with Optum Financial or transfer your HSA balance to another HSA administrator. Terminated employees who leave their accounts with Optum Financial will be charged a monthly account management fee.

Contributions to Your HSA

You can make contributions to your HSA by electing pre-tax payroll deductions or by making contributions directly to Optum Financial, up to the applicable annual IRS limits. Changes to your HSA contribution elections can be made at any time by contacting myHR or at MyDiscoverBenefits.com. You are eligible to make contributions to an HSA if you are:

- Enrolled in a Discover HSA medical program option (note: each Discover HSA option is considered a “high deductible health plan”)
- Not covered in another health plan that is not a high deductible health plan
- Not enrolled in Medicare
- Not claimed as a dependent on another person’s tax return

Discover contributes to your HSA, which can help your savings grow over time. The annual HSA contribution from Discover is based on your medical plan coverage level at the time the contribution is made, typically in late January of each year:

- $500 for You Only
- $700 for You + Spouse
- $700 for You + Child(ren)
- $1,000 for You + Family

Discover HSA contribution amounts are not adjusted for any coverage level changes you make throughout the year. If you are hired after January 1, or if you newly enroll in an HSA medical program option during the year, you will receive a prorated HSA contribution. The prorated contribution is based on the number of months that your HSA is in effect and your coverage level in effect at the time the contribution is made. You’ll receive a prorated contribution, if applicable, as soon as administratively feasible after you enroll in an HSA medical program option.

COORDINATION OF BENEFITS

The medical program contains a “non-duplication of benefits” provision, which ensures that the plan, in combination with any other plans, will never pay more than the amount the plan would pay on its own.

For example, if you cover your spouse as a dependent and your spouse is covered by another plan that pays benefits equal to or greater than the plan, the plan will generally make no additional payment. If another plan pays benefits that are less than the amount the plan would pay, the plan will pay up to the extent that total payments from both plans do not exceed what the plan would have paid for that claim.

The following coordination of benefits rules apply when a patient is covered by more than one plan:

- The plan covering the patient as an employee is considered "primary" and pays benefits up to plan limits. The plan covering the patient as a dependent is considered "secondary" and pays only to the extent that charges are eligible for reimbursement under the second plan. That means that your bills would first be submitted to the plan covering the patient as an employee, and any unpaid balances would then be submitted to the plan covering the patient as a dependent.
- The plan covering the parent whose birthday occurs earlier in the year (month and day) is primary and pays the children's benefits first. The other parent's group insurance is secondary and pays any remaining costs to the extent of coverage.
- The plan providing coverage to the active employee (or dependent of an active employee) is primary and will pay benefits before the plan that covers the individual as a retired employee (or dependent of a retired employee).

For dependents of divorced or legally separated parents:

- If there is a court order that makes one parent financially responsible for the health care expenses of the child, the plan of that parent will be primary to the plan of the other parent.
- If there is no such court order and the parent with custody of the child has not remarried, the plan of such parent will be primary to the plan of the parent without custody.
- If there is no such court order and the parent with custody of the child has remarried, the plan of the custodial parent will be primary to the plan of the step-parent. The plan of the step-parent will be primary to the parent without custody.

These rules assume the person covered by both plans is enrolled as an eligible dependent under the other person's plan.

Medicare

If you are eligible for Medicare and are still actively working, you are entitled to the same Discover health benefits offered to other employees. In this case, if you elect Medicare coverage, Medicare is the "secondary payer," paying only for some charges if not covered by the Discover plan. These rules apply to your spouse/domestic partner and eligible dependents if he/she is covered under the Discover medical program and is not disabled, and you are still working, regardless of your age.

Note: If you are actively working and covered under the Discover medical program and your dependent is Medicare- eligible due to disability, Medicare pays first for that dependent.

ACCIDENT INSURANCE

Accident insurance pays a cash benefit for covered accidents and injuries included but not limited to broken bones, burns, fractures, dislocations and lacerations. It provides one benefit payment for the type of injury plus another benefit payment for the type of care/treatment. Some common accidents and the benefit payments you may be entitled to are listed below.

Type of Injury	Potential Benefit Payment
Fracture (broken bone)	$50 - $3,000 depending on the fracture and type of repair
2nd or 3rd degree burn	$50 - $3,000 depending on the degree of the burn and the percentage of burned skin
Concussion benefit	$200
Laceration benefit	$25 - $200 depending on the length of the cut and type of repair

Type of Care/Treatment	Potential Benefit Payment
Emergency care	$25 - $150 depending on the location of care
Ambulance	$200 (ground); $750 (air)
Therapy services	$15 - $25 depending on the type of service
Hospital admission	$1,000 for the day of admission + $200 per day confinement (up to 31 days)

You may elect accident insurance for yourself, your spouse/domestic partner, and/or your dependent children. Your rates are based on your age as of January 1. Enrollment is guaranteed provided you are actively at work. For additional information, refer to the Certificate of Insurance accessible by clicking on Plan Information after logging in on the Discover benefits website.

CRITICAL ILLNESS INSURANCE

Critical illness insurance pays a cash benefit of $15,000 related to covered conditions such as stroke, Alzheimer's disease, heart attack, or major organ transplant. Some covered conditions may pay a 25% benefit; refer to the Certificate of Insurance for more information. You may elect critical illness insurance for yourself, your spouse/domestic partner, and/or your dependent children. Your rates are based on your age as of January 1. Enrollment is guaranteed provided you are actively at work, but exclusions on pre-existing conditions apply.

Your initial benefit provides a lump-sum payment upon the first diagnosis of a covered condition. A recurrence benefit may be paid when a covered person is diagnosed with another occurrence of the same covered condition for which an initial benefit was previously paid.

The maximum amount that you can receive through your critical illness plan is called the total benefit and is three times the amount of our initial benefit. This means that you can receive multiple initial benefit and recurrence benefit payments until you reach the maximum of 300%, up to $60,000.

For additional information, refer to the Certificate of Insurance (including the exclusions and limitations that apply to coverage) accessible by clicking on Plan Information after logging in on the Discover benefits website.

HOSPITAL INDEMNITY INSURANCE

Hospital indemnity insurance pays a cash benefit for covered inpatient stays at a hospital, critical care unit, or rehabilitation facility. It provides a one-time payment for admission to the hospital and then a daily benefit amount for the length of your hospital stay.

Benefit Type	Benefit Payment
Admission benefit	$1,000 for the day of admission
Confinement benefit (paid for up to 15 calendar days per year)	$100 per day
ICU supplemental confinement benefit (paid for up to 15 calendar days per year)	$100 per day

You may elect accident insurance for yourself, your spouse/domestic partner, and/or your dependent children. For additional information, refer to the Certificate of Insurance accessible by clicking on Plan Information after logging in on the Discover benefits website.

DENTAL PROGRAM

The Discover dental program encourages regular dental checkups and helps pay the cost of your dental care.

Discover offers both Standard and Premier dental program options through MetLife. Both options provide you with access to the same network of dentists and cover the same services (except for orthodontics for adults). The Premier Option covers services for non-preferred dentists at a higher level and includes orthodontia coverage for adults, so you may want to consider the Premier Option if this applies to you. Your out-of-pocket expenses may be lower if you use a dentist participating in MetLife's preferred dentist program (PDP).

MetLife is not obligated to pay benefits directly to non-network providers. Any payments MetLife makes to non-network providers is a convenience for plan participants and is not an assignment of benefits or any right under the plan to the non-network providers.

Summary of Benefits

The following is a general summary of the plan features for the dental program options. For specific details, exclusions, limitations and utilization review requirements (pretreatment estimates), refer to your applicable dental Insurance Certificate accessible by clicking on Plan Information after logging in on the Discover benefits website. For additional information, contact MetLife directly.

MetLife Dental Program Options - What You Pay for Care			
STANDARD OPTION		**PREMIER OPTION[1]**	
PDP SERVICES	**NON-PDP SERVICES**	**PDP SERVICES**	**NON-PDP SERVICES**
DEDUCTIBLE (INDIVIDUAL/FAMILY)			
$0	$100/$300	$0	$50/$150[2]
TYPE A SERVICE (DIAGNOSTIC AND PREVENTIVE CARE)			
No charge	50% of Reasonable and Customary (R&C), no deductible	No charge	0% of R&C, no deductible
TYPE B SERVICE (RESTORATIVE SERVICES)			
20% of discounted fee	60% of R&C, after deductible is met	20% of discounted fee	20% of R&C, after deductible is met
TYPE C SERVICE (PROSTHODONTICS)			
50% of discounted fee	75% of R&C, after deductible is met	50% of discounted fee	50% of R&C, after deductible is met
ORTHODONTICS			
50% of discounted fee, up to $3,000 lifetime benefit maximum per child (children only)	75% of R&C after deductible, up to $1,000 lifetime benefit maximum per child (children only)	50% of discounted fee, up to $3,000 lifetime benefit maximum per person (children and adults)	50% of R&C after deductible, up to $3,000 lifetime benefit maximum per person (children and adults)
ANNUAL BENEFIT MAXIMUM PER PERSON[3]			
$3,000	$2,000	$3,000	$2,000

[1] In accordance with state insurance laws, some states, including Louisiana, Mississippi, Montana, and Texas, may require that out-of-network expenses be treated the same as in-network expenses. Additionally, residents of Louisiana, Mississippi, Montana, and Texas are limited to the Premier Option.
[2] Deductible waived for Type A services.
[3] In no event can any one person receive more than $3,000 in benefits during a calendar year (excluding orthodontic services), even if provided by a PDP dentist.

VISION PROGRAM

The Discover vision program encourages you to have regular vision exams and pays some or all the costs associated with eyeglass lenses, frames and contact lenses. The vision program is fully insured by VSP Vision Care (VSP).

The Discover vision program allows you the freedom to receive vision care services from a network of participating doctors (in-network) or from any vision care provider you choose (out-of-network). However, benefits are greatest and your out-of-pocket costs are reduced if you visit a doctor participating in the VSP network. Services are reimbursed differently based on the service provided and whether you receive services from an in-network provider or out-of-network provider. Allowances are every 12 months, unless otherwise noted.

You can choose from two vision program options: the Standard Option and the Premier Option.

Summary of Benefits

The following is a general summary of the plan features for the vision program options. For additional information, including special programs available and the exclusions and limitations that apply to coverage, refer to the vision Evidence of Coverage document accessible by clicking on Plan Information after logging in on the Discover benefits website. For additional information, contact VSP directly.

VSP Vision Program Options – What You Pay for Care			
	Allowances for VSP and Participating Providers		Maximum Allowance for Non-Participating Providers
	Standard Option	Premier Option	
Exam	$15 copay $50 contact lens fitting and evaluation exam	$15 copay $50 contact lens fitting and evaluation exam	$30
Frame Allowance	$175 every 24 months after $25 copay	$200 every 12 months	$50
Lenses	Single vision, lined bifocal and lined trifocal lenses covered in full after copay	Single vision, lined bifocal and lined trifocal lenses covered in full after copay	Single vision: $30 Lined bifocal: $40 Lined trifocal: $50
Elective Contact Lens Allowance (instead of glasses)	$175	$200	$95
Lens Enhancements – Covered without Copay	Standard progressive lenses	• Standard progressive lenses • Tinted lenses • Impact-resistant lenses • Scratch-resistant coating • UV protection	Not applicable

VSP Vision Program Options – What You Pay for Care			
	Allowances for VSP and Participating Providers		Maximum Allowance for Non-Participating Providers
	Standard Option	Premier Option	
Lens Enhancements – Available with Copay or Savings	• Premium progressive lenses: $95 – $105 copay • Custom progressive lenses: $150 – $175 copay • Average savings of 30% on the cost for other non-covered lens enhancements including but not limited to: anti-reflective coating, tinted lenses, impact-resistant lenses, photochromic (light-reactive) lenses, scratch-resistant coating, and UV protection	• Premium progressive lenses: $95 – $105 copay • Custom progressive lenses: $150 – $175 copay • Anti-reflective coating: $30 copay • Photochromic (light-reactive) lenses: $75 copay • Average savings of 30% on the cost for other non-covered lens enhancements	Not applicable
Easy Options	Not applicable	Choice of one upgrade • Additional $75 retail frame allowance • Additional $75 contact lens allowance • Premium or custom progressive lenses covered in full • Photochromic (light-reactive) lenses covered in full	Not applicable

FLEXIBLE SPENDING ACCOUNTS

The Flexible Spending Account (FSA) program allows you to direct a part of your pay, on a pre-tax basis, into special accounts that can be used throughout the year to reimburse you for certain out-of-pocket health care expenses for you or your eligible dependents (the Health Care Flexible Spending Account or HCFSA) or work-related day care expenses for your eligible dependents (the Dependent Day Care Flexible Spending Account or DDCFSA):

- You do not pay federal income tax, Social Security (FICA) tax, federal unemployment (FUCA) tax or most state and local income taxes on the money you contribute to the FSA program.
- Your accounts are subject to IRS and plan rules.

Optum Financial is the FSA administrator. You can contact Optum Financial at 888-285-9499 or access your online account at optumfinancial.com.

How the FSA Program Works

The FSA program is comprised of three accounts:

- The Health Care Flexible Spending Account (HCFSA) for reimbursing eligible health care expenses for you and your eligible dependents;
- The “limited purpose” Health Care Flexible Spending Account (limited purpose HCFSA) for reimbursing eligible dental and vision expenses for those enrolled in a HSA medical program option; and
- The Dependent Day Care Flexible Spending Account (DDCFSA) for reimbursing eligible day care expenses for your eligible dependents.

Depending on your needs, you may decide to participate in an HCFSA and/or the DDCFSA. If you participate in an HSA medical program option, you may participate in a limited purpose HCFSA for reimbursing dental and vision expenses.

To participate, you must indicate the amount of pre-tax dollars you want to contribute for the calendar year, up to IRS or other Plan limits. Once you make your elections, contributions to your accounts continue for the entire calendar year unless:

- You terminate employment with Discover
- You become ineligible to participate in the FSA program
- Your earnings are reduced to an amount less than your annual election
- Your contribution is reduced based on IRS nondiscrimination requirements, or
- You modify your coverage due to a qualified life event (see the “Qualified Life Events” section)

Contributing to Your Accounts

When you elect to contribute to an FSA, you are directing Discover to reduce your compensation by the amount you elect. Your annual election is credited to your accounts through payroll deductions.

To open an account, you must indicate the amount you wish to put into the HCFSA and/or the DDCFSA for the plan year when you enroll. For 2023, you can contribute between $100 and $3,050 annually to the HCFSA or limited purpose HCFSA, and between $100 and $5,000 annually to the DDCFSA if you are single or married and filing a joint tax return, or between $100 and $2,500 annually to the DDCFSA if you are married and filing separate returns. You may not transfer money between the HCFSA and DDCFSA.

Federal tax law limits the amount of contributions to a DDCFSA to the lesser of your or your spouse's earned income. If your spouse is not working but is a full-time student or is disabled, your spouse's earned income is considered to be $250 a month if you have one eligible dependent or $500 monthly for two or more eligible dependents (see the "Dependent Day Care Flexible Spending Account" section).

Discover is required to perform tests on the HCFSA and the DDCFSA to ensure these accounts do not favor participants who are considered highly compensated under federal tax law. If the tests are not satisfied, pre-tax contributions of higher paid employees may be reduced. If a reduction in pre-tax contributions is necessary, the plan administrator will notify affected employees.

Contributions to these accounts are made on a pre-tax basis and therefore reduce your taxable income. Participation in the plan may reduce your contributions to Social Security, depending on your pay and the amount of your contribution, which may in turn reduce any Social Security benefits to which you may become entitled. Your contributions to an FSA will not affect any salary-related Discover plans, such as the 401(k) Plan.

If you choose not to make pre-tax contributions to the FSA program, you will be paid your compensation in cash each pay period over the plan year, subject to applicable federal income tax, Social Security (FICA) tax, federal unemployment (FUTA) tax and state and local income tax.

Health Care FSA (HCFSA) and Limited Purpose HCFSA

Using your HCFSA and Limited Purpose HCFSA

The full annual amount you elect to contribute will be available for you to use right away. Eligible health care expenses (see the "Eligible Health Care Expenses" section) for you or your eligible dependents may be reimbursed from the HCFSA. Medical expenses are incurred when the services are provided, not when billed or paid.

If you increase your contribution amount during the plan year due to a qualified life event, only expenses incurred on or after the qualified life event date are eligible for reimbursement from the additional amount.

You must incur eligible expenses by December 31 of the current year. All claims must be submitted to Optum Financial by March 31 of the following year to qualify for reimbursement. If

you terminate employment or otherwise become ineligible to participate in the HCFSA due to an employment status change prior to December 31 (excluding transfer to an international status), you may only submit claims for reimbursement incurred through your termination date, unless you elect to continue participation through COBRA (see the “Continuation of Coverage Rights Under COBRA and Other Health Coverage Alternatives” section).

Your HCFSA accounts are subject to the IRS “use it or lose it rule,” which could result in you forfeiting your account balance that you don’t use within the applicable time frame. If you have a balance in your HCFSA at the end of the plan year, up to $610 (for the 2023 plan year) will be automatically rolled over into the next plan year’s account. Any amounts over $610 remaining in your account at the end of the year will be forfeited. The $610 rollover amount will be indexed for inflation and may change each year.

In general, there are two ways you may request for claims/expenses to be paid from your HCFSA:

1) Pay for expenses out-of-pocket and reimburse yourself, or pay your provider directly:

- Sign in to your online account at Optum Financial or access the Optum Financial mobile app.
- Select "Claims" and then "Claims From Insurance Plan" to see any of your medical, dental, vision and prescription drug claims available for reimbursement. Note: your LPFSA funds can only be used for reimbursement of dental and vision expenses.
- Select "Ready for Action" next to the claim you want to reimburse and follow the prompts.

For your convenience, eligible medical, prescription drug, dental and vision claims from BlueCross BlueShield, SelectHealth, CVS Caremark, MetLife and VSP are automatically fed to Optum Financial and they are shown on the website as "Claims From Insurance Plan". You can choose which claims you'd like to be reimbursed for or to pay your provider directly from your HCFSA on the Optum Financial website – there's no need to submit an FSA claim form.

You can also choose to set up auto-pay so that you are either automatically reimbursed or your provider is automatically paid from your HCFSA any time BlueCross BlueShield, SelectHealth, CVS Caremark, MetLife or VSP feeds a claim covered under your plan(s) to Optum Financial. You may turn the auto-pay feature on or off any time, either online or by contacting Optum Financial.

2) Create and submit a manual claim.

- Sign in to your online account at Optum Financial or open the Optum Financial app.
- Only create and submit a manual FSA claim if you wish to receive reimbursement for eligible expenses that either (a) were not submitted to insurance, or (b) were submitted to insurance but were not covered by the insurance plan.
- Create and submit a manual claim by clicking on either "Pay My Provider" or "Reimburse Myself" and then by completing the "Create New Claim" process on the Optum Financial website or app or by submitting a paper claim form.

- You must attach itemized bills, receipts and/or the Explanation of Benefits (EOB) from your health plan administrator as proof of unreimbursed eligible expenses.

Always keep copies of your claim forms and supporting documentation for your files.

Note: you will need to create and submit a HCFSA claim for any services covered through HMSA.

Definition of Eligible Dependents

The definition of eligible dependents for purposes of the HCFSA differs from the definition used for other Discover health plans. You may request reimbursement from your HCFSA for expenses incurred by:

- You
- Your spouse, as determined under federal tax law
- Your dependent children, as determined under federal tax law, who will not attain age 27 by the end of the calendar year, and
- Any individual you can claim as a dependent for federal income tax purposes, regardless of whether they meet the eligibility requirements of other Discover group health plans

Notes:

- Under IRS regulations, the HCFSA program may not recognize civil union partners, domestic partners, or children of civil union partners and domestic partners as eligible dependents unless they meet the criteria listed above and the relationship is not in violation of local law.
- Your dependents' eligible expenses can be reimbursed through the HCFSA, even if they are not enrolled as dependents under any of Discover's health plans if you can claim such persons as dependents on your federal tax form.

Eligible Health Care Expenses

Only eligible expenses can be reimbursed through the FSA program. The HCFSA program will follow IRS guidelines in determining whether an expense is eligible as "medical care" as defined under Section 213 of the Internal Revenue Code. A complete list of tax-deductible health care expenses is available in IRS Publication 502 Medical and Dental Expenses. To obtain a copy, call 1-800-TAX-FORM or visit the IRS website at irs.gov. Reimbursements made in violation of the IRS rules may cause you to be subject to additional income taxes and penalties.

To be eligible, the expenses must be:

- Of a type that would be tax deductible, and
- Incurred by December 31 of the current year while you are a participant, and
- Not reimbursable under any group health plan

Once you receive a reimbursement from the HCFSA or limited purpose HCFSA, that expense cannot be claimed as a deduction on your personal income tax return.

Some examples of out-of-pocket health care expenses, which qualify for reimbursement from the HCFSA include:

- Medical, dental or vision program deductibles, coinsurance amounts and copayments
- Routine physician office visits—to the extent not covered by your medical program
- Vision care expenses, including eye exams, prescription eyeglasses, contact lenses and contact lens solution— to the extent not covered by your vision program
- Hearing care expenses—to the extent not covered by your medical program
- Amounts determined to be above Reasonable and Customary (R&C) limits under your medical and dental programs
- Certain prescribed medical supplies and equipment—to the extent not covered by the medical program (insulin and diabetic supplies, bandages, braces are eligible medical supplies)
- Dental treatment, including teeth cleaning, sealants, and fluoride to prevent tooth decay, x-rays, fillings, braces, extractions, dentures to the extent not covered by your dental program

If you are enrolled in an HSA plan, you may only contribute to a limited purpose HCFSA which limits your reimbursement to eligible dental and vision expenses. Some examples of out-of-pocket health care expenses, which qualify for reimbursement from the limited purpose HCFSA include:

- Dental or vision program deductibles, coinsurance amounts and copayments
- Vision care expenses, including eye exams, prescription eyeglasses, contact lenses and contact lens solution— to the extent not covered by your vision program
- Amounts determined to be above Reasonable and Customary (R&C) limits under your dental program
- Dental treatment, including teeth cleaning, sealants, and fluoride to prevent tooth decay, x-rays, fillings, braces, extractions, dentures to the extent not covered by your dental program

Ineligible Health Care Expenses

The following are some expenses that are not eligible for reimbursement:

- Insurance premiums
- Food purchased through weight loss programs
- Expenses for custodial care in a nursing home or other long-term care
- Cosmetic surgery or cosmetic treatments such as teeth whitening (unless to correct a congenital deformity or to correct an injury from an accident)
- For the limited purpose HCFSA only: medical and prescription drug expenses cannot be reimbursed

Dependent Day Care Flexible Spending Account (DDCFSA)

Eligible dependent day care expenses are defined as costs incurred for the care of an eligible dependent that enables you, or if you are married, you and your spouse, to work or attend school as a full-time student or if your spouse is physically or mentally incapable of self-care. The only expenses eligible for reimbursement are those incurred for the primary purpose of assuring the well-being and protection of your eligible dependent.

Definition of Eligible Dependents

For purposes of the DDCFSA, an eligible dependent is any "qualifying individual" determined in accordance with Section 21 of the Internal Revenue Code, including:

- A "qualifying child" as defined in Section 152 of the Internal Revenue Code who has not attained age 13. A qualifying child is your own child (including your son, daughter, stepson, stepdaughter, eligible foster child, adopted child or child placed for adoption) or your brother, sister, stepbrother, stepsister, half-brother, half-sister (or any of their descendants) who lives with you for more than one-half of the year and who has not provided over one-half of his or her own support.
- A person who is physically or mentally incapable of self-care, such as a disabled child or an elderly dependent parent who lives with you for more than one-half of the year and either was your dependent or would have been your dependent except that he or she:
    - has gross income for the year that is less than the exemption amount as determined by the IRS,
    - he or she filed a joint return, or
    - you, or your spouse, if filing jointly, could be claimed as a dependent on someone else's tax return.
- Your spouse who is mentally or physically incapable of self-care and who lives with you for more than one-half of the year. In addition, if you are divorced or legally separated, you may cover a child whom you cannot claim as a dependent provided that:
    - The child is under 13 or is physically or mentally incapable of self-care;
    - The child received over half of his or her support during the calendar year from one or both parents who are divorced or legally separated under a decree of divorce or separate maintenance, are separated under a written separation agreement, or lived apart at all times during the last 6 months of the calendar year;
    - The child was in the custody of one or both parents for more than half the year, and
    - You were the child's custodial parent, meaning the parent with whom the child lived for the greater number of nights. If the child was with each parent for an equal number of nights, the custodial parent is the parent with the higher adjusted gross income. The noncustodial parent cannot treat the child as a qualifying person even if that parent is entitled to claim the child as a dependent under the special rules for a child of divorced or separated parents.

For additional details of the federal tax rules, see IRS Publications 501 and 503.

Note: IRS regulations do not recognize civil union partners, domestic partners and children of civil union partners or domestic partners as eligible dependents unless they meet the criteria listed above and the relationship is not in violation of local law. You are responsible for determining whether an individual is your dependent under applicable tax law.

Eligible Dependent Day Care Expenses

You may submit a request for reimbursement from the DDCFSA for expenses incurred in a plan year that are eligible employment-related expenses and do not exceed earned income limitations to the extent you have a balance in the DDCFSA. A complete list of tax-deductible dependent day care expenses is available in IRS Publication 503 Child and Dependent Care Expenses. To obtain a copy, call 1-800-TAX-FORM or visit the IRS website at irs.gov. Expenses eligible for reimbursement from a DDCFSA include:

- Payments made for services provided in your home if these services are not provided by someone you also claim as a dependent or by your children who will be under age 19 at the end of the calendar year. Although these services may involve household maintenance, they must be attributable in part to the care of the eligible dependent.
- Payments made for day care services outside your home for a dependent child under age 13 or for other dependents who spend at least eight hours a day in your home.
- Payments made to a qualified day care center providing care for at least six people on a regular basis that requires a fee for care and that is in compliance with all applicable state and local laws.

Reimbursements from the DDCFSA may not exceed the applicable earned income limitation. If you are not married at the end of the plan year, the limit is your earned income, including your total wages, salary and other employee or self-employed compensation. If you are married at the end of the plan year, the limit is the lesser of your earned income or that of your spouse.

Ineligible Dependent Day Care Expenses

Weekend or “evening-out” baby-sitting expenses, kindergarten expenses and overnight camp expenses are ineligible. Expenses incurred by married employees with spouses who are not working, not full-time students or not physically or mentally capable of self-care are also ineligible.

Health care expenses for your dependents are not payable under the DDCFSA, nor are expenses for food or clothing.

The Dependent Care Tax Credit versus the DDCFSA

The IRS permits eligible taxpayers to take a tax credit equal to a percentage of eligible dependent day care expenses and/or fund eligible dependent day care expenses through an FSA. Just keep in mind that you can’t double dip – eligible expenses reimbursed through the DDCFSA can’t also be counted as eligible expenses to claim the Dependent Care Tax Credit. You may wish to consult with your tax advisor or view IRS Publication 503 to determine which is most tax advantageous for you—the tax credit, the DDCFSA or a combination of both.

Your W-2 Form

The amount of your annual DDCFSA contribution will be shown in Box 10 of your W-2 Form. If this amount exceeds $5,000, the amount over $5,000 is taxable income and will also be included in Box 1 of your W-2 Form.

If you elected to participate in a prior employer's DDCFSA and the combination of funds contributed through Discover and your prior employer exceeds $5,000 in a given calendar year, consult with your tax advisor on how to report the additional taxable income and your dependent day care expenses.

Requesting Payment of DDCFSA Benefits

Unlike the Health Care FSA, you can only be reimbursed for the amount credited to your DDCFSA account at the time your request for reimbursement is processed.

You must incur eligible expenses by December 31 of the current year. All claims must be submitted to Optum Financial by March 31 of the following year to qualify for reimbursement. If you terminate employment or otherwise become ineligible to participate in the DDCFSA due to an employment status change prior to December 31 (excluding transfer to an international status), you may only submit claims for reimbursement incurred through your termination date. You can't elect to continue participation through COBRA.

To use your DDCFSA funds:

- Sign in to your online account at optumfinancial.com or access the Optum Financial mobile app.
- Create and submit a manual claim by clicking on either "Pay My Provider" or "Reimburse Myself" and then by completing the "Create New Claim" process on the Optum Financial website or mobile app or by submitting a paper claim form.
- You must attach or provide a copy of a paid receipt as proof of payment of your day care expenses. You also must include the Tax Identification Number (TIN) of the day care provider. No request for reimbursement will be paid without a TIN. If the provider is a tax-exempt organization and does not have a TIN, indicate this on your claim form.

Your DDCFSA account is subject to the IRS "use it or lose it rule," which will result in a forfeiture of any account balance not used and reimbursed within the applicable time frame.

Account Balances

All contributions during any calendar year to either FSA account must be applied to eligible expenses incurred by December 31 of the current year. Eligible expenses will be paid to the extent there remains an FSA balance.

Requests for reimbursement must be submitted during the calendar year or by March 31 of the following year. All eligible health care expenses will be paid from your HCFSA and eligible dependent day care expenses from your DDCFSA. Funds cannot be transferred between your HCFSA and DDCFSA.

If there is any money remaining in your HCFSA, up to $610 (for 2023) will automatically roll over into new plan year's account. If there is any money remaining in your DDCFSA that is not used

for eligible expenses incurred by December 31 of the current calendar year, federal tax law requires that money to be forfeited. You can view your account balance online at optumfinancial.com.

Any forfeitures from FSA accounts will be used for the reasonable expense of maintaining and administering FSA accounts as permitted under applicable law.

Note: Expenses incurred prior to your hire date or enrollment in the plan may not be submitted for reimbursement. Additionally, if you increase your FSA contribution amount during the plan year due to a Qualified Life Event (QLE), only FSA expenses incurred on or after the QLE are eligible for reimbursement from the additional amount.

Plan Termination

Coverage under the FSA program will terminate at the earliest of:

- The end of the calendar year (unless you re-enroll during the annual enrollment period)
- The date you cease making contributions
- The date your FSA balance has been completely distributed before the end of the calendar year (although your contributions continue)
- The end of the month you terminate employment or become ineligible for benefits, whichever is earlier. However, you can only incur expenses for reimbursement from the HCFSA through the date you leave Discover (although you may be eligible for COBRA continuation for the HCFSA see “Continuation of Coverage Rights Under COBRA and Other Health Coverage Alternatives” section for more information).
- The date the plan or FSA program terminates

LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT AND BUSINESS TRAVEL ACCIDENT INSURANCE

The Discover term life insurance, Accidental Death and Dismemberment (AD&D) insurance and Business Travel Accident (BTA) programs provide valuable financial protection for you and your family. The information provided here is intended to be a summary. More detailed information can be found in the applicable policies.

The Hartford is the insurance carrier for the term life insurance program and makes all determinations on when benefits are payable. CIGNA is the insurance carrier for the AD&D and BTA programs and makes all determinations on when benefits are payable.

Life Insurance Program

Basic Coverage

Discover provides you with basic term life insurance coverage of one times your HWEE rounded up to the next $1,000, up to a maximum of $500,000 for yourself, at no cost to you. Under IRS rules, the value of your basic term life insurance over $50,000 is considered taxable income to you. This taxable income will be reflected on your paycheck and Form W-2.

Supplemental Coverage

You can purchase supplemental life insurance coverage for yourself up to the lesser of eight times your HWEE or $3 million. Rates are based on your age as of January 1 and vary based on your smoker/non-smoker status. Any supplemental life insurance coverage you elect for yourself is in addition to the basic term life insurance coverage provided by Discover.

Coverage for Yourself (maximum of 8 times your HWEE)			
$50,000	$250,000	$750,000	$2,000,000
$75,000	$300,000	$1,000,000	$2,500,000
$100,000	$400,000	$1,250,000	$3,000,000
$150,000	$500,000	$1,500,000	
$200,000	$600,000	$1,750,000	

You can purchase up to $200,000 of supplemental life insurance coverage for your spouse or domestic partner in the increments listed in the table below. Rates are based on your spouse's age as of January 1 and vary based on their smoker/non-smoker status. The amount of coverage you elect for your spouse or domestic partner cannot exceed the supplemental coverage you elected for yourself. To ensure that premiums are accurate, you must provide your spouse or domestic partner's date of birth and smoker/non-smoker status during enrollment.

Coverage for Your Spouse or Domestic Partner	
$10,000	$70,000
$20,000	$80,000
$30,000	$90,000
$40,000	$100,000
$50,000	$150,000
$60,000	$200,000

Coverage for Your Eligible Dependent Children

You may elect to purchase $5,000, $10,000 or $20,000 of coverage for each of your eligible dependent children who are a live birth to age 26, regardless of marital status, eligibility for other coverage or financial dependence on the parent. An employee's child has automatic coverage of $20,000 within 31 days of birth. To continue coverage after 31 days, you need to enroll your eligible child(ren) within the 31-day enrollment period following their date of birth.

Evidence of Insurability (EOI) Requirements

EOI is required:

- For your supplemental coverage if increasing more than one coverage level, enrolling for the first time if previously eligible (any amount) or electing coverage above $1 million.

- For your spouse/domestic partner if increasing more than one coverage level, enrolling for the first time if previously eligible (any amount) or electing coverage above $30,000.
- For your and/or your spouse/domestic partner if previously declined for any supplemental insurance amount.

If EOI is required, you can submit your EOI information online through The Hartford's website using the link provided on the Discover benefits website or in subsequent communications from The Hartford. You will know immediately after completing the online EOI process if the additional coverage you selected is approved, denied or if you will need to provide more information to The Hartford. If you are unable to compete the online process, you may obtain a paper EOI form by calling The Hartford. You must complete the EOI process within 60 days of your initial enrollment or your EOI may be denied. The Hartford will contact you if additional information is required to complete EOI after you submit.

Elections requiring The Hartford's approval will be effective the date the EOI is approved. Coverage elected during annual enrollment will become effective the later of January 1 or the date the EOI is approved. Until The Hartford approves the EOI, you or your spouse or domestic partner will partner will be covered by, and you will pay for, the highest coverage level allowed without EOI. It is your responsibility to follow up with The Hartford regarding the status of any EOI. All increases are subject to the "active at work" rule (see the "Active at Work" Rule section below).

There is a two-year contestability clause in the event of death occurring within two years of EOI approval. The Hartford reserves the right to withhold benefits if The Hartford determines that misrepresentation of EOI has occurred.

"Active at Work" Rule

If you are ill or injured and away from work on the day your coverage (or any increase in coverage) would become effective, the effective date of coverage (or increase) and any increase in premium will be deferred for yourself and eligible dependents to the date you return to work for one full day. As an exception, coverage provided under the 31-day child automatic coverage from live birth provision is not subject to the "Active at Work" rule.

Accelerated Death Benefit

If you or your dependents have a life expectancy of less than 24 months, you can request an accelerated death benefit from the term life insurance plans. To qualify for an accelerated benefit, you, or your covered dependent must:

- Be insured for at least $10,000
- Under the normal retirement age
- Have not assigned ownership rights under the coverage, unless The Hartford receives a release from the assignee

If you qualify, you may request a minimum accelerated benefit amount of $3,000 and a maximum amount of $500,000, but the amount you request cannot exceed 75% of the total amount of your life insurance. This accelerated death benefit option may only be exercised once.

If an accelerated benefit is chosen, coverage will remain in force and the amount remaining will be the full amount prior to the early payout minus the amount that was accelerated. The final amount remaining will not increase or decrease due to subsequent changes in HWEE.

Life Insurance Program Exclusions/Change in Coverage

There are no exclusions (causes of death for which a benefit would not be paid) under the life insurance program.

In certain circumstances, you may not be eligible for life insurance coverage even if you have paid premiums for such coverage. If coverage is provided in error and it is later determined that you or your dependents were not eligible for life insurance coverage due to failure to obtain EOI, meet the "Active at Work" rule or for some other reason (as determined by the plan), you shall receive a full refund of any insurance premiums you have paid in error. You shall have no right to a claim for life insurance from The Hartford, the Plan or Discover.

Basic and Supplemental Life Insurance Portability and Conversion

If you no longer meet the eligibility requirements for coverage under the group policy, you may elect to continue your employee term life insurance and the coverage of your dependents through either portability or conversion. To continue dependent coverage, you or your spouse must continue voluntary coverage.

The terms and conditions of coverage under a portability or conversion policy will not be the same terms and conditions that are applicable to coverage under the Discover plan. Rates will differ from rates you paid as a participant in the Discover group insurance plan.

Contact The Hartford for an election form and additional information, including rates. All coverage is continued without EOI.

<u>Portability of Coverage</u>

Portability is a provision which allows you and your dependents to continue coverage under a group portability policy when coverage would otherwise end due to certain qualifying events.

You may elect to continue 50%, 75%, or 100% of the amount of life insurance which is ending for you or your dependent, rounded to the next higher multiple of $1,000. However, the Amount of Life Insurance that may be continued will not be less than $5,000 and will not exceed:

- $250,000 for You;
- $50,000 for Your Spouse; or
- $10,000 for Your Dependent Child(ren).

If You elect to continue 50% or 75%, you may not continue any portion of the remaining amount under the portability provision at a later date.

To elect portability, you must submit a completed application with the required premium to The Hartford. The Hartford must receive this within 60 days after life insurance terminates.

<u>Conversion Right</u>

If life insurance coverage, or any portion of it, under the Discover policy ends for any reason, except nonpayment of premium, you and your dependents may have the right to convert the

coverage that terminated to an individual conversion policy. Limitations apply if coverage under the policy ends because the policy is terminated or coverage for an eligible class is terminated.

To convert your coverage, you must complete and submit the appropriate form to The Hartford. The Hartford must receive this within 60 days of when your life insurance terminates. The Hartford will verify your eligibility for coverage and send you a conversion policy proposal. You must complete and return the request form and pay the required premium for coverage within the time specified in the proposal.

Retiree Life Insurance Program

Retiree Life Insurance only applies to those enrolled after December 31, 1988 and prior to April 1, 1993. No new enrollments are allowed in the retiree life insurance program.

The program is administered and insured by The Hartford Life and Accident Insurance Company (The Hartford). More detailed information can be found in the applicable policy.

AD&D and BTA Insurance Programs

Discover offers the following accident insurance programs to provide financial protection if, within 365 days of an accident, you or a covered dependent die or suffer dismemberment, loss of sight, speech or hearing, coma, or suffer paralysis as a result of the accident:

- Basic AD&D insurance program
- Supplemental AD&D insurance program
- Business Travel Accident (BTA) insurance program Covered accidents include all accidents while coverage is in effect, other than those listed in the Accident Program Exclusions section.

The accident programs are underwritten by Life Insurance Company of North America (LINA), an affiliate of CIGNA.

A final death certificate is required for any claims if you or a covered dependent die as the result of an accident. The AD&D insurance programs require that you file a claim within 31 days of the loss. The BTA insurance program requires that you file a claim within 365 days, but no later than 15 months.

Basic AD&D Insurance Coverage

Discover provides you with coverage of one times your HWEE rounded up to the next $1,000, up to $500,000, for yourself, known as your principal sum, at no cost to you.

Supplemental AD&D Insurance Coverage

- **Coverage for yourself.** You may elect to purchase additional coverage for yourself only (over and above basic AD&D coverage) for $50,000 or in multiples of $100,000 subject to a maximum of $1 million. The coverage amount is known as your principal sum.
- **Coverage for your spouse or domestic partner.** If you elect to cover yourself plus your spouse or domestic partner, your spouse or domestic partner is insured for 100% of your elected principal sum to a maximum of $1 million.

- **Coverage for yourself plus eligible dependent children.** If you elect to cover yourself plus your eligible dependent children, each child is insured for 25% of your elected principal sum to a maximum of $250,000.
- **Coverage for yourself plus family.** If you elect to cover yourself plus family, your spouse or domestic partner is insured for 75% of your elected principal sum to a maximum of $750,000, known as his/her principal sum, and each child is insured for 25% of your elected principal sum to a maximum of $250,000, known as the child's principal sum.

If an insured dependent child suffers a covered dismemberment, loss of sight, speech, hearing, coma or paralysis, the benefit will be doubled, to a maximum of $250,000. If your child subsequently dies within 365 days of the covered accident, only the loss of life benefit will be paid.

Business Travel Accident (BTA) Insurance Coverage

Discover provides BTA insurance coverage at no cost to you. BTA coverage is provided while you are traveling on company business away from the premises of your regular assignment. Your coverage begins at the actual start of the business trip—the moment you leave your home or workplace, whichever occurs last. Your coverage ends the moment you return to your workplace or home, whichever occurs first.

- **Coverage for yourself.** The amount of your BTA coverage is five times your HWEE rounded to the next $1,000, subject to a minimum amount of $250,000 and a maximum amount of $3 million. This amount is known as your principal sum.
- **Coverage for your spouse or domestic partner and eligible dependent children.** Your spouse or domestic partner and dependent children are covered for losses sustained while traveling with or in conjunction with your business travel and/or in connection with your relocation, provided these trips are at Discover's expense and direction:
    - Your spouse or domestic partner's principal sum is 50% of your principal sum.
    - Each dependent child's principal sum is 20% of your principal sum.

A domestic partner is considered an eligible dependent, provided he or she meets the criteria listed in the Domestic Partnership Eligibility section prior to the business trip.

Payment of Benefits

Full benefits under the accident programs are paid for certain losses, including death, dismemberment or paralysis. Partial benefits are paid for other losses. If, within 365 days of the accident, you or your eligible dependents suffer a covered loss listed on the next page, the payment shown will be made:

COVERED LOSS	PAYMENT
Loss of life	The principal sum
Loss of two or more hands or feet	The principal sum
Loss of sight in both eyes	The principal sum

COVERED LOSS	PAYMENT
Loss of one hand or foot and sight in one eye	The principal sum
Loss of speech and hearing (in both ears)	The principal sum
Loss of one hand or foot	1/2 the principal sum
Loss of sight in one eye	1/2 the principal sum
Loss of speech	1/2 the principal sum
Loss of hearing (in both ears)	1/2 the principal sum
Loss of thumb and index finger of the same hand	1/4 the principal sum
Loss of all four fingers of the same hand	1/4 the principal sum
Loss of all the toes of the same foot	1/4 the principal sum
Quadriplegia	The principal sum
Paraplegia	The principal sum
Hemiplegia	The principal sum
Uniplegia	1/2 the principal sum

Unless otherwise specified, only one benefit—the highest—will be paid if you or your dependents suffer more than one loss resulting from a single accident. The principal sum is the amount defined in the "Supplemental AD&D" Insurance Coverage" and "Business Travel Accident (BTA) Insurance Coverage" sections.

These are accident-only policies. These programs do not pay benefits for losses caused by or resulting from illness, disease or bodily infirmity.

Designating a Beneficiary

You can designate a person, estate or trust as your beneficiary under coverage for yourself for the life and accident program. You are automatically the beneficiary for spouse/domestic partner or child life insurance. Death benefits payable under the dependent coverage will be paid to you, if living, otherwise to your estate.

You can change beneficiaries for coverage for yourself at any time. Any requests to add or change a beneficiary must be made online at MyDiscoverBenefits.com or with myHR. A change will take effect immediately on the date it is successfully submitted online by you or by an authorized myHR Service Center Representative.

If you designate a trust as beneficiary for your coverage, it will need to meet the following requirements:

- The trust is a valid trust under state law (or would be but for the fact that there is no corpus)
- The trust is irrevocable or will, by its terms, become irrevocable upon your death
- The trust beneficiaries must be identifiable within the trust The full amount of your life and accident (AD&D and BTA) insurance coverage is payable to your named beneficiaries. Benefits are normally paid in a lump sum. However, other payment methods may be available from the insurance carrier.

Life Insurance Program

If there is no proper beneficiary form on file with myHR or if your named beneficiary predeceases you, life insurance program benefits on your life will be paid in the following order of priority:

- All to your surviving spouse or domestic partner;
- If your spouse or domestic partner does not survive you, in equal shares to your surviving children;
- If no child survives you, in equal shares to your surviving parents;
- The executors or administrators of your estate.

Dependent Life Insurance

You, the employee, are the beneficiary for dependent life insurance.

Basic AD&D

The share of any beneficiary who does not survive you will pass equally to any surviving beneficiaries unless otherwise specified. If there is no proper beneficiary form on file with myHR, if your named beneficiary predeceases you, or if you die while benefits are payable to you, basic AD&D benefits will be paid in the following order of priority:

- spouse (does not include a domestic partner);
- child or children;
- mother or father;
- sisters or brothers;
- your estate.

Supplemental AD&D

The share of any beneficiary who does not survive you will pass equally to any surviving beneficiaries unless otherwise specified. If there is no proper beneficiary form on file with myHR, if your named beneficiary predeceases you, or if you die while benefits are payable to you, supplemental AD&D benefits will be paid in the following order of priority:

- spouse or domestic partner;
- child or children;
- mother or father;
- sisters or brothers;
- your estate or the estate of your spouse and/or dependent children.

Business Travel Accident

The share of any beneficiary who does not survive you will pass equally to any surviving beneficiaries unless otherwise specified. If there is no proper beneficiary form on file with

myHR, if your named beneficiary predeceases you, or if you die while benefits are payable to you, BTA benefits will be paid in the following order of priority:

- spouse (does not include a domestic partner);
- child or children;
- parents;
- siblings;
- estate of the covered person.

Assignment of Benefits

You have the right to absolutely assign all of your rights and interest under the life insurance policy.

If you decide to assign your life insurance policy benefits, contact myHR to obtain the appropriate paperwork from the insurance carrier(s) necessary to execute the assignment of benefits.

There may be tax consequences to any assignment or transfer of ownership of life insurance policy benefits. Consult a tax advisor before you decide to assign policy benefits.

If You Terminate or Become Ineligible for Benefits

Your active basic and supplemental life insurance coverage will end on the day your employment ends, you lose eligibility, or you stop making the required payments, whichever is earlier. You may port or convert life insurance, as referenced in this document.

If you die within the 60-day period in which you are eligible to apply for conversion, and before an election is made to either port or convert coverage, your life insurance coverage will be in force.

If you leave Discover due to an involuntary termination without cause (for example, due to a reduction in force or facility closing), you and your spouse's or domestic partner's and covered dependent children's (if any) active basic and supplemental life insurance coverage may be eligible to be continued for a period following your termination date at no cost to you if you have:

- Been covered under the life insurance program for at least one year
- Not reached age 60 on the date your employment terminates (even if your spouse is over age 60), and
- Not ported or converted your coverage to an individual policy

If you meet the eligibility criteria listed above, life insurance in effect on the day your employment terminated will be continued at no cost to you for one month for each year that you have been covered under the life insurance program, not to exceed three months.

If you are receiving LTD benefits, basic life insurance continues until the earlier of the date you stop receiving LTD benefits, the date you reach age 65 or your settlement effective date if you receive a lump-sum settlement. All other benefits generally cease at your date of termination from Discover. See the "Impact of Work or Life Events on Coverage" section for more details.

If you are receiving LTD benefits and are under age 65, you may continue your supplemental life insurance coverage by paying the same rates as active employees. This does not apply to dependent life insurance coverage. You will be billed monthly by myHR. Upon termination of your LTD benefits or attaining age 65, you may convert your supplemental life insurance to an individual policy.

AD&D and BTA Programs

Basic and supplemental AD&D insurance and BTA insurance coverage for you and your dependents will terminate on the earliest of the following:

- The date your employment terminates for any reason
- The date you become ineligible for benefits due to an employment status change
- If you stop making the required contributions for this coverage (supplemental AD&D insurance coverage only)
- The date the program or accident program terminates Dependent coverage will also cease when your dependents are no longer eligible (see the "Eligibility" section). Conversion and portability policies are not available for accident program coverage.

AD&D and BTA insurance are not convertible or portable.

LONG-TERM DISABILITY INSURANCE

Long-Term Disability (LTD) benefits pay you 60% of your HWEE (up to a maximum of $20,000 per month) after you have been disabled for at least 180 consecutive days, in accordance with the disability program.

LTD insurance is provided by The Hartford. The information provided here is intended to be a summary. More detailed information regarding LTD coverage is found in The Hartford Policy (including The Hartford Group Long-Term Disability Schedule of Benefits #GLT-805593), which are a supplement to this SPD and can be found under Plan Information on MyDiscoverBenefits.com or by calling myHR. If you elect to participate in LTD coverage, you are eligible to receive LTD benefits after being on an approved disability for 180 consecutive days (the "elimination period").

Enrollment and Eligibility Waiting Period

Non-exempt employees are eligible to make LTD elections as part of their newly eligible enrollment event. However, non-exempt employees are only eligible for LTD benefits after six continuous months of benefits-eligible employment with Discover and/or its participating subsidiaries. This is called the LTD waiting period. If you are a non-exempt employee in the waiting period upon the start of a disability, you will not be eligible for LTD benefits for that disability. You must have completed the waiting period by the first date of a disability to be eligible to receive LTD benefits.

If you fail to opt out of LTD coverage when first eligible, you will be enrolled in such coverage and must remain in such coverage until the following annual enrollment, effective the first of the following plan year, or with a qualified life event if reported on a timely basis.

Evidence of Insurability (EOI)

EOI is not required if you enroll in LTD if you enroll when first eligible. Enrolling in LTD if coverage was previously waived requires you to submit EOI and be approved by The Hartford prior to your coverage becoming effective. The Hartford may deny your request for LTD coverage if its EOI requirements are not met. If EOI is required, your enrollment in LTD coverage will not be effective until your EOI is approved by The Hartford.

If you terminate employment with Discover, are subsequently rehired within 24 months, and make an election to enroll in LTD within 31 days of your rehire date, your coverage will be approved by The Hartford and you will not need to submit EOI or complete a new LTD waiting period. However, if you are rehired after 6 months, pre-existing condition limitations apply. See the LTD Certificate and Schedule of Benefits for details.

Pre-Existing Condition Exclusion

The Hartford will not pay any benefit for any disability that results from, or is caused by, a pre-existing condition unless, at the time you become disabled you have been continuously insured under the policy for 12 consecutive months. A pre-existing condition means any bodily injury, sickness, mental illness, pregnancy, or episode of substance use disorder or any manifestations, symptoms, findings, or aggravations related to or resulting from any of these for which you received medical care during the 3 consecutive month period that ends the day before your effective date of coverage or the effective date of a change in coverage.

"Active at Work" Rule

Under the LTD Program, the "Active at Work" rule applies. If you are ill or injured and away from work on the day your coverage was scheduled to become effective, the effective date of coverage and any premium due for such coverage will be deferred to the date you return to work for one full day.

LTD Benefits

LTD benefits provide a monthly income to you after you have been disabled for at least 180 consecutive days (the "elimination period"). Although you need not be confined in a hospital or an extended health care facility to receive LTD income (other than mental or nervous conditions lasting beyond 24 months), you must be under the regular care of a physician and you must be determined by The Hartford to be disabled.

The monthly benefit amount that you will be paid while you are disabled is calculated as follows:

- 60% of your HWEE (as defined in the "Health and Welfare Eligible Earnings" section) at the time of disability, offset by other income benefits (as defined in the certificate of insurance). The minimum monthly benefit is the greater of $100 or 10% of the benefits based on monthly income loss before the deduction of other income benefits.
- Up to a maximum benefit of $20,000 per month

When combined with other income benefits, if any, the monthly LTD benefit may not exceed 60% of your HWEE. No federal or state taxes will be withheld from your benefit.

Eligible pay as defined in the "Health and Welfare Eligible Earnings" section is limited to $400,000.

Definition of Disability

For the first 24 months following your 180-day elimination period, you are disabled if The Hartford determines that you are prevented from performing one of more of the essential duties of your occupation, and as a result your current monthly earnings are less than 80% of your indexed pre-disability earnings.

After receiving LTD benefits for 24 months, you are disabled if The Hartford determines that you are prevented from performing one of more of the essential duties of any occupation, and as a result your current monthly earnings are less than 80% of your indexed pre-disability earnings.

You will continue to receive a monthly benefit up to the program's maximum benefit period (as defined in the "Maximum Benefit Period" section) as long as you continue to be disabled as determined by The Hartford.

Elimination Period

The elimination period is the number of days that must elapse during a period of disability before LTD benefits become payable. The elimination period for LTD coverage is 180 consecutive days.

Maximum Benefit Period

Your LTD benefits continue for as long as you remain disabled (see the "Definition of Disability" section), subject to the following maximum benefit periods:

Maximum Duration of Benefits	
Age When Disability Begins	**Maximum Benefit Period**
Prior to Age 62	To Age 65, or for 42 months, if greater
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

Survivor Benefit

A survivor benefit may be payable if you die while disability benefits are payable to you for a continuous period of disability. A single lump sum payment equal to 3 times your monthly benefit will be payable to your spouse. If you do not have a spouse, surviving children will receive an equal share.

For purposes of LTD insurance, spouse includes your domestic partner provided that you meet the requirements as outlined in the policy. Children means your surviving unmarried children, step children, legally adopted children who, at the time of your death, are primarily dependent

on you for support and maintenance and who are under age 25 or who are related to you by blood, marriage or domestic partnership and who (1) lived with you in a regular parent-child relationship and (2) were eligible to be claimed as dependents on your federal income tax return for the last tax year prior to your death.

Premiums While on LTD

Your premiums for LTD coverage will be waived while LTD benefits are payable.

Termination of LTD Benefits

LTD benefits end on date first occurs:

- You voluntarily stop your coverage
- You no longer meet coverage eligibility criteria
- Your employment with the Employer ends (includes job elimination and severance)
- The required premiums or contributions are not made
- The group Policy ends
- You become covered under another employer group plan

Benefit payments will stop on the earliest of the date:

- You are no longer disabled;
- You fail to furnish proof of loss;
- You are no longer under the regular care of a physician;
- Your date of death;
- You refuse to provide required documentation;
- You reach the maximum duration of benefits; or
- Any other reason listed under termination of payment in the policy.

In addition, The Hartford reserves the right to terminate your LTD benefits if you fail to provide evidence of disability or any supplemental information requested by The Hartford. You are not eligible to port or convert your LTD policy.

Contact The Hartford or myHR for more information on Discover's LTD insurance coverage, including, for example, exclusions, limitations, and other program benefits.

Please note: Eligible employees may be able to receive short-term disability (STD) benefits from Discover Financial Services. However, the STD benefit will be documented and administered under Discover's Leave of Absence Program Standard instead of this plan. Please review the STD program under the Discover's Leave of Absence Program Standard for more information regarding any STD program.

LEGAL ASSISTANCE PROGRAM

The Legal Assistance Program, administered by MetLife Legal Plans, gives you access to a network of attorneys who can assist you with a wide range of routine legal matters. You can enroll in the Legal Assistance Program when you first become eligible for benefits, during Annual Enrollment, or within 31 days of a Qualified Life Event.

Examples of covered services include:

- Wills and trusts
- Debt matters
- Family law relating to adoption, guardianship, and prenuptial agreements
- Immigration assistance
- Real estate transactions
- Traffic violations
- Document preparation, such as deeds, affidavits, and elder law
- Defense of civil lawsuits

You'll also have access to digital tools to create wills, living trusts, and other legal documents.

Access to the legal assistance program is available on metlife.com/mybenefits. For more information on the program, including covered services and exclusions, contact MetLife Legal Plans.

If you choose to work with an out-of-network attorney, you will be reimbursed for attorney fees according to a set fee schedule. Contact MetLife Legal Plans for a copy of the out-of-network fee reimbursement schedule and for more information on requirements prior to using an out-of-network attorney. You will be responsible to pay the difference, if any, between the plan's payment and the out-of-network attorney's charge for services.

LONG-TERM CARE INSURANCE

No new enrollments are allowed in the long-term care insurance program. This section only applies to those enrolled after April 15, 2004 and prior to August 1, 2011.

The Discover Long-Term Care (LTC) insurance program is administered and insured by Metropolitan Life Insurance Company (MetLife) and designed to pay for certain expenses in the event you or your eligible covered family members can no longer perform certain everyday activities due to the effects of aging, illness or accident.

Long-term care coverage is summarized in MetLife's long-term care outline of coverage, which is a supplement to this SPD.

Policies issued prior to April 15, 2004 are not sponsored by Discover. For information about pre-April 15, 2004 policies, refer to your LTC Insurance Policy provided to you from MetLife at the time of enrollment or call MetLife at 800-984-8650 for details.

LIVE AND WORK WELL PROGRAM

The Employee Assistance Program (EAP) provides you and your eligible family members a confidential service to help resolve personal issues. To protect confidentiality, EAP services are provided by a third-party vendor, Optum, a division of UnitedHealth Group. Optum delivers the Live and Work Well program, accessible by telephone and online 24 hours a day, seven days a week. There is no fee to you or your family when you use the EAP.

The Optum EAP has resources and provides referrals to public and private agencies that aid in areas such as stress management, financial management, substance use disorder, and family counseling. Through the program, you may gain access to professional counseling assistance directly for yourself and eligible family members. All employee-initiated inquiries are treated confidentially and no information is provided to Discover without your consent.

While any expenses incurred by utilizing services referred to by the Optum EAP are your responsibility, various types of treatment may be covered under Discover's medical plans. The EAP professional at Optum will assist you in coordinating needed services, but you must file medical claim forms and follow your medical plan option procedures and requirements for coverage to apply.

Eligibility

Discover Live and Work Well program is available to all employees and their dependents immediately upon employment.

Objectives

The objectives of the EAP are to:

- Assist employees and eligible dependents with personal, emotional, family and work-related issues;
- Provide counseling or other appropriate resources and referrals;
- Maintain and protect individual confidentiality to the maximum extent practicable through direct access to an independent EAP provider; and
- Enhance employee's productivity and assist them to lead meaningful and healthy lives.

For more information, contact Live and Work Well directly at 800-622-7276, or visit them at liveandworkwell.com (access code: Discover).

Benefits Summary

Live and Work Well is Discover's free, confidential resource and referral service for employees, their spouses, domestic partners, and families. Access the Live and Work Well Program from home or anywhere you have a phone or an Internet connection:

Phone: 800-622-7276

Online: liveandworkwell.com (access code: Discover).

The Optum EAP offers traditional services, including:

- Ability to log in to liveandworkwell.com and download hundreds of educational materials;

- Access to Discover dedicated EAP consultants who support employees reporting to our major locations;
- Customized e-newsletters sent to you on a variety of topics; and
- Up to seven sessions per issue per year with a counselor in the EAP network to discuss personal or family issues at no charge.

Optum provides help in the areas of:

- Addiction and recovery
- Smoking cessation
- Emotional well-being
- Health and wellness
- Parenting and childcare
- Stress management
- Family related concerns
- Education
- Midlife and retirement
- Older adults/elder care
- Disability management
- Everyday issues
- Work
- Managing people and teams
- Financial management
- Legal

Confidentiality

This service is provided by Discover and information about an individual's use of Live and Work Well Program is completely confidential. In rare situations, when an employee's job performance or attendance is unsatisfactory and the situation remains uncorrected after supervisory assistance, the employee may be referred by management to the EAP. Confidentiality of such information and records is maintained to the maximum extent possible.

Cost to Employee

There is no cost to you or your eligible dependents for using the Live and Work Well Program. Telephonic counseling is available 24 hours a day, seven days a week for situations in which employees need immediate assistance. You also a have access to seven counseling sessions (per issue, per year) with a professional in the EAP network. If your counseling sessions go beyond the allocated amount covered by the EAP, your medical plan's mental health benefits might pay for some of your expenses. Contact your medical plan administrator to inquire about specific coverage.

If you use resources or services recommended by the Optum EAP, such as a childcare center or a treatment program, you are responsible for those costs. Certain treatments may be covered under Discover's medical plans for those individuals who participate in such plans. Contact your medical plan administrator to inquire about coverage for specific mental health or other services in advance of any treatments to ensure you understand your plan coverage.

Continuation of EAP coverage under COBRA is available for the Discover Live and Work Well Program at no cost to you. Your EAP coverage will stop when your COBRA period ends. See the "Continuation of Coverage under COBRA and Other Health Coverage Alternatives" section for more details.

THE COMMUTER BENEFITS PROGRAM

The Commuter Benefits Program (CBP), administered by WageWorks, allows you to use pre-tax dollars to pay for certain work-related commuting expenses. Discover provides a $60 monthly subsidy for participants in the program; parking expenses are not eligible for the Discover subsidy.

The CBP is comprised of two types of commuting expenses:

- Transportation expenses, including qualified fares for riding buses, trains, subways, ferries and other types of mass transportation or vanpools, and
- Parking expenses, including the cost of parking at or near your place of work or at or near a place from which you commute to work by mass transit, such as a park-and-ride lot. The cost of parking at or near your home is not included under any circumstances.

When you enroll in the CBP for eligible transportation expenses, you are authorizing WageWorks to purchase your transit pass directly from your transportation provider. The pass will be mailed to you.

When you enroll in the CBP for eligible parking expenses, you are authorizing WageWorks to pay your parking service directly. If you pay for parking expenses affiliated with the Discover facility where you work through payroll deduction, are living overseas, or if WageWorks cannot pay the parking facility directly, you can elect to have your pre-tax deduction (up to the allowable IRS limit) allocated to a CBP account to which you can submit claims for direct reimbursement.

You may make both transportation and parking expense elections, but you must elect each separately.

If you elect to have WageWorks purchase your pass or pay your parking facility directly and the cost exceeds the pre-tax monthly dollar limit, any additional cost will be deducted from your pay on an after-tax basis.

Enrollment

To enroll in the CBP, you must make an election at wageworks.com or by calling WageWorks. You can enroll during any monthly enrollment period if you are employed and meet the plan's eligibility requirements. There is no annual "open enrollment" period. If you are a new hire, it may take up to two weeks for your information to become available on the WageWorks website. You may enroll once your information can be verified on the website.

If you are ordering a transit pass, you must generally make your monthly election by the 10th of the month to ensure delivery of your pass for the following month. Your payroll deduction is taken once a month from the paycheck you receive on the last business day of the month prior to the benefit month in which you enroll. Once you enroll, your monthly election will continue to be taken from the last paycheck of each month, until:

- You change your election
- You end your participation
- You become ineligible to participate

- Your pay is less than the total amount you elect to contribute

Access to WageWorks is de-activated during a leave of absence. If you wish to re-instate your WageWorks account, you will need to re-enroll by contacting WageWorks upon your return from leave.

Express Payment Option

If you commute on the Long Island or Metro-North railroads, WageWorks will coordinate your enrollment with your existing Mail&Ride account through the Mail&Ride express payment option. Contact WageWorks for more information.

Changing Your Coverage Elections

You can change your CBP elections monthly. To change or stop your election, you must contact WageWorks online or by phone. You must make your elections by midnight, Eastern Time, on the 10th of the month for your change or stop to become effective the following month (unless you are using the Express Payment Option). Employees in the New York City area purchasing passes for the Long Island Rail Road or Metro-North must make their election by midnight, Eastern Time on the 4th of the month. Changes made after the cutoff for the current month will be effective for the second following month.

Contribution Limits

By law, you can contribute no more than the following monthly amounts on a pre-tax basis:

- $300 (for 2023) per month for transportation expenses
- $300 (for 2023) per month for parking expenses

The monthly limits may be indexed annually (in fixed increments) by the IRS.

If the cost of your pass or parking facility exceeds the pre-tax dollar amount you elect, any additional cost will be deducted from your pay on an after-tax basis.

If any portion of your transportation amount is subsidized by another Discover program, the pre-tax contribution amount for your transportation pass or parking facility will automatically be reduced by the subsidized portion that you are eligible to receive, not to exceed the IRS limit per month.

Establishing a CBP Account

If your parking provider does not accept payment directly from WageWorks or you park at different locations, you can elect to have parking reimbursement accounts set up through WageWorks. Discover will reduce your taxable base salary and commissions by the amount elected and the amount deducted will be credited to your account. You may submit claims for reimbursement online or by mail or fax to WageWorks on or after the first of the benefit month in which the expense is incurred.

IRS Rules

There are IRS rules you need to keep in mind as you make your elections:

- Federal tax laws require that elections be made on a prospective basis.

- Expenses incurred only during a month that you were a participant or have an account balance are eligible for reimbursement. Expenses are incurred when you receive the voucher or similar item (parking expenses are incurred at the beginning of the parking month).
- Any unused account balance remaining at the end of each month will be available for use in future months, but the maximum amount you can be reimbursed each month is the lesser of your total account balance and the legal monthly maximum.
- You must submit your claims for reimbursement within 180 days after the expense has been incurred.
- You may not transfer money between the transportation and parking accounts.
- Unused funds in your account will be forfeited if your employment with Discover is terminated.

Transportation Expenses

You may pay for qualified mass transit or vanpooling expenses through the CBP through pre-tax payroll deductions.

Qualified Mass Transit Expenses

Qualified mass transit expenses include any pass, ticket, token, fare card, voucher or other fares for buses, trains, BART, streetcars, ferries, or similar means that entitle you to transportation (or transportation at a reduced price), provided that such transportation is on mass transit facilities. Mass transit may be publicly or privately operated.

Qualified Vanpooling Expenses

Qualified vanpooling expenses are expenses incurred for transportation to and from work and your home, but only if:

- In a “commuter highway vehicle” with seating capacity for at least six adults (not including the driver).
- At least 80% of the mileage use can be reasonably expected to be for the purposes of transportation between work and residences.
- On trips during which the number of employees carried is at least one-half of the adult seating capacity of such vehicle (not including the driver).

This can include transportation furnished by Discover.

Monthly Transportation Expense Estimate

You can use the commuter savings calculator available on wageworks.com to calculate your monthly transportation needs and to estimate your potential cost savings.

Riders of the Long Island Rail Road, Metro-North and WMATA should contact WageWorks for details on how to link existing accounts.

Passes Not Received

If you do not receive your transportation pass by the first day of the benefit month, purchase your replacement pass and contact WageWorks customer service via e-mail at help@wageworks.com or by calling **877-WAGEWORKS**.

You must report any passes not received to WageWorks by the third workday of the benefit month for which the pass is effective. WageWorks will generally reimburse you via a check for the cost of the replacement pass upon receipt of documentation of your expense (for example, a receipt or used transit pass and a completed Special Handling Form).

In a rare situation, WageWorks may direct you to contact the agency directly. A Special Handling Form is available from WageWorks Customer Service. Your receipts and Special Handling Form can be faxed to the number on the Special Handling Form. WageWorks must receive your receipt and completed Special Handling Form by the 10th of the benefit month for which you are claiming reimbursement in order for you to receive reimbursement.

If your original pass arrives after you receive a replacement pass, you must return the original pass to WageWorks. Contact WageWorks for instructions on how to return the pass.

WageWorks will not issue reimbursements for incorrect or incomplete address information, for orders shipped to addresses that are not valid U.S. postal addresses or for orders shipped to P.O. boxes, private post office boxes or mailrooms.

Reimbursements or credit under these terms is your sole remedy for damages incurred as a result of late passes or passes not received.

There will be no charge to you to replace one pass during the calendar year. You will be responsible for the cost of any additional replacement passes.

WageWorks will not issue reimbursement if your pass is lost or stolen after you receive it.

Parking Reimbursement Expenses

You may pay for qualified parking expenses through pre-tax payroll deductions.

Qualified Parking Expenses

Qualified parking expenses are parking expenses you incur at or near the business premises of Discover, which enable you to get to work. Qualified parking expenses also include expenses incurred at or near a location from which you commute, to get to work by mass transit, vanpooling, in a commuter highway vehicle or by carpool. Parking expenses incurred at or near your home are not considered qualified expenses.

Direct Pay for Parking

You can elect to have WageWorks make a payment directly to your parking facility each month (called “Pay My Provider”) using your payroll deduction. If the monthly cost of your parking expense is greater than the allowable IRS pre-tax limit, any additional amount will be deducted from your pay on an after-tax basis, up to a $700 total maximum monthly deduction.

You must request Pay My Provider by the 10th of the month for the payment to be made to your parking facility by the first of the following month.

Pay My Provider is mailed to the parking facility providers monthly.

If you pay for your parking on a daily, weekly, quarterly, or annual basis, you should establish a parking reimbursement account (called “Pay Me Back”) and submit a claim form so you can be reimbursed for your parking payments.

If you pay for your parking one year in advance, you must file a claim (and a copy of your receipt, if provided) at the beginning of each month for 1⁄12 of your annual expenses or at the end of each quarter for the prior three months’ expenses.

If you currently have a payroll deduction taken for parking expenses affiliated with the Discover facility where you work, WageWorks cannot pay the parking facility directly. You must establish a Pay Me Back parking CBP account and submit a claim for reimbursement.

Ineligible Expenses

By law, the following expenses are not eligible for reimbursement from the CBP:

- Parking or transportation expenses that are not work-related car or vanpooling expenses with fewer than six passenger seats (not including the driver)
- Spouse’s, domestic partner’s or dependent’s parking or transportation expenses
- Tolls (for example, bridges, turnpikes, and E-Z Pass)
- Gas
- Mileage allowances or other operating costs for your personal vehicle
- Taxis or limousines
- Traffic tickets
- Payments to a fellow participant in a carpool or to a friend who drives you to work
- Parking at a mall or similar location where you stop on your drive to or from your place of work
- Parking at or near your home (even if you work out of your home)
- Business travel expenses

Requesting Payment of Out-of-Pocket Expenses

After you have incurred an eligible expense, you must request payment by submitting a claim form to WageWorks or by submitting your claims online through your WageWorks account. Parking expenses are incurred at the beginning of the parking month.

All claim forms must be signed and completed in their entirety or the claim will be denied. Claim forms are available online through the Help section of the WageWorks website.

The following information must be documented on each claim form:

- The name of the service provider or type of expense incurred (for example, parking garage)
- Amount of the expense incurred

- The date of service
- Your signature

Receipts must be attached when they are available. Always keep copies of your claim forms and supporting documentation for your files.

Send your completed claim forms to WageWorks by fax to **877-353-9236** or by mail to: WageWorks Claim Administrator, P.O. Box 14053, Lexington, KY 40512. You can view the status of your claim online at wageworks.com within 24 hours after it is received.

For reimbursement of expenses that do not have receipts available (for example, metered parking), log on to the WageWorks website and click submit receipt or claim, click on the benefit month you are claiming and provide the information requested, then click submit claim. You will then be prompted to submit your receipt. If you use metered parking then you will submit the claim without a receipt. If you park at a parking garage that provides receipts you can submit your receipt.

Reimbursements are limited to the Pay Me Back election amount each month. You can request reimbursement for up to six months of expenses on the same claim form. However, you will only receive reimbursement up to your available balance each month.

Balance Forward Option

If you have a balance in your account for a particular benefit month for which you do not have an eligible expense, you may request that any balance remaining for that benefit month be applied toward your next pending month's election. The request must be made on the claim reimbursement form for that particular month or online if submitting your claim online. If you choose this Balance Forward option, your next payroll deduction will be reduced by that benefit month's balance in your account.

In general, claims for reimbursement must be submitted within 180 days after the date the expense was incurred. If you do not file a claim within 180 days of the month in which you made the election, the 180-day old balance will automatically be applied to and reduce your payroll deduction for the next pending month's election.

Method of Reimbursement

Reimbursements for both transportation and parking expenses will be paid to you through your regular paycheck (similar to travel and entertainment expenses). The earnings code "CommReimb" will be used to reflect the reimbursement on your paycheck. This money is not included as part of your gross taxable earnings.

If you terminate and submit claims for reimbursement after your last day worked, your reimbursement will be sent to you directly by check to your home address.

Claim Submission Deadline

Claims must be submitted within 180 days after the expense has been incurred. All claims with dates of service older than 180 days will be denied.

If your employment ends or you otherwise become ineligible to participate in the CBP, you may only submit claims for reimbursement of expenses incurred through your termination date. Any unclaimed balance after 180 days cannot be returned to you and will be forfeited.

SEVERANCE PLAN

Additional SPDs are available for other benefits offered under the plan, including severance pay and change in control severance benefits.

PAYMENT OF BENEFIT CLAIMS AND APPEALS

Discover's plan is written to comply with applicable legal requirements.

Claim forms are available from the claim administrators.

Claim forms and documentation are not required for HSA accounts. To pay claims from your HSA, log into your online account at optumfinancial.com.

You may make a written claim for benefits as described below. Routine requests for information regarding your benefits under the plan and other similar inquiries will not be considered benefit "claims" that require processing under Employee Retirement Income Security Act of 1974, as amended (ERISA), or the plan's claims procedures. If you wish to make a claim for plan benefits in accordance with your rights under ERISA, you must do so in writing, except as described below.

Extensions to the required deadlines to file and process claims and appeals, to the extent they are available under applicable law, will apply and claims will be processed accordingly.

Medical Program

For treatment or benefits from a medical program in-network provider, there are generally no claim forms to file. For treatment or benefits from an out-of-network provider, you must submit a claim form to the claim administrator to have your expenses reimbursed.

You must request a payment of benefits by submitting a claim form within 90 days of the date the expense is incurred. If it is not reasonably possible to submit the request for payment within this time, more time, not in excess of one year of the date the expense is incurred, will be allowed. Generally, no claim forms submitted more than one year after the date of service will be accepted.

Dental Program

You must request payment of benefits by submitting a claim form to be reimbursed for eligible dental expenses. However, if you identify yourself as a participant in the MetLife PDP program when using a PDP dentist, the dentist may be willing to submit the claim form on your behalf. When using a non-PDP dentist you should bring the claim form with you when you visit the dentist. Claim forms should be submitted directly to MetLife, the claims administrator.

You must request a payment of benefits by submitting a claim form within 90 days of the date the expense was incurred directly to MetLife. If it is not reasonably possible to submit the request of payment within this time, more time, not in excess of one year of the date the

expense was incurred, will be allowed. Generally, no claim forms submitted more than one year after the date of service will be accepted.

Vision Program

When you receive services from a VSP network doctor, claim forms are not required. When you receive services from an out-of-network provider, you must pay the provider directly for all charges. To request payment of benefits, submit a claim form (include itemized receipts) online at vsp.com or mail to:

VSP
Attention: Claims Services
P. O. Box 385018
Birmingham, AL 35238-5018

Requests for payment must be submitted within one year of the date of service.

Accident, Hospital and Critical Illness Insurance

You must call or notify MetLife in writing within 30 days of the date of the loss to request a claim form. You must complete the claim form and provide proof of loss no later than 90 days after the date of loss. If notice of claim or proof is not given within these time limits, the delay will not cause a claim to be denied or reduced if such notice and proof are given as soon as is reasonably possible, but in no event, other than in the absence of the legal capacity of the claimant, later than 12 months from the date of the loss.

Life Insurance

To request payment of life insurance benefits, you or your beneficiary must contact myHR and submit a copy of the death certificate and other supporting documentation as required.

myHR will assist you or your beneficiary with requesting payment of benefits by completing claim forms and submitting them to the insurance company.

AD&D and BTA Insurance

To request payment of AD&D or BTA insurance benefits, you or your beneficiary must contact myHR to request a claim form. You, or your beneficiary must submit a certified copy of the death certificate with the manner of death, accident report, or other supporting documentation as required along with the completed claim form to the insurance company.

LTD Program

The LTD provider will:

- Request additional information, if needed
- Either accept or deny the claim, and
- Notify you of its determination in a timely manner

If you become disabled while on an unpaid leave, and are participating in LTD, you must contact the LTD provider directly to request payment of LTD benefits. You will be required to complete the 180-day elimination period prior to receiving LTD benefits.

Legal Assistance Program

A claim form is not required for in-network eligible expenses.

To request payment of out-of-network attorney fees, you must request a claim form prior to receiving service from the out-of-network attorney. Claim forms for reimbursement of eligible out-of-network services are available by calling MetLife Legal Plans.

LTC Program

You, your doctor, or representative must contact MetLife and request a determination of benefit eligibility based on your inability to perform the activities of daily living on your own. MetLife must approve the request for benefit eligibility and may also require access to your medical records.

MetLife will pay benefits only upon receipt of written proof deemed adequate by MetLife, in its discretion, that expenses for covered services were incurred. Written proof of claim must be submitted no later than 90 days after the end of the calendar year in which the expenses were incurred. Failure to submit proof of claim within the time limit may result in a claim denial, unless it is shown that it was not reasonably possible, as determined by MetLife, to provide the proof of claim within the time period or that the proof of claim was submitted as soon as reasonably possible. Claim forms are available from MetLife. If MetLife approves the request for payment of benefits, MetLife will send written notice of the decision no later than 10 business days after all necessary information is received.

After MetLife has approved your request for payment, reimbursement for covered services will be paid directly to you. Payments for most services can be made directly to the provider at your request and the request of the providers. This does not include payments for alternate plan of service and/or transition expense benefit as defined in the LTC section.

The Daily Benefit Amount (DBA), selected by you, determines the maximum amount that can be received each day. The amount payable will not exceed the DBA selected for expenses incurred during any day you receive covered services.

Concurrent Review

When you are receiving benefits for covered services, MetLife will review your case from time to time to see that the standards for eligibility to receive benefits are still being met. MetLife may review records and/or contact you, your doctor or someone else familiar with your condition. If it is determined that you are no longer eligible to receive benefits, you will be notified by MetLife.

If Benefits Are Not Paid

If you or your dependent’s claim for payment under the plan is denied, you or your dependent can file an appeal. Certain health plans also offer a voluntary third level of review. Information about filing claims and appeals, including applicable timeframes, is included in the following section. You should contact benefit vendors directly for information on the claims and appeals process related to the type or amount of benefits payable.

Right to Reimbursement (Subrogation Agreement)

If you or any other person receives a recovery in any form, including (but not limited to) a judgment, settlement, payment or compensation of any type with respect to an injury or condition for which the plan has provided benefits or advanced money (regardless of fault, negligence or wrongdoing) from any tortfeasor, liability insurer, uninsured or underinsured motorist insurer, medical program coverage or other source (a "recovery"), you or such other person must repay the plan in full for any benefits that have been or may be paid, payable or advanced by the plan (the "subrogated amount"), including any reasonably foreseeable expenses not yet incurred, whether or not you or such other person has been "made whole" for the injuries or condition suffered.

Each person receiving benefits or advanced money from the plan has an obligation and duty to reimburse the plan to the extent of the subrogated amount and is deemed to give the plan a first lien on any recovery for the subrogated amount. The plan may also, in its sole discretion, seek to impose a constructive trust through the courts on a recovery to the extent of the subrogated amount. This right of first priority in contravention of any "make whole" doctrine shall not be affected or limited in any way by the manner in which the person or entity responsible for paying any recovery designates or characterizes the recovery. The plan specifically disclaims the "common fund doctrine" and any payment of the subrogated amount to the plan shall be without reduction, set-off or abatement for attorneys' fees or costs incurred by you or any other person in obtaining the recovery. You or any other claimant of a recovery must promptly inform the plan of the filing of a lawsuit, making a claim against any third party, the scheduling of settlement negotiations or the intention of any third party to make payment of any kind to your benefit or on your behalf to which this section may reasonably apply. If it is determined that a third-party may be responsible for the payment of benefits paid or money advanced by the plan, you or any other person may be contacted by the plan or its representative to provide information regarding any potential recovery, you or such other person consent to being so contacted and agree to cooperate in obtaining any recovery. Furthermore, you and any other person who may receive a potential recovery agree to segregate and hold any recovery in a separate fund for the purpose of reimbursing the plan the subrogated amount until such time as the subrogated amount has been reimbursed to the plan.

The plan may, in its sole discretion, require you or any other person, as a precondition of payment of benefits or advance of money, to sign a written assignment of any recovery to the plan to the extent of the subrogated amount. In the event that the plan does not receive payment of the subrogated amount, the plan and the plan administrator have the full discretion and authority, either together or individually, to bring any action against you or any other person who has received or may receive a recovery in any capacity or against any person responsible for the injuries or condition suffered or for the payment of any potential recovery, or reduce or set-off the subrogated amount against future benefit payments. Such action may include filing suit against you or such other person in a court of law to recover 100% of the subrogated amount plus the plan's attorneys' fees and court costs related to such suit.

Except as stated in the plan or as required by applicable law, the plan is not required to pay any expenses for past illnesses or injuries that are settled where you or another person have received a recovery, and the plan's rights of subrogation and reimbursement of the subrogated

amount apply, even if the original injury or illness happened before coverage under the plan began.

The payment of benefits under the plan is conditioned upon the terms of this section and each person receiving benefits or advanced money from the plan agrees that such benefits or money is paid or advanced on condition of full reimbursement to the plan in the event of a recovery. By accepting any benefits under the plan, you are indicating your agreement to repay the subrogated amount. The plan's rights to subrogation and reimbursement of the subrogated amount will not be reduced by any equitable defenses that may be raised by you or any third party (whether such third party has received benefits or is responsible for payment of a recovery), including, but not limited to, any common fund doctrine, contributory negligence doctrine, make whole doctrine or uninsured motorist rules or statutes. If any court of competent jurisdiction finds any portion of this section void or unenforceable, such portion shall be of no force and effect but shall not affect the validity or enforceability of any other portion hereof.

Claims and Appeals Process Under the Plan

The following is a general summary of the claims and appeals process for the plan.

Claims and Appeals for Type or Amount of Benefits Payable

For the type or amount of benefits payable under Medical, Prescription Drug, Dental, Vision, AD&D, BTA, FSAs, Accident, Critical Illness, Hospital Indemnity, Legal Assistance, Life Insurance and Long-Term Disability, the initial request for determination of benefits (including any pre-service claims) is the claim; an appeal is your request for review of the denial of a claim. Routine requests for information are not claims for benefits under ERISA. Claims and appeals procedures are set forth in plan materials provided by benefits vendors. If there is any conflict between this SPD and the materials provided by benefits vendors, the materials provided by benefits vendors will prevail.

In most cases, benefits to which you are entitled are paid upon your request. If you have a question or concern regarding the type or amount of benefits payable, call the appropriate administrator or insurer's member services as described in the "Claim Administrators" section. If member services cannot resolve the issue to your satisfaction, you, or an authorized representative (your spouse or adult child, or another person authorized, in writing or by a court on your behalf) have the right to file an appeal with the appropriate reviewer. Member services of the appropriate administrator or insurer can instruct you on the process to file an appeal.

The person or entity that reviews your claim or appeal, called the "reviewer," depends on the program involved, the type of request for review, the amount involved and whether it is a claim or appeal. The following chart shows the reviewer for both claims and appeals for type or amount of benefits payable.

Program	Claim Reviewer	Appeal Reviewer
BlueCross BlueShield Medical	BlueCross BlueShield	BlueCross BlueShield
CVS Caremark Prescription Drug	CVS Caremark	CVS Caremark
SelectHealth HSA Medical	SelectHealth HSA	Select Med HDHP
SelectHealth HMO Medical	SelectHealth HMO	Select Med HMO
HMSA Medical	HMSA	HMSA

Program	Claim Reviewer	Appeal Reviewer
MetLife Dental, Accident, Critical Illness and Hospital Indemnity	MetLife	MetLife
VSP Vision	VSP	VSP
Life Insurance	The Hartford	The Hartford
Long-Term Disability	The Hartford	The Hartford
AD&D and BTA	LINA	LINA
Flexible Spending Accounts	Optum Financial	Optum Financial
Legal Assistance Plan	MetLife Legal Plans	MetLife Legal Plans

Certain health plan administrators or insurers offer an external review with an Independent Review Organization (IRO) not associated with the administrator and a voluntary third level of review. Check with your health plan administrator or insurer for details.

Claims and Appeals for Eligibility, Coverage, Amount of Premiums, and Other Matters Not Covered by Administrator's or Insurer's Contract

For any claims or appeals related to eligibility, coverage, amount of premiums, and other matters not covered by the administrator's or insurer's contract, contact myHR to file a claim or appeal.

Your claim is your initial request for review related to eligibility, coverage, amount of premiums, and other matters not covered by the administrator's or insurer's contract. Your claim must be in writing, you must use the form provided by myHR, and you should include all documentation that you consider relevant and a statement of why you believe your claim should be granted. The claim must be returned to myHR using the instructions provided on the form.

Generally, the Discover Benefit Plan Claims Committee will review your claim. However, if the amount involved in your claim is $20,000 or less, the Discover Benefit Plan Claims Committee may delegate your claim to be decided by Discover's Director of Benefits or another delegate. The Director of Benefits determines whether the amount involved exceeds $20,000.

If you are not satisfied with the claim reviewer's decision, you have the right to file an appeal to request a review of the denial of your claim. See "How do I file an appeal if my claim is denied?" and "When must I file an appeal?" sections below.

The person or entity that reviews your claim or appeal, called the "reviewer," depends on the program involved, the type of request for review, the amount involved and whether it is a claim or appeal. The following chart shows the reviewer for both claims and appeals for review related to eligibility, coverage, amount of premiums, and other matters not covered by the administrator's or insurer's contract.

Program	Type of Review	Claim Reviewer (First Level Review)	Appeal Reviewer[1] (Second Level Review)
Medical, Dental, Vision, Life Insurance, LTD, AD&D, BTA, Legal Assistance, Accident, Critical Illness, Hospital Indemnity	Eligibility, coverage, amount of premiums and other matters not covered by administrator's or insurer's contract	Claims Committee or their delegate	Hearing Panel
EAP, Wellness Benefits, Severance Pay Plan, Change in Control	All	Claims Committee or their delegate	Hearing Panel

Certain health plan administrators offer a voluntary third level of review. Check with your health plan administrator for details.

Authorized Representatives

If you wish, you may designate an authorized representative (including an attorney) to pursue a claim or appeal on your behalf. The plan administrator may establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. You will bear the fees and expenses of any representative whom you designate to act on your behalf.

Each claim for benefits under the plan must be filed in accordance with the procedures set forth in the applicable plan documents. All claims for benefits must be duly filed no later than the deadline for that plan set forth in the applicable plan documents. All claims for benefits will be processed and may be appealed in accordance with the procedures for such plan set forth in the applicable plan documents. A participant may designate an authorized personal representative to act on his or her behalf on a benefit claim filed under an applicable plan. To authorize a personal representative to act on a participant's behalf with respect to a benefit claim, the participant must submit a written request on a form approved by the plan administrator, which the participant signs and which authorizes the representative to act on their behalf with respect to the benefit claim. A participant must sign and submit the approved form to the plan administrator and have such request approved prior to the authorized representative taking any action on behalf of a participant's benefit claim. If a party is not properly designated as an authorized personal representative under the plan, the plan administrator will not communicate with that party with respect to any benefit claim or other exercise of a participant's rights under the plan. With respect to any urgent pre-service or concurrent care claim, a participant's treating physician or other health care professional may act as an authorized representative in exercising a participant's rights under the plan. An assignment of benefits by a participant to a health care provider does not constitute a designation of an authorized personal representative for purposes of the plan.

When will I receive a decision on my claim or appeal?

Deadlines differ depending on the program involved, the nature of the review requested and whether it is a claim or appeal. Unless otherwise specified below, initial claim determinations will be decided within 90 days of receipt, but a 90-day extension is allowed if the reviewer needs additional time due to special circumstances. Appeals will be decided within 60 days of receipt, but a 60-day extension is allowed if the reviewer needs additional time due to special circumstances.

Claims and appeals involving disability benefits will be decided within 45 days, but the time for decision may be extended for two additional 30-day periods provided that, prior to any extension period, you are notified in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which you can expect a decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date your response to the request is received.

The following chart shows where different deadlines apply:

	Claim Reviewer	Appeal Reviewer
Medical, Dental, and Vision – Urgent Care Reviews	ASAP, but within 72 hours of receipt; 48-hour extension after you provide any additional needed information	ASAP, but within 72 hours of receipt
Medical, Dental, and Vision – Pre-Service Reviews	15 days; 15-day extension	30 days
Medical, Dental, and Vision – Concurrent Care Reviews	See concurrent care review definition	See concurrent care review definition
Medical, Dental, and Vision – Post-Service Reviews	30 days; 15-day extension	60 days
Life, AD&D, BTA, Critical Illness, Hospital Indemnity, Accident, and Legal Insurance	30 days; 15-day extension	60 days
FSAs	30 days; 15-day extension	60 days
LTD	45 days; two 30-day extensions	45 days; two 30-day extensions
LTC	60 days; 60-day extension	60 days; 60-day extension

What happens if my claim is denied?

If your claim is denied, in whole or in part, you will receive a written or electronic notice containing the following information (for urgent care medical review, you may receive oral notice followed by a written or electronic notice within three business days):

- The specific reasons for the denial
- Reference to the specific plan provisions on which the denial is based

- A description of any additional material or information which you must provide to complete your claim and an explanation of why such material or information is necessary; incomplete claims will be treated as part of the request for information and extension process and not as a denial unless you do not respond to the request for information within the required time period
- Instructions and deadlines for making an appeal, including a statement of your right to file a lawsuit under ERISA if your appeal is denied
- In the case of a health claim involving urgent care, a description of the expedited review process for these types of claims
- For health and disability benefits, a statement that a free copy of any internal rule, guideline, protocol, or other similar criterion relied on in denying your claim will be provided to you on request
- For health and disability benefits, if the denial was based on a clinical judgment or experimental treatment or similar exclusion or limit, a statement that a free explanation will be provided to you upon request
- For disability benefits, an adverse benefit determination will be in writing and will include a discussion of the decision, including, if applicable, an explanation of the basis for disagreeing with or not following:
    - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration

How do I file an appeal if my claim is denied?

Generally, your appeal must be in writing. Send a statement of why you believe your appeal should be granted, along with all documentation that you consider relevant, to the appeal reviewer listed previously. You will be provided, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to your appeal under applicable legal standards.

Health and disability benefits: The appeal reviewer will be someone other than the claim reviewer or its subordinate. The appeal reviewer will not give deference to the denial of claim. If your claim was denied based on a medical judgment, the appeal reviewer will consult with a health care professional who has appropriate training and experience in the relevant field of medicine (and who was not consulted in connection with the denial of your claim). The appeal reviewer also will identify, at your request, any medical or vocational expert consulted in connection with the denial of your claim.

When must I file an appeal?

Your appeal must be filed in a timely manner. Unless otherwise specified here, you must file your appeal within 180 days following the date your claim is denied. Certain insured programs require that appeals be made as soon as possible; check with the insurer for details. If you fail to file by this period, any appeal is barred.

What happens if my appeal is denied?

If your appeal is denied, in whole or in part, you will receive a written or electronic notice containing the following information:

- The specific reasons for the denial;
- Reference to the specific plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to your claim under applicable legal standards;
- A statement of your right to file a lawsuit under ERISA after you have exhausted the plan's administrative claims and appeals procedures;
- For health and disability benefits, a statement that a free copy of any internal rule, guideline, protocol, or other similar criterion relied on in denying your appeal will be provided to you on request;
- For health and disability benefits, if the denial was based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that a free explanation will be provided to you on request;
- For disability benefits, before you receive an adverse benefit determination on review, you shall be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the appeal reviewer in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date;
- For disability benefits, before you receive an adverse benefit determination on review based on a new or additional rationale, you shall be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

May I have my appeal reheard?

You may be eligible to request an independent external review of a denied appeal related to medical or prescription drug benefits within four months after the date you receive notice that your appeal has been denied from BCBS or CVS Caremark and 180 days from the date you receive notice that your appeal has been denied from SelectHealth. Within five business days after receipt of your external review request, the claim administrator will complete a preliminary review of the request to determine whether:

- The appellant was covered under the plan at the time the health care item or service was provided
- The denial of the appeal does not relate to a failure to meet eligibility requirements under the plan
- The appellant exhausted the plan's internal administrative claims and appeals processes, and
- The appellant provided all of the information and forms required to process an external review.

The claim administrator will notify you whether your appeal is eligible for external review or whether any additional information may be required, in which case you will have not less than 48 hours to provide such additional information.

External reviews will be done by an Independent Review Organization (IRO) that is not related to the claim administrator. Notice of the IRO's final decision will be made within 45 days of receipt of the appeal for review. Expedited IRO reviews may be available where delay would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function or if the final denied appeal relates to the availability of care, continued state or health care item or service for which the claimant received emergency services but has not been discharged from a facility. Notice of the IRO's decision will be made to the plan and to you and will contain:

- A general description of the reason for the review and all details surrounding the claim such as date of service, health care provider, amount, etc.
- The date the IRO received the request for review and the date of IRO decision
- References to evidence or documentation considered
- Discussion of the principal reasons for the IRO decision
- A statement that the decision is binding except as otherwise provided under applicable state or federal law
- A statement that judicial review may be available to the claimant
- Contact information for consumer health assistance

You do not have to ask for an external review to bring a legal action for a benefit. The period of time in which your external review is processed will not be counted against you in determining the timeliness of any later legal action you may bring.

Contact your health plan administrator for more information about an external review. All decisions of the external reviewer are final, conclusive and binding.

If, however, you believe that the external reviewer did not follow the terms of the plan or has violated law, you may bring a legal action under ERISA. See the "Civil Actions under ERISA" section for more information, including deadlines.

How do I contact the persons and entities named in these procedures?

Send all correspondence and documents to the Claims Committee, Hearing Panel, Director of Benefits or myHR to:

Discover myHR Service Center
Attn: Discover Benefit Determination Review Team
P.O. Box 1407
Lincolnshire, IL 60069-1407
Fax: 847-554-1441

What else should I know about how the reviewers make decisions?

The administrators and fiduciaries of Discover's benefit plans, including the reviewers, have discretionary authority to interpret the plans and make determinations under the plans. Any decision made pursuant to this authority is given full force and effect unless arbitrary or capricious. See the "Other Important Information" section of this SPD for details.

Definitions

Urgent care review:

A claim or appeal that requires expedited notification or authorization for medical treatment because the longer time periods applicable to other types of reviews 1) could seriously jeopardize your life or health or ability to regain maximum function or 2) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the requested treatment. Urgent care reviews are decided on an expedited basis. Urgent care reviews may be requested orally and all necessary information, including the decision on appeal, will be sent to you by telephone, fax, or another expeditious method. If you do not provide sufficient information to determine whether, or to what extent, your claim or appeal is covered, you will be notified within 24 hours after the plan receives your request for review of the specific information needed to complete the review. You will have at least 48 hours to provide this information. If you do not follow the plan's procedures for filing an urgent care review, you generally will be notified of the failure and the proper procedures within 24 hours.

Pre-service review:

A claim for treatment where prior plan approval or notification is required in order for the plan to cover the cost of the treatment or benefit. If you fail to submit needed information, the extension notice will describe the information needed and you will have 45 days to provide it. If you do not follow the plan's procedures for filing a pre-service claim, you generally will be notified within five days.

Concurrent care review:

May arise when the plan has approved treatment to be provided over a period of time or a number of treatments. A reduction or termination by the plan of the course of treatment (other than by plan amendment or termination) before the end of the originally approved period of time or number of treatments is considered a claim denial. If the plan has approved a course of

treatment and subsequently reduces or terminates that approval, you will be given sufficient advance notice to allow you to appeal the decision before it takes effect. If a course of treatment involves urgent care, your claim will be decided as soon as possible, taking into account the medical exigencies, but within 24 hours after the plan receives your request, as long as your request is made at least 24 hours before the end of the course of treatment. If your request is not made at least 24 hours before the end of the course of treatment, it will be treated as a new urgent care claim and decided within the time frame described above for urgent care claims. If a course of treatment does not involve urgent care, your request to extend the course of treatment will be treated as a new claim and decided within the time periods that apply to the type of claim (pre-service or post-service).

Post-service review:

A claim for which you do not need prior approval in order to have the benefit or treatment covered. A request for payment for medical care already received by you is a post-service claim. If a decision is not made within 30 days because you fail to submit necessary information, you will have 45 days to provide this information.

If your review is not for urgent care, pre-service or concurrent care, it will be treated as a post-service review.

Civil Actions under ERISA

You may not bring a lawsuit to recover benefits under a benefit plan, enforce your rights under the terms of the plan or clarify your rights to future benefits under the plan, or challenge the plan administrator's (or claim administrator's or appeal administrator's) determinations until you have exhausted the plan's administrative process described in this SPD.

Benefits under the Plan will be paid only if the claim administrator or the IRO, as applicable, decides in its sole discretion that a claimant is entitled to them. In determining claims and appeals for benefits the claim administrator and the IRO, as applicable, have the authority to interpret the plan, to resolve ambiguities, to make factual determinations, and to resolve questions relating to eligibility for the amount of benefits.

Subject to applicable law, any decision made in accordance with these claims and appeal procedures is final and binding on all parties. A misstatement or other mistake of fact shall be corrected when it becomes known and claim administrator and the IRO, as applicable, shall make such adjustment on account thereof as it considers equitable and practicable. All decisions and communications to claimants and other persons regarding a claim or appeal for benefits under the plan shall be held strictly confidential by the claimant, claim administrator, the IRO, the plan administrator, and their agents.

No action at law or in equity shall be brought to recover benefits under the plan until the appeal rights herein provided have been exercised and the plan benefits requested in such appeal have been denied in whole or in part. If any judicial proceeding is undertaken against the plan, its fiduciaries, or any employer to appeal the denial of a claim, challenge the amount of any benefit under the plan, or bring any other action under ERISA other than a breach of fiduciary duty claim, the evidence presented shall be strictly limited to the evidence timely presented to claim administrators and the IRO, as applicable. In addition, any such action against the plan or its fiduciaries must be filed in a court of law within the earlier of the following dates:

- Six months following the date your appeal has been denied
- Three years following the date services related to the amount you are appealing were performed, or
- The end of the otherwise applicable statutory limitation period If you fail to file by this period, any claim is barred.

Except as otherwise preempted by federal law, the plan will be administered, construed and enforced according to the laws of the State of Illinois and in courts situated in Illinois.

Provided, however, that any action brought against the insurance carrier under an insured participating benefit must be filed within the time limit set forth in the applicable insurance contract or certificate of coverage or such other time limit as may be established under applicable state insurance law.

YOUR ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The plan administrator may make a reasonable charge for copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may be able to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description (see the section entitled "Continuation of Coverage Rights Under COBRA and Other Health Coverage Alternatives") and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Pre-Existing Conditions Under Your Group Health Plan

There are limitations on plans imposing a pre-existing condition exclusion and such exclusions are generally prohibited under the Affordable Care Act.

Prudent Action 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 the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit to which you are entitled under the plan 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 to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. You may not start legal action against the plan, the plan administrator, the claim administrator, your employer, or any other plan fiduciary until you have completed the plan's claim and appeal process (including external review by an independent third party, if available) and have received a final decision regarding your claim and subsequent appeal. You must start legal action to recover benefits under the plan within the timeframes described in this SPD. 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 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.

As described in the section, "Claims and Appeals Process Under the Plan," you are required to exhaust the plan's administrative remedies before filing suit to recover benefits, enforce your rights under the plan or clarify your right to future benefits under the plan.

Assistance With Your Questions

If you have any questions about the plan, contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, 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.

CONTINUATION COVERAGE RIGHTS UNDER COBRA AND OTHER HEALTH COVERAGE ALTERNATIVES

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of any medical, dental, vision, and health care flexible spending account coverage you are enrolled in under the plan, including the onsite health clinics listed under the "Medical Program" section, immediately prior to an event that causes you to lose eligibility for such coverage. This notice also contains important information about other health coverage options that may be available to you through the Health Insurance Marketplace at **HealthCare.gov** or **1-800-318-2596**. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. See the Health Insurance Marketplace section for additional details. Also, as noted in the "Live and Work Well Program" section, continuation of EAP coverage is available at no cost to you and your eligible family members through the COBRA period. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, contact myHR.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Group health plan coverage includes any medical, dental, vision and health care flexible spending account coverage you, your spouse, or your dependent children are enrolled in under the plan, including the onsite health clinics listed under the "Medical Program" section, immediately prior to the qualifying event. Specific qualifying events are listed later in this notice. After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse or your dependent children could become qualified beneficiaries if coverage under the plan is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage generally must pay for that coverage.

You will become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events happens:

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

Your spouse will become a qualified beneficiary if they lose coverage under the plan because any of the following qualifying events happens:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- Your death;
- Your entitlement to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated.

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

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- Your death;
- Your entitlement to Medicare benefits (under Part A, Part B, or both);
- Your divorce or legal separation; or
- The dependent stops being eligible for coverage under the plan as a “dependent child.”

When Is COBRA Coverage Available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after it has been notified that a qualifying event occurred. For the following qualifying events, Discover will notify myHR of the qualifying event:

- Your hours of employment are reduced;
- Your employment ends;
- Your death; or
- Your entitlement to Medicare benefits (under Part A, Part B, or both) (typically upon reaching age 65).

You Must Give Notice of Some Qualifying Events

For the following qualifying events, you or a family member must notify myHR within 60 days after the qualifying event occurs:

- Your divorce or legal separation;
- Your dependent’s loss of eligibility for coverage as a “dependent child”;
- Your entitlement to Medicare benefits (under Part A, Part B, or both) for any reason other than reaching age 65; or
- You or your qualified beneficiary has been determined to be disabled (under Title II or XVI of the Social Security act) as of the date of your termination of employment. This notification must also occur within the initial 18-month continuation coverage period.

You must notify myHR of the qualifying event by logging into your benefits account at MyDiscoverBenefits.com or by calling **844-DFS-**myHR (**844-337-6947**).

How Is COBRA Coverage Provided?

Once myHR receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect continuation coverage on behalf of your spouse and dependent children. Your spouse may also elect continuation coverage on behalf of your dependent children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 18 months for qualified beneficiaries:

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

When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 36 months for your spouse and dependent children:

- Your death;
- Your divorce or legal separation; or
- Your dependent stops being eligible for coverage under the plan as a “dependent child.”

When the qualifying event is your reduction in hours or your termination of employment and you became entitled to Medicare benefits less than 18 months before the qualifying event, additional coverage for your spouse and dependents may be available. Your spouse and dependents would be eligible to receive up to 36 months of COBRA continuation coverage from the date of your entitlement to Medicare. For example, if you became entitled to Medicare 8 months before the date your employment terminates, COBRA continuation coverage for your spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months prior to the qualifying event).

There are two other ways in which an 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage

COBRA coverage may be available for you and your non-disabled family members for up to a total of 29 months if all the following events occur:

- You, your covered spouse or your covered dependents (including newborn and newly adopted children) are determined to be disabled as defined by the Social Security Act prior to the qualifying event or during the first 60 days of COBRA coverage;
- The Social Security Administration’s disability determination is received within the disabled individual’s 18 months of COBRA coverage;
- The disability must last at least until the end of the 18-month period of continuation coverage; and

- myHR is notified of the Social Security Administration's disability determination within 60 days of the disabled individual's receipt of a Social Security disability award. If the disability determination occurred before COBRA coverage started, you're required to notify myHR within the first 60 days of COBRA coverage.

You, your covered spouse, or your covered dependents must notify myHR within 60 days of receipt of the disability determination and prior to the end of the initial 18-month continuation period to receive the coverage extension. To notify myHR of the disability determination event, call 844-DFS-myHR (844-337-6947).

You, your covered spouse, or your covered dependents must notify myHR within 30 days of the date the disability ends by calling 844-DFS-myHR (844-337-6947).

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. Additional continuation coverage is available only if the event would have caused your spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred. These events include:

- Your death;
- Your entitlement to Medicare (under Part A, Part B, or both);
- Your divorce or legal separation; or
- Your dependent stops being eligible for coverage under the plan as a "dependent child."

You, your covered spouse, or your covered dependents must notify myHR within 60 days after the event occurs in order to receive this additional coverage. To notify myHR of the additional qualifying event, call 844-DFS-myHR (844-337-6947).

Events That May Change Continued Coverage

Once your COBRA coverage begins, you may be able to change your COBRA coverage elections in limited circumstances based on plan rules if you experience a qualified change in status. You, your covered spouse or your covered dependents must notify myHR by calling 844-DFS-myHR (844-337-6947) within 31 days of the qualified change in status to change your COBRA coverage.

See the "Qualified Life Events" section for detailed information on allowable changes in status. If you are allowed to add family members to COBRA coverage, this may result in a higher premium for this additional coverage.

You may also change COBRA coverage if a child is born to the covered employee or placed for adoption with the covered employee during the 18-, 29-, or 36-month continuation period. In such cases, you must notify myHR by calling 844-DFS-myHR (844-337-6947) within 31 days of the birth or placement to cover the new dependent as a qualified beneficiary under COBRA. There may be a higher premium for this additional coverage.

Events That End Continued Coverage

COBRA coverage will end automatically upon the expiration of the 18-, 29-, or 36-month continuation periods described on the previous pages. In addition, COBRA coverage will end automatically if any of the following situations occur:

- Discover stops providing group health benefits;
- Premiums are not paid within 30 days of the due date (with the exception of the initial premium which is due within 45 days of your election date); or
- A person eligible for continued benefits becomes covered under any other group health plan (unless the health plan has an enforceable preexisting condition clause) or becomes entitled to Medicare. If your Medicare benefit begins before you elect COBRA coverage, you can continue COBRA coverage as well as Medicare; Medicare would pay primary.

If your coverage ends because of expiration of the 18-, 29-, or 36-month limit, you may be able to convert coverage to an individual policy if this right currently exists in the plan.

Are there other coverage options besides COBRA Continuation Coverage?

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

You should compare your other coverage options with the COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to another coverage, you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options. If you do not enroll in COBRA during your initial qualifying event, you will not be able to enroll in COBRA at a later date.

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after your group health plan coverage based on current employment ends.

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

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

For more information visit www.medicare.gov/medicare-and-you and www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Health Insurance Marketplace

You are able to buy coverage through the Health Insurance Marketplace. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. In the marketplace, you could be eligible for a tax credit that lowers your monthly premiums. The marketplace allows you to see what your premium, deductibles, and out-of-pocket costs will be before you decide to enroll. Being eligible for COBRA does not limit your eligibility for coverage through the marketplace or to a tax credit. For more information about health insurance options available through a Health Insurance Marketplace, visit healthcare.gov or call **1-800-318-2596**.

When can I enroll in Marketplace coverage?

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

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

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation 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 something called a "special enrollment period." But be careful though—if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

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

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan) if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

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

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication—and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- 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 their benefits to specific service or coverage areas—so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If you have questions about COBRA or your rights to coverage contact 844-DFS-myHR (844-337-6947).

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at dol.gov/ebsa or call their toll- free number at **1-866-444-3272**. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assistor in your area who you can talk to about the different options, visit HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect you and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

Your Rights Under ERISA

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Domestic Partner Coverage

COBRA does not provide continuation coverage for your domestic partner and their dependents. Discover offers coverage similar to COBRA coverage for domestic partners and their dependents. In general, the continuation of coverage offered for domestic partners is the same and subject to the same rules as the continuation coverage offered under COBRA.

For More Information

In the event of certain qualifying events, you will receive information on your rights to continue coverage, including information on the cost of coverage. If you have any questions, you should contact myHR.

Web: MyDiscoverBenefits.com

Phone: 844-DFS-myHR (844-337-6947), between 8 am and 6 pm Central Time, Monday through Friday

myHR provides COBRA administration services on behalf of the plan administrator, Discover Financial Services. Please address any written correspondence to:

Discover myHR Service Center
Dept. 10820
P.O. Box 64116
The Woodlands, TX 77387-4116

YOUR RIGHTS TO HEALTH INSURANCE PORTABILITY UNDER HIPAA

If you terminate participation in the medical program, including terminating COBRA coverage, federal law may affect your medical coverage if you subsequently enroll or become eligible to enroll in medical coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be denied or excluded for medical conditions that you experienced or sought treatment for during the six months prior to the time you enroll in a group health plan (known as a "pre-existing condition"). Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). This means that you will receive treatment as provided under the new plan for conditions unrelated to your pre-existing condition, but benefits will be denied or excluded for your pre-existing condition until the end of the 12-month or 18-month waiting period. However, the 12-month (or 18-month) exclusion period is reduced by the length of time that you were covered under a prior health plan within the prior 63 days.

You are entitled to a certificate that will show evidence of the length of your prior medical coverage under this plan. If you buy medical insurance other than through an employer group medical plan, a certificate of prior coverage may also help you obtain credit against a pre-existing condition exclusion period. Contact your state insurance department for further information.

myHR will promptly provide a certificate of prior coverage (referred to as "Certificate of Creditable Coverage") to you and to each of your dependents who were participating in the medical program upon request by contacting myHR at 844-DFS-myHR (844-337-6947). If you are beginning employment with a new employer, or purchasing individual coverage, check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

Your Privacy Rights: Notice of Privacy Practices

It is the plan's policy to protect your medical information to the extent required by any applicable law, including HIPAA.

The plan may share your medical information with other Discover group health plans, with Discover and with others for the purposes of treatment, payment and health care operations and for certain other legally permitted purposes. To the extent required by law, Discover will not use any medical information about you to make employment-related decisions.

The plan will make reasonable efforts to use, share or request only the minimum necessary information to accomplish the intended purpose, taking into consideration practical and technological limitations. You also have certain privacy-related rights, including the right to access, request restrictions on and request amendments to your health records. Details about the plan's privacy policies, including your privacy rights, are found in the Notice of Privacy Practices available on MyDiscoverBenefits.com or by contacting myHR.

Patient Protection

The medical benefit programs generally allow the designation of a primary care provider, but you are not required to designate a primary care provider. You have the right to designate any primary care provider who participates in-network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the medical benefit programs or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in-network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your medical plan.

Medical Plan Coverage Resource

Summary of Benefit Coverage (SBC) documents are available to help you compare medical plans available to you. The SBCs illustrate key provisions of coverage under the medical plans and provide examples for you to reference. Current SBCs for each medical program can be found online at MyDiscoverBenefits.com. For a free paper copy of SBCs, you may contact myHR at 844-DFS-myHR (844-337-6947).

Women's Health and Cancer Rights Act of 1998

Do you know that your health program, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance or copayment applicable to other medical and surgical benefits provided under this plan. Therefore, the same deductibles and coinsurance or copayment as in effect at the time of services apply. If you would like more information on WHCRA benefits, call myHR at 844-337-6947 or your medical plan.

Newborns' and Mothers' Health Protection Act

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Marketplace Notice

Discover is required to provide to all U.S. participants a Notice on Health Insurance Marketplace Coverage Options and Discover Benefits to comply with rules under the federal Patient Protection and Affordable Care Act (ACA), also known as Obamacare. The notice provides information on the health insurance marketplace coverage options and Discover benefits. For a free paper copy of the Marketplace Notice, call myHR at 844-DFS-myHR (844-337-6947). If you need further information about the marketplace in your state, go to healthcare.gov, or call **800-318-2596**.

OTHER IMPORTANT INFORMATION

Plan Name and Number

Discover Financial Services Welfare Benefits Plan - 501

Plan Year

The plan year runs from January 1 through December 31.

Administrative Information/Type of Administration

The plan is a welfare benefit plan subject to ERISA.

This SPD along with any insurance contracts constitutes the plan document. In addition to this SPD, there are other SPDs, which describe additional plan benefits, including the Severance Policy Summary Plan Description and the Discover Financial Services Change in Control Severance Policy Summary Plan Description.

The plan provides general welfare plan benefits to eligible employees and their eligible dependents. The welfare benefits described in this SPD include:

- Medical, dental, vision and prescription benefits
- Accident insurance
- Critical illness insurance
- Hospital indemnity insurance
- Health care and dependent day care flexible spending account and health savings account benefits
- Basic, supplemental and retiree life insurance
- Basic and supplemental AD&D insurance - provides accidental death and dismemberment insurance benefits

- BTA insurance - provides business travel accident benefits
- Long-term disability insurance
- Long-term care insurance - provides access to long-term care insurance for those eligible
- Legal assistance program - provides legal assistance benefits
- Employee assistance program - provides employee assistance benefits under the Live and Work Well Program
- Wellness benefits - provides annual health evaluation and wellness credit to eligible employees
- Commuter benefits - provides pre-tax commuter assistance benefits
- On-site medical clinic

Plan Sponsor

Discover Financial Services
c/o myHR Service Center
Dept. 10820
P.O. Box 64116
The Woodlands, TX 77387-4116
844-DFS-myHR (844-337-6947)

Overnight deliveries:
Discover Financial Services
c/o myHR Service Center
Dept. 10820
8770 New Trails Drive
The Woodlands, TX 77381

Federal Employer Identification Number: 36-2517428

In addition to the plan sponsor, the following companies are participating employers in the plan:

All majority-owned U.S. subsidiaries and affiliates of Discover Financial Services with U.S. employees are employers participating in the plan. As of January 1, 2023, the list of participating employers includes:

- Discover Financial Services
- DFS Corporate Services LLC
- DFS Services LLC
- PULSE Network LLC
- Diners Club International, Ltd.
- Discover Bank
- Discover Products Inc.

- The Student Loan Corporation
- DFS International Inc.

An updated list of employers participating in the plan may be obtained by written request to the plan administrator at the address shown. Plan participants may also receive, upon written request to the plan administrator, information as to whether a particular employer participates in the plan, and if the employer does participate, the employer's address.

Plan Administrator and Named Fiduciary

Discover Financial Services Employee Benefits Committee
c/o myHR Service Center
Dept. 10820
P.O. Box 64116
The Woodlands, TX 77387-4116
844-DFS-myHR (844-337-6947)

Overnight deliveries:
Discover Financial Services
c/o myHR Service Center
Dept. 10820
8770 New Trails Drive
The Woodlands, TX 77381

Additionally, the plan administrator may delegate certain fiduciary functions to third-party administrators, including, without limitation, claims and appeals administration, as described in this SPD.

Agent for Service of Legal Process

The designated agent for the service of legal process is:

Law and Compliance Department
Attn: General Counsel
Discover Financial Services
2500 Lake Cook Road
Riverwoods, IL 60015

Service of legal process also may be made on the plan administrator.

Plan Funding

Certain medical benefits under the Discover Welfare Benefit Program are self-funded. Discover pays administrative fees to BlueCross BlueShield and CVS Caremark and funds benefit payments from general assets and employee contributions, as determined by Discover in its discretion. These benefits are not insured by Discover, BlueCross BlueShield or CVS Caremark. Certain benefits under the Discover Health and Welfare Benefits Program are insured through insurance contracts. Discover pays insurance premiums to Hawaii Medical Services Association and SelectHealth from general assets and employee contributions, as determined by Discover in its discretion. Hawaii Medical Services Association and SelectHealth

are responsible for paying your benefits only as provided under the terms of the insurance policies.

Benefits under the dental program are fully insured Metropolitan Life Insurance Company (MetLife). Discover pays insurance premiums to MetLife for the dental program from general assets and employee contributions, as determined by Discover in its discretion. MetLife is responsible for paying your benefits only as provided under the terms of the insurance policy.

Benefits under the vision program are fully insured by Vision Service Plan of Illinois (VSP). Discover pays insurance premiums to VSP from employee contributions, as determined by Discover in its discretion. VSP is responsible for paying your benefits only as only as provided under the terms of the insurance policy.

Benefits under the accident, critical illness and hospital indemnity insurance programs are fully insured by Metropolitan Life Insurance Company (MetLife). Discover pays insurance premiums to MetLife from employee contributions, as determined by Discover in its discretion. MetLife is responsible for paying your benefits only as provided under the terms of the insurance policies.

The FSA program is an unfunded plan. All payments are made from Discover's general assets. This means that your "contributions" described in this SPD are your salary reductions, credited to your bookkeeping accounts under the FSA. Your HCFSA is credited with the full amount of your election at the beginning of the year, and you may make a claim from your HCFSA whether or not your salary has been reduced by the amount of your claim. Your DDCFSA is credited with the amount of your salary reductions as they are made, and you may make a claim from your DDCFSA to the extent your account has a positive balance. As of December 31, any amount not claimed by you for DDCFSA eligible expenses (and above $610 for HCFSA eligible expenses in 2023) is forfeited from your bookkeeping accounts. Benefits under the FSA are not insured by Optum Financial in the unlikely event that Discover is unable to pay claims under the FSA.

Your HSA is opened the first of the month after your medical program coverage takes effect. Your HSA is funded through your "contributions" or salary reductions as described in this SPD. Your HSA is credited with your contributions on a pay period basis during the plan year. Discover contributions to your HSA are made annually, typically by the end of January, if you are employed as of January 1 of the plan year. If you are a newly hired employee who enrolled in an HSA medical program option or if you enrolled in an HSA medical program option due to a qualified life event, a prorated Discover contribution to your HSA will generally be made by the end of the month in which your HSA medical program coverage takes effect. Other contributions will be made as soon as administratively possible.

Benefits under the basic and supplemental life insurance programs are fully insured by The Hartford. Discover pays insurance premiums to The Hartford from general assets and employee contributions, as determined by Discover in its discretion. The Hartford is responsible for paying your benefits only as provided under the terms of the insurance policies.

Benefits under the retiree life insurance program are fully insured by The Hartford. Discover pays insurance premiums to The Hartford from general assets, as determined by Discover in its discretion. The Hartford is responsible for paying your benefits only as provided under the terms of the insurance policy's amendatory rider.

Benefits under the basic and supplemental AD&D insurance program and BTA insurance programs are fully insured by Life Insurance Company of North America (LINA). Discover pays insurance premiums to LINA from general assets and employee contributions, as Determined by Discover in its discretion. LINA is responsible for paying benefits only as provided under the terms of the insurance policies.

Benefits under the LTD program are fully insured by The Hartford. Discover pays insurance premiums to The Hartford from employee contributions, as determined by Discover in its discretion. The Hartford is responsible for paying your benefits only as provided under the terms of the insurance policy.

Benefits under the legal assistance program are provided by MetLife Legal Plans. Discover pays premiums to MetLife Legal Plans from employee contributions, as determined by Discover in its discretion. MetLife Legal Plans is responsible for paying benefits only as provided under the terms of the program.

Generally, wellness programs are self-funded through the general assets of Discover.

Benefits under the employee assistance program are provided by Optum, a division of UnitedHealth Group. Discover pays insurance premiums to Optum from general assets, as determined by Discover in its discretion. Optum is responsible for providing and/or paying your benefits only as provided under the terms of the policy.

Discover pays for commuter benefits from employee contributions and through the general assets of Discover.

Discover pays administrative fees from general assets to Alight for benefits recordkeeping and administration and for the administration of COBRA.

Claim Administrators

Medical Plans

- BlueCross BlueShield of Illinois, 300 East Randolph, Chicago IL 60601 / Phone: 877-217-7985
- CVS Caremark, 2211 Sanders Road, Northbrook IL 60062
- Hawaii Medical Service Association, P.O. Box 860, Honolulu HI 96814
- SelectHealth, 4646 West Lake Park Boulevard, Salt Lake City UT 84120 / Phone: 800-538-5038

Accident Insurance Program

MetLife, Attn: Accident Insurance Product, P.O. Box 80826, Lincoln, NE 68501-0826 / Phone: 866-626-3705 / Fax: 855-306-7350

Critical Illness Insurance Program

MetLife, Attn: Critical Illness Insurance Product, P.O. Box 80826, Lincoln, NE 68501-0826 / Phone: 866-626-3705 / Fax: 855-306-7350

Hospital Indemnity Insurance Program

MetLife, Attn: Hospital Indemnity Insurance Product, P.O. Box 80826, Lincoln, NE 68501-0826/ Phone: 866-626-3705 / Fax: 855-306-7350

Flexible Spending Accounts Program

Optum Financial, Claims Department, P.O. Box 622317, Orlando, FL 32862-2317 / Phone: 888-285-9499

Dental Program

MetLife, P.O. Box 981282, El Paso TX 79998-1282 / Phone: 800-942-0854

Vision Program

VSP, 3333 Quality Drive Rancho, Cordova CA 95670 / Phone: 800-877-7195

Basic, Supplemental and Retiree Life Insurance Programs

The Hartford, P.O. Box 2999, Hartford, CT 06104 / Phone: claims - 800-563-1124, convert and port - 877-320-0484

Basic and Supplemental AD&D and BTA Insurance Programs

Life Insurance Company of North America, 1600 West Carson Street, Suite 300, Pittsburgh PA 15219

Long-Term Disability Program

The Hartford, P.O. Box 2999, Hartford, CT 06104 / Phone: 888-437-8660

Legal Assistance Program

MetLife Legal Plans, Inc., 1111 Superior Avenue, Suite 800, Cleveland OH 44114-2507 / Phone: 800-821-6400

Live and Work Well Program (Employee Assistance Program)
P.O. Box 30755, Salt Lake City, UT 84130-0755 /Phone: 800-622-7276

Concentra Onsite Health Clinics
5080 Spectrum Drive, Suite 1200W, Addison, TX 75001/Phone: 866-944-6046

Commuter Benefits Program

WageWorks, P.O. Box 14053, Lexington KY 40512 / Phone: 877-353-9236

If the Plan Is Terminated or Modified

Although Discover and its affiliates expect to continue the plan and each of the programs indefinitely, Discover Financial Services, by action of its Board of Directors (or its delegate, the Senior Vice President—Human Resources), necessarily reserves the right to amend, modify or discontinue the plan or any benefits under any of the programs offered the plan at any time for any reason or from time to time.

Plan Documents Govern

To the extent benefits are provided under an insurance contract, benefits provided by the plan are limited to the coverage of the insurance contract.

No Guarantee of Employment

Neither this SPD nor participation in the plan is a guarantee of continued employment.

Confirmation of Your Elections

Any elections that you make under the plan will become effective once the election is processed by myHR (and EOI is approved, if applicable) and you are actively at work (for LTD, life, AD&D and BTA insurance). You will receive confirmation of your elections (either electronic or paper), which you should check carefully to make sure that it reflects your intent. If it is incorrect, call a benefits representative immediately. If you do not receive a confirmation online or in the mail within 10 business days, it is your responsibility to call a benefits representative.

It is your responsibility to follow up on any election that requires EOI.

Right to Audit

Discover audits the coverage of dependents, including spouses, domestic partners and children, to ensure that no ineligible person is enrolled in the plan. This is known as the dependent verification process. Any person who fails to cooperate or who intentionally provides false or misleading information to the plan for the purpose of obtaining benefits may lose any or all benefit coverage and may be required to repay any benefits improperly received.

Employees may be subject to further corrective action, up to and including termination of employment and forfeiture of executive compensation.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the plan, the plan administrator and other plan fiduciaries shall have the exclusive right and discretionary authority to make any findings necessary or appropriate for any purpose under the plan, including to interpret and resolve any ambiguities in the terms of the Plan and to determine eligibility for and entitlement to plan benefits. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

Indemnification

To the fullest extent permitted by law, Discover and its affiliates will indemnify and hold harmless the plan administrator, each member of the Employee Benefits Committee, the Claims Committee, the Hearing Panel and each other employee, officer and director of Discover or of any member of Discover's Affiliated Group, to whom fiduciary responsibilities are delegated under the plan against any cost or expense (including attorneys' fees) or liability (including any sum paid in settlement of a claim with the approval of Discover) arising out of any act or omission to act, except in the case of willful misconduct or lack of good faith.

Plan Expenses

All fees and expenses incurred in connection with the operation and administration of the plan, including legal, accounting, actuarial, investment, Trustee, management and administrative fees and expenses may be paid out of any trust or plan assets to the extent legally permitted. The plan sponsor may advance amounts properly payable by the plan or trust and then obtain reimbursement from the plan or trust.

Governing Law

The plan shall be governed by federal law, and, to the extent not preempted by federal law, including but not limited to the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Patient Protection and Affordable Care Act, and the laws of the State of Illinois.

Claim Forms

Claim forms are available from the contacts listed above.

ABOUT THIS BOOKLET

This booklet is the Summary Plan Description (SPD) for the medical, dental, vision, critical illness, accident, hospital indemnity, prescription drug, flexible spending accounts, life, AD&D, BTA, LTD, long-term care, commuter benefits, legal, employee assistance, pre-tax benefits and post-tax benefits offered under the Discover Financial Services Welfare Benefits Plan (plan) as in effect January 1, 2023. This SPD explains in easy-to-understand language the applicable terms of the plan. Additional SPDs and booklets are available for other benefits offered under the plan, including the Severance Policy Summary Plan Description (updated January 1, 2017, June 1, 2018 and November 1, 2019) and the Discover Financial Services Change in Control Severance Policy Summary Plan Description (amended and restated October 15, 2014). You should read these SPDs carefully and keep them with your other important papers for future reference.

Discover Financial Services (Discover) sponsors the plan and reserves the right to amend the plan or discontinue the plan at any time in its sole discretion.

Please note, On May 4, 2020, the U.S. Departments of Labor and the Treasury issued guidance that temporarily extended the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals. To protect individuals from losing benefits, the agencies adjusted deadlines that may be missed during the Outbreak Period associated with COVID-19, which began March 1, 2020 and ended July 10, 2023. Applicable deadlines were generally the earlier of one year after your original deadline or the extended deadline following the end of the Outbreak Period (July 10, 2023). Reference Summaries of Material Modifications for the prior SPD for more details.

We hope you find this information helpful to you and your family. If you have questions, you should contact myHR:

- Online: MyDiscoverBenefits.com
- Online service is generally available 24 hours a day, 7 days a week

- By phone: 844-DFS-myHR (844-337-6947)
- You may contact a myHR Service Center Representative by phone from 8 am to 6 pm Central Time, Monday through Friday, except certain holidays.

There is a great deal of plan information available to you through the benefits website at MyDiscoverBenefits.com. Once you become eligible to participate in the plan, log on to MyDiscoverBenefits.com or call a myHR representative to enroll, name a beneficiary and make, or change, benefit elections. After you have begun participating, refer back regularly to MyDiscoverBenefits.com for updated information, including annual enrollment materials and other summaries of material modification and other important notices regarding the plan and administration. If you do not have access to the Internet, you may obtain access to all this information by calling a myHR representative.

The plan provides eligible employees of Discover and its participating affiliates and, in certain cases, their eligible dependents with welfare benefits under several different programs offered from time to time (programs). This SPD summarizes some of the benefits provided under the plan, as noted above. Other benefits provided under the plan are summarized in other SPDs. This booklet and certain other documents, including such other SPDs, any applicable insurance contracts, and any other applicable plan documents incorporated in to and are a part of the official plan documents. If there is any conflict between the information in the plan documents and any other materials, including any verbal representation, the plan documents control.

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