2023

Curative PPO Benefit Booklet

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Welcome

Building a Healthy Tomorrow Together

Benefit Booklet. This Benefit Booklet is a guide to your Health Plan benefits provided by Curative. It includes definitions of terms you should know and detailed information about your Curative Health Plan. Included in the booklet will be a comprehensive Table of Contents to help you locate information, but if you have any questions, please contact Curative Member Services at 855-428-7284.

You are responsible for carefully reading this Benefit Booklet so you will be aware of all the benefits and requirements in the Curative Health Plan, including definitions, limitations and exclusions. The Summary of Benefits chart will break down the copays, deductible, and coinsurance percentages for the most typical services Members utilize.

Information and forms can be found at our website www.curative.com. For specific information and forms regarding your Prescription Benefits you may also find this information at www.curative.com/drugs.

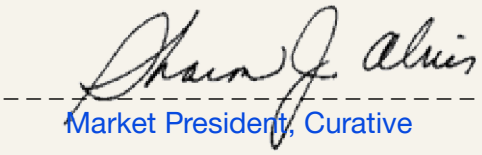
ID Cards. The ID Card issued to you by Curative identifies you as a Member in the Curative Health Plan offered by your employer. This ID Card contains essential information about you, your employer, and the benefits to which you are entitled. Always remember to carry your ID Card with you, present it when receiving health care services or supplies, and make sure your provider always has an updated copy.

You will also have access to your ID Card online at the Curative Member Portal accessible at health.curative.com. Or you can request another ID Card at any time, by requesting it online at health.curative.com or contacting Curative Member Services at 855-428-7284.

CERTIFICATE OF COVERAGE

Curative Insurance Company
(herein called “Curative” or “Carrier”)

Hereby certifies that it has issued a **Managed Health Care and Pharmacy Benefits** Contract (herein called the “Plan”). Subject to the provisions of the Plan, each Employee (Member) to whom a Curative Identification Card (ID Card) is issued, together with their eligible Dependents for whom enrollment is initially made and accepted, shall have coverage under the Plan, beginning on the Effective Date shown on the ID Card, if the Employer makes timely payment of total premium due to Curative. Issuance of this Benefit Booklet by Curative does not waive the eligibility and Effective Date provisions stated in the Plan.



Market President, Curative

The Summary of Benefits enclosed with this Benefit Booklet indicate benefit percentages, Deductibles, Copay Amounts, maximums, and other benefit and payment issues that apply to the Plan.

The Summary of Benefits specifies benefits for:

Managed Health Care *(Network)* coverage

Pharmacy Benefit coverage

NOTICE OF SEPARATE AVAILABLE COVERAGE

This notice is required by Texas legislation to be provided to you. It is to inform you, the Employee, that your Employer has selected this health benefit coverage.

THE INSURANCE CONTRACT UNDER WHICH THIS BENEFIT BOOKLET IS ISSUED IS NOT A CONTRACT OF WORKERS’ COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS’ COMPENSATION SYSTEM.

Summary of Benefits

In-Network and Out-of-Network benefits apply to eligible employees and their dependents and services are limited to the allowable amount as determined by Curative. All In-Network providers have agreed to accept the Curative allowable amount as payment in full.For Out-of-Network providers, any charges over the allowable amount for services are the patient's responsibility in addition to the deductible and coinsurance.

If you complete your Baseline Visit within 120 days of your effective date in the Curative Plan, all medical in-network copays, deductibles, and coinsurances will be waived so that your cost for provider services in-network will always be $0. Maximum visits, limitations and tiered Pharmacy benefits will continue to apply.

During the first 120 days enrolled in the Curative Plan, all copays, deductibles, and coinsurance will be waived for in-network services for all members.

The Baseline Visit is a meeting with a Curative Clinician to onboard you to the Curative Health Plan, understand your health goals and how we can best work with you to meet your current and future healthcare needs. The Baseline Visit will also include an Evaluation of Preventive recommendations indicated by the United States Preventive Services Task Force (USPSTF) and evaluate whether your immunizations are up to date, all designed to keep you healthy.

Coverage	Curative In-Network	Curative In-Network	Curative Out-of-Network
	When compliant with Baseline Visit (see above)	When non-compliant with Baseline Visit (see above)	
Annual Deductible	**$0**	$5,000/person $10,000/family	$10,000/person $20,000/family
Coinsurance Percentage	**0%**	20% Medical; 25% Pharmacy (with $25/mo cap on insulin)	50%
Annual Out-of-Pocket Maximum (Medical)	**$0**	$7,500/person; $15,000/family	$15,000/person $30,000/family
Lifetime Maximum Benefit	**No Limit**	No Limit	$0 million

Coverage	Curative In-Network	Curative In-Network	Curative Out-of-Network
	When compliant with Baseline Visit (see above)	When non-compliant with Baseline Visit (see above)	
OFFICE SERVICES			
Preventative Care	**$0 copay**	$0 copay	$50 copay
Child Immunizations for children under the age of 6 Covered at 100%	**$0 copay**	$0 copay	$0 copay
Family Practice Internal Medicine OB/GYN Pediatrics (Office/Virtual Visit)	**$0 copay**	$25 copay after deductible	$50 copay after deductible
Specialist (Office/Virtual) Visit	**$0 copay**	$50 copay after deductible	$100 copay after deductible
Telemedicine – On Demand with a 24/7/365 Doctor Visit	**$0 copay**	$0 copay	No coverage
Urgent Care	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Lab and X-Ray	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Other Tests	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Allergy Testing	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Allergy Serum/Injections (if no office visit billed)	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
PHARMACY BENEFITS **(a $25/month cap on cost-sharing obligations applies for insulin included on the Curative Formulary Drug List)**			

Coverage	Curative In-Network	Curative In-Network	Curative Out-of-Network
	When compliant with Baseline Visit (see above)	When non-compliant with Baseline Visit (see above)	
Preferred Drugs (includes certain Generic, Brand Name, & Specialty drugs)	**$0 copay**	$50 copay after deductible	50% coinsurance after deductible
Non-Preferred Brand Name & Generics Drugs (annual max out-of-pocket)	**$50 copay**	$100 copay after deductible	50% coinsurance after deductible
Non-Preferred Specialty Drugs (annual max out-of-pocket)	**$250 copay**	20% coinsurance after deductible	50% coinsurance after deductible
EMERGENCY CARE (limited to services in the United States)			
Ambulance Service	**$0 copay**	20% coinsurance after deductible	20% coinsurance after deductible
Hospital / Free Standing Emergency Room	**$0 copay**	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room Physicians	**$0 copay**	20% coinsurance after deductible	20% coinsurance after deductible
OUTPATIENT CARE			
Observation	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Surgery - Facility	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Surgery - Physician	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Lab and X-Ray	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Advanced Imaging Scans	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Other Tests	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible

Coverage	Curative In-Network	Curative In-Network	Curative Out-of-Network
	When compliant with Baseline Visit (see above)	When non-compliant with Baseline Visit (see above)	
Outpatient Procedures in Physician's Office	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
INPATIENT CARE			
Hospital - Semi-private Room and Board	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Hospital Inpatient Surgery	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Physician	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
OBSTETRICAL CARE			
Prenatal and Postnatal Care Office Visits	**$0 copay**	$25 copay after deductible (first visit only)	50% coinsurance after deductible
Delivery - Facility/Inpatient Care	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Obstetrical Care and Delivery - Physician	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Newborn Care- covered for first 30 days without enrollment	**$0 copay**	20% coinsurance after deductible (covered under mother's deductible first 30 days)	50% coinsurance after deductible
THERAPY			
Physical Therapy	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Occupational Therapy	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible

Coverage	Curative In-Network	Curative In-Network	Curative Out-of-Network
	When compliant with Baseline Visit (see above)	When non-compliant with Baseline Visit (see above)	
Speech and Hearing Therapy	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Applied Behavioral Analysis	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
EXTENDED CARE			
Skilled Nursing Facility	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Home Health Care Services	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Hospice Care Services	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
BEHAVIORAL HEALTH			
Mental Illness - Office/Virtual Visit	**$0 copay**	$25 copay after deductible	$50 copay after deductible
Mental Illness - Intensive Outpatient and Partial Hospitalization	**$0 copay**	20% coinsurance after deductible	$50 copay after deductible
Mental Illness - Inpatient	**$0 copay**	20% coinsurance after deductible	$50 copay after deductible
Substance Use Disorder - Office/Virtual Visit	**$0 copay**	$25 copay after deductible	$50 copay after deductible
Substance Use Disorder - Intensive Outpatient and Partial Hospitalization	**$0 copay**	20% coinsurance after deductible	$50 copay after deductible
Substance Use Disorder - Inpatient Treatment	**$0 copay**	20% coinsurance after deductible	$50 copay after deductible
OTHER SERVICES			

Coverage	Curative In-Network	Curative In-Network	Curative Out-of-Network
	When compliant with Baseline Visit (see above)	When non-compliant with Baseline Visit (see above)	
Durable Medical Equipment	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Prosthetic Devices	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Hearing Aids	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Bariatric Surgery (limited to one surgery per lifetime)	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Breastfeeding Support and Services (1 pump per pregnancy)	**$0 copay**	$0 copay	50% coinsurance after deductible
Acupuncture (Limited to 20 visits per calendar year)	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible
Wigs (limited to $200 annual benefit)	**$0 copay**	20% coinsurance after deductible	50% coinsurance after deductible

*The Curative Plan covers preventive care services in accordance with the requirements of the Affordable Care Act and implementing regulations and guidance thereunder (the “ACA”). To the extent any services under the Plan constitute preventive care services as defined in the ACA, coverage will be provided as required by law.

How your Curative plan works

Choice of Providers and How Coverage Will Be Applied

You have freedom of choice in choosing your provider.

If you choose from the extensive list of high quality In-Network Providers who have contracted with Curative, you will receive the benefits at a higher level and will never be balance billed. **Find an In-Network Provider at www.curative.com/get-care or you can call or text Curative Member Services at 855-428-7284.**

You may choose any type of provider licensed to provide services covered as benefits under the plan. The type of provider you choose will not change your benefits under the plan.

In-Network

You will not be billed by in-network providers for amounts over your applicable copay, deductible, and coinsurance. If you attend a Baseline visit within the first 120 days of enrollment, these amounts will always be zero. This means with the completion of the Baseline Visit you will pay $0 for access to any type of in-network medical care.

Some benefits may be processed as an In-Network benefit when provided by Out-of-Network providers. When you are provided services by Out-of-Network providers at an In-Network Facility these services will be processed as an In-Network benefit, and you will not be balance billed by these providers over your applicable in-network copay, deductible, and coinsurance. This means as long as you go to an in-network hospital or other provider facility, you do not have to worry about surprise bills from any Out-of-Network providers who may work at the In-Network facility.

Find an In-Network Provider at www.curative.com/get-care or you can call or text Curative Member Services at 855-428-7284.

Out-of-Network

If you choose a provider that is not contracted with Curative, they will be considered an Out-of-Network provider. Services, supplies or care received from Out-of-Network providers will be subject to a lower level of benefit coverage and Curative is unable to protect you from the provider sending you a balance bill, except as prohibited by law. Curative will not terminate, or threaten to terminate, a member's participation in the plan solely because the member uses an out-of-network provider.

Balance Billing

You are protected from balance billing or surprise billing when you receive services from an out-of-network provider in the following situations:

- Emergencies
- Services from facility-based providers in a network facility
- Laboratory service providers when services are provided in connection with a service from a network provider
- Diagnostic imaging services from an out-of-network provider when services are provided in connection with a service from a network provider

Curative will pay the Allowable Amount to these Out-of-Network Providers. If you receive a balance bill from a provider based on any amount greater than the Allowable Amount in these situations, please contact Curative Member Services at 855-428-7284.

The Baseline Visit

Curative has designed the Baseline Visit as the kick-off to your future health success. The Baseline Visit combines onboarding to the Curative plan with a comprehensive visit to give you a 360-degree view of your health, establish your health goals and how Curative can best support you in achieving them. The focus is to help you take action early to be healthy, happy and live your best life. The Baseline Visit is provided at no cost to you. When you complete your Baseline Visit within 120 days of enrollment, and within 120 days of any renewal enrollment date, your waiver on all copays, deductibles and coinsurance on In-Network services will be extended for the full year. Curative wants you to have access to the highest quality care, when you need it. With the completion of the Baseline Visit all In-Network Medical services will have a $0 Copay, $0 Deductible and 0% Coinsurance. You can refer to the Summary of Benefits for more details.

Please remember: for the first 120 days you will automatically qualify for the $0 Copay, $0 Deductible and 0% Coinsurance for In-Network medical services, but you must complete the Baseline Visit within 120 days from your enrollment date to extend this cost-sharing waiver for the full plan year, otherwise you will be subject to copays, deductibles and coinsurance for In-Network services.

The completed Baseline Visit will not impact any Out-of-Network benefits.

Pharmacy Benefits

Curative provides a three-tiered pharmacy Benefit designed to get you access to the most clinically and cost-effective drugs with $0 copay, $0 deductible and 0% coinsurance.

- Preferred Drugs: includes drugs to treat almost-all clinical conditions that have been selected by our Pharmacy team as the most clinically and cost effective and are available for $0 (subject to the completion of the Baseline Visit as with other In-Network Benefits). Curative includes many drugs on our Preferred list including brand name drugs and specialty drugs that may have high out-of-pocket costs on other plans, our goal is to get you the care you need without out-of-pocket costs.

- Non-Preferred Drugs: includes drugs that are more expensive than Preferred drugs where a comparable drug is available on the Preferred list. These drugs are available with a $50 copay for non-specialty drugs or a $250 copay for select specialty-drugs. The member's copay will never exceed 50% of the total allowed amount.

The Curative Pharmacy Benefit is designed to provide an option with $0 out-of-pocket cost for most clinical conditions. There is also flexibility and choice if you prefer a specific brand name drug. Please see the Pharmacy section below for more details.

The Plan Covers Services that are Medically Necessary

Curative covers services that are Medically Necessary. Throughout the descriptions of What is Covered, you will note the references to Medically Necessary or Medical Necessity. Below is an explanation of these terms.

Medically Necessary/Medical Necessity

means the health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider; and (d) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. No service is a Covered Service unless it is Medically Necessary.

Allowable Amount

The Allowable Amount is the maximum amount that will be paid by Curative for a medical service, supply, or drug. The allowable amount is the amount based upon usual and customary rates paid for similar services in the Covered Services area.

Provider and Pharmaceutical Discount Cards and Plans

A Member's out-of-pocket costs that are paid by either a Provider or Pharmaceutical Discount Card or Plan are not counted towards the Member's applicable Deductible or Maximum Out-of-Pocket amount.

Statement by Members

In the absence of fraud, a statement made by a Member is considered a representation and not a warranty and may not be used in any contest under the policy, unless a copy of the written instrument containing the statement is or has been provided to the person making the statement or, if the statement was made by the Member and the Member has died or become incapacitated, the Member's beneficiary or personal representative.

What your Curative plan covers

The following medical expenses are covered by the Curative Plan. Covered services may be subject to limitations as noted in this section, the Benefit Summary or the Limitations and Exclusions section of this Benefit Booklet.

For any applicable deductible, copay, or coinsurance information, please refer to the Benefit Summary for your Plan.

Acquired Brain Injury

Benefits for medically necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neurofeedback therapy, remediation, post-acute transition services and community integration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

To ensure that appropriate post-acute care treatment is provided, Curative includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

- Has incurred an acquired brain injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or prevention of, or slowing of, further deterioration.

Note: Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury. Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury. Treatment for an Acquired Brain Injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Acupuncture

Curative covers for the treatment of Musculoskeletal disorders. There is a limitation of 20 visits in a calendar year.

Advanced Imaging (Prior Authorization required)

Curative covers diagnostic imaging services when medically necessary including, but not limited to, MRIs, PET Scans, and CT Scans.

Allergy Care

Allergy injections (immunotherapy) and allergy tests (skin test, scratch test and RAST) are covered if administered by a physician, allergist, or specialist. Serum and Oral Drops are covered when provided directly by prescribing physicians and are not considered part of the pharmacy benefits.

Ambulance Services

Curative covers Ambulance Services when medically necessary as noted below:

- The patient’s condition must be such that ambulance services are the only form of transportation that would be medically acceptable; or
- The patient is transported to the nearest site when the appropriate facilities for the treatment of the injury or illness involved or in the case of organ transplant, to the approved transplant facility.

Air Ambulance Services are medically necessary as noted below:

- The time needed to transport a patient by either base or advanced life support land ambulance poses a threat to the patient's survival;
- The point of pick-up is inaccessible by land vehicle; or
- Great distances, limited time frames, or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities for treatment (i.e. transport of a critically ill patient to an approved transplant facility with a waiting organ)

The following services are not medically necessary, as they do not require ambulance transportation:

- Ambulance service when the patient has been legally pronounced dead prior to the ambulance being summoned.
- Services provided by an ambulance crew who do not transport a patient but only render aid. For instance:
    - Ambulance dispatched and patient refuses care or transport; or
    - Ambulance dispatched and only basic first aid was rendered.

Non-emergency transports between medical facilities may be considered medically necessary for a patient who has a medical condition requiring treatment in another location and is so disabled that the use of an ambulance is the only appropriate means of transfer. Disabled means the patient's physical conditions, their mobility, is unable to stand and sit unassisted or requires continuous life support systems. Non-emergency transport from a patient's home is not covered.

Transfers by medical vans or commercial transportation (such as physician owned limousines, public transportation, cab, etc.) are not covered.

Amino Acid-Based Elemental Formulas (Prior Authorization required)

Regardless of the formula delivery method, medically necessary Amino Acid-Based Elemental Formulas are covered under the Curative plan when prescribed by a physician and medically indicated.

Anesthesia

Curative covers the administration of anesthesia, other than local infiltration anesthesia, in connection with a covered surgical procedure, provided the anesthesia is administered and charged by a physician other than the operating surgeon or his assistant.

Anesthesia means the administration of spinal anesthetic, rectal anesthetic, or the administration of a drug or other anesthetic agent by injection or inhalation, if the purpose is to obtain muscular relaxation, loss of sensation or loss of consciousness.

Assistant Surgeon (Prior Authorization required)

Curative covers the services of a physician who is actively assisting the operating surgeon when the condition of the patient or the type of surgical service requires such assistance.

Autism Spectrum Disorder

Generally recognized services prescribed to Autism Spectrum Disorder by the Member's physician or behavioral health practitioner in a treatment plan are available for a Curative plan Member. Generally recognized services such as:

- Evaluation and assessment services;
- Screening at 18 and 24 months;
- Applied behavior analysis (Prior Authorization required);
- Speech therapy;
- Occupational therapy; or
- Physical therapy.

Blood Transfusions

Curative covers blood transfusions to maintain or replace blood volume, to provide deficient blood elements and improve coagulation, to maintain or improve transport of oxygen and in exchange for blood removed in the treatment of Rh incompatibility in a newborn. In addition, blood transfusion coverage is provided for liver failure in which toxins accumulate in the blood and in some other types of toxemia. Coverage includes autologous, direct donation, regular administration, and whole blood.

Breastfeeding Support and Services

Benefits will be provided for breastfeeding counseling and support services by a provider, during pregnancy and/or in the postpartum period. Benefits include the purchase of manual or electric breast pumps and supplies. Standard manual and electric pumps purchased at a retail store, through non-network providers or non-network Durable Medical Equipment suppliers (DME) are covered up to $500. Network providers and DME suppliers have options available with no cost-sharing requirements. If purchased from a contracted provider, they will file the claim for you. If not, you will need to submit a manual claim for reimbursement with an itemized receipt.

Coverage is provided for one pump per pregnancy. For assistance, please contact Curative Member Services at 855-428-7284.

Clinical Trials

Benefits will be provided for routine patient care costs in connection with a phase I, phase II, phase III, or phase IV Clinical Trial if the Clinical Trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is one of the following:

(1) Approved or funded by one or more of the following:
- the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- the National Institutes of Health;
- the Agency for Health Care Research and Quality;
- the Centers for Medicare & Medicaid Services;
- a qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
- the United States Department of Energy if certain approvals are in place;
- the United States Department of Defense if certain approvals are in place;
- the United States Department of Veterans Affairs if certain approvals are in place; or
- an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

(2) Conducted under an investigational new drug application reviewed by the Food and Drug Administration, or the trial is exempt from having an investigational new drug application.

Benefits will be paid if the research institution conducting the Clinical Trial agrees to accept reimbursement at the rates established under the Plan as payment in full for the routine patient care provided in connection with the clinical trial. Benefits will not be provided for:

(1) The investigational item, device, or service itself;

(2) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

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

Diabetic Management Services

Curative covers expenses associated with the treatment of diabetes for individuals diagnosed with insulin-dependent or non-insulin-dependent diabetes, elevated blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels. Emergency refills of diabetes equipment or diabetes supplies, dispensed to the enrollee in accordance with applicable state law, will be covered in the same manner as for a nonemergency refill of diabetes equipment or diabetes supplies. Covered Health Services will be consistent with minimum standards

for coverage adopted by the Commissioner of Insurance pursuant to applicable state law and include:

Diabetic Equipment:

- Blood glucose monitors (including non-invasive glucose monitors and monitors for the blind);
- Insulin pumps and necessary accessories (infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin, and other required disposable supplies); and
- Podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes.

Insulin Pump Supplies can be obtained in 30-day amounts through this Durable Medical Supply benefit or in a 90-day amount through a Participating Mail Order Pharmacy. Call Curative Member Services at 855-428-7284 for more information.

Diabetic Prescriptions:

- Insulin and insulin analog preparations;
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and
- Glucagon emergency kits

Diabetic Supplies:

- Test strips for blood glucose monitors;
- Lancets and lancet devices;
- Visual reading and urine test strips and tablets which test for glucose, ketones and protein;
- Injection aids, including devices used to assist with insulin injection and needleless systems;
- Insulin syringes; and
- Biohazard disposable containers.

Note: All diabetic supplies listed above, along with blood glucose monitors (including noninvasive glucose monitors and monitors for the blind), are covered under the prescription drug program.

Diabetic Management Services/Diabetic Self-Management Training Programs, includes initial and follow-up instruction concerning:

- The physical cause and process of diabetes;
- Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
- Prevention and treatment of special health problems for the diabetic patient;

- Adjustment or lifestyle modifications; and
- Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Training will include the development of an individualized management plan that is created for and in collaboration with the patient (and/or family) to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and diabetic supplies.

Diagnostic and Screening Mammograms

Curative will cover, for a female 35 years of age or older, an annual screening by all forms of low-dose mammography for the presence of occult breast cancer. Covered Health Services under this section will be treated in the same manner as other radiological examinations under the Plan and will be subject to the same dollar limits, deductibles, and coinsurance factors as coverage for other radiological examinations under the Plan.

Curative will also provide mammogram coverage for diagnostic imaging that is:

- no less favorable than the coverage for a screening mammogram;
- designed to evaluate an abnormality detected by a patient and an individual with dense breast tissue;
- not limited to females age 35 years or older; and
- in accordance with applicable coverage requirements for preventive care services under federal law.

Durable Medical Equipment (Prior Authorization required for DME exceeding $750 in charges)

Curative covers the rental (or purchase at the discretion of Curative) of therapeutic supplies and rehabilitative equipment required for therapeutic repeated use. These items include, but are not limited to, a standard wheelchair, crutches, walker, bedside commode, hospital-type bed, suction machine, artificial respirator, or similar equipment.

Equipment to alleviate pain and provide patient comfort (including, but not limited to, over-the-counter splints or braces, air conditioners, humidifiers, dehumidifiers, air purifiers, physical fitness and whirlpool bath equipment, personal hygiene products and home air fluidized beds) is not covered, even if prescribed by your physician.

Emergency Care

Your Curative Plan covers medical emergencies in the United States. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

In case of an emergency call 911 or go to the nearest emergency room. If you require hospitalization, notify the Curative Health Plan at the number on the back of your ID Card within 48 hours of admission, or as soon as reasonably possible.

All emergency care facilities connected to and associated with an inpatient facility, whether provided by a In-Network provider or Out-of-Network providers, will be covered at the In-Network level of benefits. Out-of-Network emergency care providers are prohibited by law from balance billing you for any amount above the amount paid by your Plan. If you continue to be treated by an Out-of-Network provider after you receive emergency care and you can safely be transferred to the care of an In-Network provider, Out-of-Network benefits will be applied. In such a case, out-of-Network providers may balance bill you for any charges exceeding the allowable amount.

What is an emergency?

Emergency care means healthcare services provided in a hospital emergency facility (emergency room), freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate care could result in:

- Placing the person's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant woman, there is serious jeopardy to the health of the fetus, there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Formulas for Phenylketonuria or a Heritable Disease (Prior Authorization Required)

Curative covers formulas necessary to treat phenylketonuria or a heritable disease to the same extent that the Plan provides coverage for prescription drugs.

Gender Affirmation Surgery and Treatment (Prior Authorization Required)

Curative covers medically necessary surgery, related to the treatment for a Transgender Member who:

- Has reached physical maturity and is 18 years of age and older;
- Has been diagnosed with Gender Dysphoria specific to the same gender for 12 months or greater; and
- Has been under the care of a Psychiatrist/Psychologist for 12 months or greater.

Covered services may include, but are not limited to:

- Psychological evaluations as needed;
- Psychotherapy;
- Hormone therapy;
- Medically indicated prescriptions; and

Services that are not covered include, but are not limited to:

- Breast augmentation or removal.
- Facial treatment or reconstruction surgery.
- Laryngeal prominence modification.

For questions regarding Gender Affirmation Surgery and Treatment coverage, please contact Curative Member Services at 855-428-7284.

Hearing Care and Cochlear Implants

Curative covers therapy due to the loss or impairment of hearing.

Coverage includes both routine care (one exam per year) and for medical conditions or accidents. Hearing aids are limited to 1 Binaural Hearing Aid or 2 Monaural Hearing Aids every 36 months, excluding add-ons, deluxe/upgrade options, batteries, etc.

Cochlear Implants and related services and supplies, including fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids, are eligible for Members 18 years old and younger when determined to be medically necessary. Coverage includes treatment for habilitation and rehabilitation, an external speech processor and controller with necessary components and replacement every three years.

Home Health Care (Prior Authorization required)

Curative covers medically necessary services and supplies provided in the patient's home during a visit from a home health agency as part of a physician's written home health care plan. Coverage includes:

- Coordinated Home Care provided by a Registered Nurse (RN), Advanced Practice Nurse (APN) or Licensed Vocational Nurse (LVN);
- Part-time or intermittent home health aide services for patient care;
- Physical, occupational, speech and respiratory therapy services provided by licensed therapists;
- Supplies and equipment routinely provided by the home health agency; and
- If care is taught to a caretaker, this service will not be covered after training has been provided.

Home health care benefits are not provided for food or home-delivered meals, social casework or homemaker services, transportation, or services provided primarily for custodial care.

Hospice Care (Prior Authorization required)

Curative covers services provided by a hospice to patients confined at home or in a hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

The following services are covered for hospice care in the home:

- Part-time or intermittent nursing care by a Registered Nurse (RN), Advanced Practice Nurse (APN) or Licensed Vocational Nurse (LVN);
- Part-time or intermittent home health aide services for patient care;
- Physical, respiratory, and speech therapy by licensed therapists; and
- Counseling services routinely provided by the hospice agency, including bereavement counseling.

The following services are covered in a Hospice facility:

- All usual nursing care by a Registered Nurse (RN), Advanced Practice Nurse (APN) or Licensed Vocational Nurse (LVN);
- Room and board and all routine services, supplies and equipment provided by the hospice facility;
- Physical, speech and respiratory therapy services by licensed therapists; and
- Counseling services routinely provided by the hospice facility, including bereavement counseling.

Hospital Admission (Prior Authorization required)

Curative covers room and board (up to the hospital's semi-private room rate), general nursing care, and other hospital services and supplies. It does not cover personal items such as telephones and television rentals.

Infertility Services

Testing for diagnosis of infertility is covered.

Lab and X-ray Services

Curative covers medically necessary laboratory and radiographic procedures, services, and materials, including diagnostic X-rays, X-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests, and therapeutic radiology services when ordered by a provider.

Network providers are responsible for referring patients to in-network labs, imaging centers or an outpatient department of an in-network hospital for medically necessary lab and X-ray services that are not available in a provider's office. However, you should always remind your provider that you will receive a higher level of benefits offered under your plan when using in-network providers.

In some situations, a provider or facility will refer the results of lab tests or x-rays to a radiologist or pathologist for a professional interpretation of the results. If an Out-of-Network provider is used, the Member will be responsible for any expenses exceeding the allowable amount.

Maternity Care (Prior Authorization for delivery required)

Curative covers maternity related expenses for Members. Maternity care includes diagnosis of pregnancy, pre- and post-natal care, and delivery. Curative covers inpatient care for the mother and newborn child in a healthcare facility for a minimum of 48 hours following an uncomplicated vaginal delivery and for a minimum of 96 hours following an uncomplicated delivery by Cesarean section. Concurrent reviews will be required for prolonged stays exceeding the standard coverage period.

Inpatient hospital expenses incurred by the mother for delivery of a child will not include charges for routine well-baby nursery care of the newborn child during the mother's hospital admission for the delivery. These charges will be considered expenses of the child and may be subject to the benefit provisions and benefit maximums described in the Benefit Summary, however during the first 30 days the newborn will not have a separate deductible from the mother when utilizing in-network providers. Complications of Pregnancy are covered as any other covered illness or sickness under the Plan.

Curative will cover administration of newborn screening tests required by Section 33.011, Texas Health and Safety Code, including for the cost of a newborn screening test kit in the

amount provided by the Department of State Health Services on the date the test was administered.

Curative will only allow services provided by a midwife if affiliated with a contracted Network OB/GYN provider.

How are doctor's charges for maternity care covered?

- Any services received in-network during the first 120 days are covered at a $0 copay, $0 deductible and 0% co-insurance.
- If you have completed your CWA during the first 120 days of enrollment there will be no copay or deductible for in-network services.
- If you have not completed your Baseline Visit within the first 120 days, services received in-network starting on your 121st day of enrollment may be subject to a copay after the deductible is met. Delivery charges will be subject to the deductible and coinsurance.
- All out of network services are subject to deductibles and coinsurance.

How is a newborn child covered under the Curative Plan?

Curative automatically provides coverage for a newborn of a covered Member for the first 30 days after the date of birth, but this coverage terminates at the end of 30 days unless the newborn is added to the employee's coverage. To add coverage for the newborn beyond the first 30 days, you must make the appropriate changes to your benefit election within the 31-day period after the birth. Enrollment changes must be made through your employer's Benefits Office You will need to enroll your newborn in the Curative Health Plan within 31 days of birth. If you fail to enroll at that time, your next opportunity will be at Open Enrollment. You may then enroll for coverage for your dependent during the next open enrollment period or when a qualified change of status event occurs. Please contact your employer's Benefits Office with questions or changes in status information.

For grandchildren to be eligible for newborn coverage, the grandchild must be added to the employee's coverage for benefits within 31 days of the newborn's birth. An eligible grandchild must be a dependent of the employee for federal tax purposes at the time the application for coverage of the grandchild is made. Consult your employer's Benefits Office for more information about grandchildren as eligible dependents.

For in-network services, the newborn's deductible is included in the mother's deductible if she is enrolled in the Curative plan and not separate for the first 30 days.

Medical Expenses

Curative provides coverage for medical expenses for you and your covered dependents. These benefits include, but are not limited to:

- Service of physicians and other professional providers;

- Services of certified registered nurse-anesthetist (CRNA);
- Diagnostic X-ray and laboratory procedures;
- Radiation therapy;
- Anesthetics and its administration, when performed by someone other than the operating physician or other professional provider;
- Oxygen and its administration provided the oxygen is used;
- Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Member;
- Prosthetic appliances, required for the alleviation or correction of conditions arising from an accidental injury occurring or illness commencing after the Member's effective date of coverage under the Curative plan, excluding all replacements of such devices other than those necessitated by growth to maturity of the Member;
- Services and supplies used by the Member during an outpatient visit to a hospital, a therapeutic center, or a substance use disorder treatment center, or scheduled services in the outpatient treatment room of a hospital;
- Certain diagnostic procedures including, but not limited to, bone scan, cardiac stress test, CT Scan, MRI, myelogram, PET Scan;
- Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes; and
- Injectable drugs, administered by or under the direction or supervision of a physician or other professional provider

Services and supplies for medical expenses must be furnished by or at the direction or prescription of a physician or other professional provider. A service or supply is furnished at the direction of a physician or other professional provider if the listed service or supply is:

- Provided by a person employed by the directing physician or other professional provider;
- Provided at the usual place of business of the directing physician or other professional provider; or
- Billed to the patient by the directing physician or other professional provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Mental Health / Behavioral Health

Curative covers the treatment of Mental Health and Behavioral Health on the same basis as any other illness.

Mental health treatment is a planned, structured, and organized care plan to promote stable mental health. A program may include different facilities and modalities, such as intensive inpatient treatment, inpatient rehabilitation/treatment, partial hospitalization, intensive outpatient treatment or a series of these levels of treatments without a lapse in treatment. A series is complete when a Member is discharged on medical advice to

outpatient care or when a Member fails to materially comply with the mental health treatment program.

The Curative Plan covers charges for inpatient and outpatient mental health and behavioral health care for:

- Individual or group psychotherapy;
- Diagnosis or treatment of a condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system used by Curative; and
- Diagnosis or treatment of any symptom, condition, disease or disorder by a provider, or any person working under the direction or supervision of a provider, when the eligible expense is for:
    - Individual and group psychotherapy;
    - Counseling;
    - Psychological testing and assessment;
    - Hospital visits or consultations in a facility providing such services
    - Inpatient Care; and
    - Electroconvulsive treatment

Serious Mental Illness means a psychiatric illness as defined by the American Psychiatric Association in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Curative covers medically necessary inpatient and out-patient treatment for Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, a Residential Treatment Center, or a Residential Treatment Center for Children and Adolescents.

Intensive Outpatient Program / Partial Hospitalization Treatment Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness conditions. If you are recovering from severe and/or chronic Mental Illness conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute inpatient, residential care or a Partial Hospitalization Treatment Program.

All inpatient and certain outpatient treatment for behavioral health should be Prior Authorized by calling Curative Member Services at 855-428-7284.

Obesity (Prior Authorization required)

Surgical treatment of morbid obesity may be covered when it satisfies the criteria established by Curative medical policy guidelines.

Covered medical expenses for bariatric surgery include charges made by a hospital or a physician for the surgical treatment of morbid obesity of a Member.

All underlying medical conditions that will likely impact or complicate the patient's surgical and postoperative course must be adequately controlled before surgery.

Covered procedures include:
• Open or laparoscopic Roux-en-Y gastric bypass;
• Laparoscopic sleeve gastrectomy; or
• Open or laparoscopic biliopancreatic diversion with or without duodenal switch.

Coverage is limited to one procedure per lifetime under this plan regardless of when or where the surgery was performed.

Contact Curative Member Services at 855-428-7284 for current medical necessity determination criteria.

Oral Surgery (Prior Authorization required)

When medically necessary as deemed by Curative and prescribed by your doctor, covered oral surgery is limited to:

- Services provided to a newborn for treatment or correction of a congenital defect;
- Correction of damage caused solely by external violent accidental injury to healthy, un-restored natural teeth and supporting tissues, if the accident occurs while the Member is covered by the Curative Plan. Initial visit must occur within 72 hours of the accident and treatment must be completed within 24 months; or
- Orthognathic surgery for Members 18 years old and younger.

What oral surgery is covered?

Covered oral surgery means maxillofacial surgical procedures limited to:

- Excision of non-dental related neoplasms; including benign tumors and cysts, and all malignant and premalignant lesions and growths;
- Incision and drainage of facial abscess;
- Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; or
- Surgical and diagnostic treatment of conditions affecting the temporomandibular joint with radiographic evidence of derangement.

General dental services are NOT covered by the Curative Plan.

Organ and Tissue Transplants (Prior Authorization required)

Organ and tissue transplants (bone marrow, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung) and related services and supplies are covered if:

- Transplant is not experimental/investigational in nature;
- Donated human organs or tissue or an approved artificial device are used;
- Recipient is a Member under the Curative Plan;
- Recipient meets all the criteria established by Center of Excellence (COE) Hospital in its written policy guidelines; and
- Recipient meets all the protocols established by the COE hospital in which the transplant is performed.

Covered services and supplies include:

- Evaluation of organs or tissues including, but not limited to, the determination of tissue matches;
- Donor search and acceptability testing of potential live donors;
- Removal of organs or tissues from deceased donor; and
- Transportation of organs or tissues from deceased donors

Covered services and supplies related to an organ or tissue transplant include, but are not limited to, X-rays, laboratory testing, chemotherapy, radiation therapy, and complications arising from such transplant.

Services and supplies NOT covered by Curative include:

- Living and/or travel expenses of the recipient or live donor;
- Expenses related to maintenance of life for donor; for purposes of organ or tissue donation;
- Purchase of the organ or tissue; or
- Organs or tissue (xenograft) obtained from another species.

Orthotics

Curative covers appropriate orthotic devices that adequately meet the medical needs of the Member to participate in ADL/standard activities. Orthotic devices include, but are not limited to, braces (i.e. an orthopedic appliance used to support, align, or hold body parts in a correct position) and crutches, including rigid back, leg or neck braces; casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets; and physician-prescribed, directed or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.

Non-covered items include, but are not limited to, splints and bandages available for purchase over the counter for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace; specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or effect changes in the foot; or foot alignment, arch supports, elastic stockings, and garter belts.

Maintenance and repairs to orthotics resulting from accident, misuse or abuse are the Member's responsibility and not covered by Curative.

Outpatient Facility Services (Prior Authorization may be required)

Curative covers the following services provided through a hospital outpatient department or a free-standing facility when medically necessary:

- Radiation therapy;
- Chemotherapy;
- Dialysis;
- Rehabilitation services; and
- Outpatient surgery.

Palliative Care (Prior Authorization required)

Curative provides Palliative Care coverage for Members with a chronic, complex, or terminal illness.

Prenatal Testing

Benefits for eligible expenses incurred for prenatal genetic and chromosomal metabolic testing include amniocentesis and chorionic villus sampling (CVS). These tests are eligible for coverage for the specific conditions:

- NIPT / NIPS is covered in the first trimester of pregnancy; and
- Quad Screen and Nuchal Translucency is covered in the second trimester of pregnancy

Preventative Care

Curative encourages preventative care and maintenance of good health.

Covered services under this benefit must be billed by the provider as "preventative care". Preventative care benefits will be provided for the following covered services. When using network providers, the services will not be subject to a copay, deductible, coinsurance or dollar maximum unless stated as covered on the same basis as for any other illness.

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

- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved; and
- Evidence based preventive care recommended by American Academy of Pediatrics and Bright Futures.
- Immunizations are available from your provider or at a Pharmacy location.

The preventative care services described above may change as USPSTF, or other national guidelines are modified. For the most recent list of recommended services, check with your doctor or visit www.healthcare.gov.

More about Preventive Care Benefits:

Benefits for the Prevention and Detection of Osteoporosis

Benefits are available on the same basis as for any other illness to qualified Members for medically accepted bone mass measurement for the detection of low bone mass and/or to determine the Member's risk of osteoporosis and fractures associated with osteoporosis.

Qualified Members are those who are:

- Postmenopausal and not receiving estrogen replacement therapy
- An individual with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures
- An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or effectiveness of approved osteoporosis drug therapy

Medications for the prevention and treatment of osteoporosis can be found on the formulary with a $0 copay. These include alendronate, risedronate, ibandronate, and zoledronic acid.

Benefits for the Prevention and Detection of Breast Cancer

Benefits are available for annual screening low-dose digital mammograms and breast tomosynthesis for a Member who is 35 years of age and older.

Benefits for Certain Tests for Detection of Prostate Cancer

Benefits are available to male Members for a medically recognized diagnostic examination for the detection of prostate cancer. Benefits will include:

- A physical examination for the detection of prostate cancer; and
- A prostate-specific antigen test used for the detection of prostate cancer for each covered male who is at least 50 years of age and asymptomatic, or 40 years of age with a family history of prostate cancer or another prostate risk factor.

Benefits for Colorectal Cancer Screening

Benefits are available for colorectal cancer screening for Members who are 45 years of age and older and who are at normal risk for developing colon cancer coverage for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include:

- A Cologuard Test performed every 3 years;
- A colorectal cancer examination, preventive services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals; and
- An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

Benefits for Certain Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Benefits are available to each woman 18 years of age or older enrolled in the Plan for expenses for an annual medically recognized diagnostic examination for the early detection of ovarian cancer and cervical cancer. This includes:

- a CA 125 blood test;
- a conventional Pap smear screening or a screening using liquid-based cytology
- methods, as approved by the United States Food and Drug Administration, alone
- or in combination with a test approved by the United States Food and Drug
- Administration for the detection of the human papillomavirus; and
- any other test or screening approved by the United States Food and Drug
- Administration for the detection of ovarian cancer.

Benefits for Early Detection Tests for Cardiovascular Disease

Benefits are available for one of the following non-invasive screening tests for atherosclerosis and abnormal artery structures and function every 5 years. Eligible tests are available to each Member who is diabetic or has a risk of developing coronary heart disease and who is:

- A male older than 45 years of age and younger than 76 years of age; or
- A female older than 55 years of age and younger than 76 years of age.

Eligible Tests include:

- Computed tomography (CT) scanning measuring coronary artery calcifications; or
- Ultrasonography measuring carotid intima-media thickness and plaque.

Benefits for Speech and Hearing Services

Benefits are available on the same basis as for any other illness for the services of a provider to restore the loss of or correction of impaired speech or hearing function. For more information regarding this benefit refer to the Hearing Care and Cochlear Implants information in this section.

Benefits for Screening Tests for Hearing Impairment

Benefits are available for a covered dependent child for a screening test for hearing loss from birth through the date the child is 30 days old and for necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months old.

Immunizations

Benefits are available for immunizations for those recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) based on the Member's age requirements.

Immunizations that are covered at 100% in-network and out-of- network for covered children until they reach their 6th birthday are:

- Diphtheria;
- Haemophilus influenzae type b;
- Hepatitis B;
- Measles;
- Mumps;
- Pertussis;
- Polio;
- Rubella;
- Tetanus;
- Varicella; and
- Any other immunizations that may be required by law

Professional Services

Covered services must be medically necessary as determined by Curative and provided by a licensed physician or by other covered health providers as listed below. Benefits for services for diagnosis and treatment of illness or injury are available on an inpatient or an outpatient basis or in a provider's office.

Covered Health Providers:

- Advanced Practice Nurse (APN)
- Board Certified Behavioral Analyst
- Doctor of Medicine
- Doctor of Optometry

- Doctor of Osteopathy
- Doctor of Podiatry
- Doctor of Psychology
- Licensed Audiologist
- Licensed Chemical Dependency Counselor
- Licensed Dietician
- Licensed Hearing Instrument Fitter and Dispenser
- Licensed Marriage Family Therapist (LMFT)
- Licensed Clinical Social Worker
- Licensed Nurse Practitioner
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Licensed Professional Counselor
- Licensed Speech-Language Pathologist
- Physician Assistant (PA)

Prosthetic Devices (Prior Authorization required)

Curative covers appropriate prosthetic devices that adequately meet the medical needs of the Member to participate in ADL/standard activities. These prosthetic devices include replacements necessitated by growth to maturity of the Member. Coverage is provided for medically necessary artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices (excluding dental appliances and the replacement of cataract lenses).

Maintenance and repairs to prosthetic devices resulting from accident, misuse or abuse are the Member's responsibility.

For purposes of this definition, a wig or hairpiece is not considered a prosthetic appliance.

Reconstructive Surgery (Prior Authorization required)

Curative covers charges made by a physician, hospital or surgery center for reconstructive services and supplies, including:

- Surgery needed to improve significant functional impairment of a body part;
- Surgery to connect the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18;
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury. (Note: Injuries that occur as a result of a medical (i.e. non-surgical) treatment are not considered accidental injuries, even if planned or unexpected); and
- Surgery to correct Craniofacial abnormalities up to the age of 18.

Covered expenses include reconstruction of the breast on which a medically necessary mastectomy for malignancy was performed, including an implant and areola reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of a mastectomy, including lymphedema. Reconstructive Surgery coverage does not include the replacement of prior elective breast implants.

Elective Cosmetic Surgery is NOT covered.

Reconstructive surgery is covered to the extent required by the Women's Health and Cancer Rights Act of 1998.

Rehabilitation Services (Physical, Speech and Occupational Therapies) (Prior Authorization required)

Curative covers rehabilitation services and physical, speech and occupational therapies that are medically necessary, meet or exceed the treatment goals for the Member, and are provided on an inpatient or outpatient basis or in the provider's office. For a physically disabled person, treatment goals may include maintenance of function or prevention or slowing of further deterioration. See limitations that apply to the number of visits per year in the Summary of Benefits for Physical and Occupational Therapies.

For inpatient rehabilitation, the Member must participate in at least 15 hours per week of intensive rehabilitation therapy.

Curative will provide Benefits for Covered Health Services provided to a child and determined to be necessary to and provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Texas Human
Resources Code. Rehabilitative and habilitative therapies will be covered in the amount, duration, scope, and service setting established in the child's individualized family service plan.

Skilled Nursing Facility (Prior Authorization required)

Curative covers care in a Skilled Nursing Facility and includes:

- Room and board;
- Routine medical services, supplies, and equipment provided by the skilled nursing facility;
- General nursing care by a Registered Nurse (RN), Advanced Practice Nurse (APN) or Licensed Vocational Nurse (LVN); and
- Physical, occupational, speech therapy, and respiratory therapy services by a licensed therapist.

Substance Use/Opioid Use Disorder Treatment/Behavioral Health (Prior Authorization Required)

Substance Use Disorder Treatments are an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility which may include, but is not limited to, Acute Treatment Services and Clinical Stabilization Services. It does not include programs which are primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental disabilities or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Substance Use Disorder means a condition or disorder that falls under any of the substance use disorder diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Substance Use Disorder Treatment Facility means a facility (other than a hospital) whose primary function is the treatment of Substance Use Disorder and is licensed by the appropriate state and local authority to provide such service, when operating within the scope of such license. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

A series of treatments is a planned, structured, and organized program to promote substance-free status. A program may include different facilities and modalities, such as inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient treatment or a series of these levels of treatments without a lapse in treatment. A series is complete when a Member is discharged on medical advice or when a Member fails to materially comply with the treatment program.

Inpatient treatment of substance use disorder must be provided in a substance use disorder treatment center. Benefits for the medical management of acute, life-threatening intoxication (toxicity) in a hospital will be available on the same basis as any other illness.

Curative covers medically necessary inpatient and out-patient treatment for Substance Use Disorder in a Day Treatment Facility, a Crisis Stabilization Unit or Facility, a Residential Treatment Center, or a Residential Treatment Center for Children and Adolescents.

Intensive Outpatient Program / Partial Hospitalization Treatment Program services may be available with less intensity if you are recovering from Substance Use Disorder conditions. If you are recovering from Substance Use Disorder conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute inpatient, residential care, or a Partial Hospitalization Treatment Program.

All inpatient and certain outpatient treatment for behavioral health should be Prior Authorized. If you have questions contact Curative Member Services at 855-428-7284.

Opioid Cumulative Dosing

To ensure your medication is safe and effective and as recommended by the CDC Guideline, your opioid medication may require further review by your pharmacy. Please see Opioid Cumulative Dosing under Pharmacy for details.

Telemedicine / Telehealth

Curative covers the use of synchronous, interactive audio, video, or other electronic media for the health care provided by your Physician. These services can be for either a medical or mental health related issue. Telemedicine / Telehealth services provided by a preferred or contracted provider are covered by Curative on the same basis and to the same extent that the Plan covers the service in an in-person setting.

Telemedicine On Demand

Curative also offers at no cost to the Members a **Telemedicine On Demand** Visit with a 24/7/365 On Demand synchronous, interactive audio, video, or other electronic media to deliver health care as needed by a contracted telemedicine On Demand Physician or Pediatrician. These services can be for either a medical or mental health related issue.

Some of the typical conditions that can be treated by a Telemedicine On Demand Visit include, but are not limited to:

- COVID-19, cold and flu symptoms
- Skin rashes and infections
- Pink eye
- Cough and sore throat
- Insect bites and stings
- Earaches and swimmer’s ear
- Seasonal allergies
- Sinus infections
- Urinary tract infections
- Yeast infections
- Nausea and diarrhea
- Minor back or shoulder pain
- Minor injuries, sprains, and strains
- Minor trauma, burns or lacerations
- General health and medication questions

- Stress, anxiety, or depression

Wigs

Wigs are approved under the plan when hair loss is the result of an injury, disease, or treatment of a disease, not to exceed a maximum $200 annual benefit.

Your prescription drug benefits

Curative wants to ensure Members have access to high quality prescription drugs. The Prescription Drug Program covers medically necessary prescriptions based upon the following:

- The drug is included on our approved Formulary Drug List;
- It has been approved by the United States Food and Drug Administration (FDA) for at least one indication; and
- Is recognized by the following for treatment of the indication for which it is prescribed
    - a prescription drug reference compendium approved by the Texas Department of Insurance; or
    - substantially accepted peer-reviewed medical literature.

We list all of our covered drugs in a covered drug list, or Formulary. The drug list will show if your drug is on formulary and if it is a Preferred, Non-Preferred Generic and Brand Name, or Non-Preferred Specialty Drug. That in combination with your pharmacy choice, determines your drug cost. Curative will not remove or restrict a drug through a formulary change unless the change is made at your Plan renewal date.

For a list of the Curative Formulary Drug List, visit our website at www.curative.com/pharmacy or call Curative Member Services at 855-428-7284.

Any Members cost-share, limitations and exceptions for a prescription is noted in the Summary of Benefits. Using drugs on the Preferred Drug List will save you money. The categories of prescription benefit levels noted in the Summary of Benefits are:

Preferred Drugs are a list of Generic, Brand Name and Specialty medications preferred for their clinical effectiveness and opportunities to help contain Member and plan costs. Curative has designed this level of benefit to include at least one drug of each type, including high-cost specialty drugs, so that a Preferred option is always available for any situation.

Non-Preferred Generic and Brand Name Drugs are medications that are not on the Preferred Drug list because there are more effective and/or less expensive alternatives available. These medications require a higher copay.

Non-Preferred Specialty Drugs are typically the highest cost prescriptions and used to treat complex chronic conditions including, but not limited to, rheumatoid arthritis, psoriasis, cancer and multiple sclerosis that are not on the Preferred Drug list because there are more effective and/or less expensive alternatives available.

If you qualify for the In-Network cost-sharing waiver (either in the first 120 days of enrollment or after completion of the Baseline Visit):

- Preferred drugs will be available with $0 copay, $0 deductible and 0% coinsurance,
- Non-preferred Generic and Brand Name drugs will be available with $50 copay, $0 deductible and 0% coinsurance.
- Non-preferred Specialty drugs will be available with $250 copay, $0 deductible and 0% coinsurance.

Note: Some Drugs will require Prior Authorization, Step Therapy and Quantity Limitations. See the Formulary for additional information.

If you are prescribed a new medication by your provider, the first prescription dispensed may be limited to a 14-day supply (at ½ copay), and then the remainder of the 30-day supply may be dispensed to determine safety, tolerability, and efficacy.

Limits on Copays

Curative will not require you to make a payment for a prescription drug at the point of sale in an amount that is greater than the lesser of:

- The applicable copayment
- The allowable claim amount for the prescription drug
- The amount you would pay if you purchased the drug without using a health benefit plan
- or any other source of drug benefits or discounts.

Limits on Insulin Cost-Sharing

Cost-sharing for insulin included on the Curative Formulary Drug List shall not exceed $25.00 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.

Prescription Eye Drops

Prescription eye drops to treat a chronic eye disease or condition can be refilled if you pay at the point of sale the required copay and:

- The original prescription states that additional quantities of the eye drops are needed
- The refill does not exceed the total quantity of dosage units authorized by the prescribing
- provider on the original prescription, including refills; and
- The refill is dispensed on or before the last day of the prescribed dosage period and:
    - not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops are dispensed;
    - not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops are dispensed; or
    - not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops are dispensed.

Prescription Drug Synchronization

Curative will prorate any cost-sharing amount charged for a partial supply of a prescription drug if:

- The pharmacy or the enrollee prescribing physician or health care provider notifies the health benefit plan that:
    - the quantity dispensed is to synchronize the dates that the pharmacy dispenses the enrollee's prescription drugs; and
    - the synchronization of the dates is in the best interest of the enrollee
- You agree to the synchronization
- The proration is based on the number of days; supply of the drug actually dispensed

Pharmacy Access

With your Curative Plan you can go to any In-Network Pharmacy of your choice. If you select a Network Pharmacy, your cost for the prescription will be reduced significantly. Curative allows a 90-day supply for certain maintenance medications both at retail and mail order pharmacies. To obtain a 90-day supply the prescription must be written for a 90-day quantity and be filled at an in-network pharmacy. Note: This does not apply to Specialty medications. You may obtain your prescriptions from several Pharmacy options:

- Retail Pharmacies: Pick up your prescriptions at a network neighborhood pharmacy or have them delivered conveniently from a designated pharmacy. Find a contracted Network Pharmacy near you at www.curative.com/pharmacy.
- Mail Order Pharmacies: Have your maintenance (long term) medications conveniently delivered to your home saving you time and money. You can enroll in mail order at www.curative.com/pharmacy.
- Specialty Pharmacies: This program is for Members who are prescribed specialty drugs. It allows Members who need these medications to get them at a highly reduced cost. There are some specialty drugs on the Preferred Drug. Find

information on contracted pharmacies for specialty medications at www.curative.com/pharmacy.

Using contracted network pharmacies is the most cost-effective way to use your pharmacy benefit.

When obtaining your prescriptions from a non-network pharmacy, this licensed pharmacy must be located in the United States. For any non-network pharmacy prescriptions, the Member will be required to submit a claim themselves with an itemized receipt and verify if any Prior Authorization or Step Therapy is required. Claim forms are available by calling Curative Member Services at 855-428-7284.

Off-Label Coverage

Curative will cover a drug prescribed to treat a chronic, disabling, or life-threatening illness covered under the plan if the drug:

(1) has been approved by the United States Food and Drug Administration for at least one indication; and
(2) is recognized by the following for treatment of the indication for which the drug is prescribed:
    (A) a prescription drug reference compendium approved by the commissioner for purposes of this section; or
    (B) substantially accepted peer-reviewed medical literature.

Coverage of a drug under this section includes coverage of medically necessary services associated with the administration of the drug.

Coverage of a drug under this section does not include:

(1) experimental drugs that are not otherwise approved for an indication by the United States Food and Drug Administration;
(2) any disease or condition that is excluded from coverage under the plan; or
(3) a drug that the United States Food and Drug Administration has determined to be contraindicated for treatment of the current indication.

Opioid Cumulative Dosing

Per CDC guidelines, to ensure your medication is safe and effective, your medication may be limited for any of the following scenarios: 1.) You are prescribed a dose above the recommended quantity 2.) You are currently using other medications such as benzodiazepines that may interact with your opioids or 3.) You are new to opioid treatment. Curative will limit your opioids to a maximum of 7 days if you're new to opioid treatment and limit your dose to a maximum of 90 Morphine Milligram Equivalents (MME) per day for all members.

Your pharmacy may work with your doctor to obtain the necessary information to help process your claim. If you have any condition(s) such as cancer, sickle cell disease or in palliative care, this limitation may not apply to you. Call Member Services at 855-428-7284 if you have any questions about your pharmacy claims.

Opioid Overdose

Curative will cover preferred generic naloxone (injection and nasal spray) at $0 copay. These medications will help to prevent an overdose and do not require a prescription to be filled by your pharmacy. See the Preferred Drug List (PDL) for a list of preferred naloxone medications.

Vaccinations at Pharmacies

Curative covers select medically necessary vaccinations administered through Pharmacies. Eligibility for vaccination coverage may depend on determining factors for some vaccinations, including, but not limited to, age and recommended frequency of the vaccination. Note:

- Travel vaccinations are NOT covered through the pharmacy benefit; and
- When obtaining your vaccination from a non-network pharmacy, you will be required to submit a claim with an itemized receipt.

The following vaccines will be covered at your pharmacy this is not all inclusive, see the PDL for a complete list:

Pneumococcal Vaccine	Influenza (Flu shots)	Human Papilloma Virus (HPV)
Shingrix	Hepatitis B	Meningococcal Vaccine
COVID-19 Vaccines		
Pfizer-BioNTech	Moderna	Johnson and Johnson

Smoking Cessations

Your pharmacy benefit will allow coverage for Over-the-counter (OTC) Smoking Cessations agents such as patches, gums, and lozenges. These will be covered with a $0 copay. A prescription from your doctor is needed to obtain these products from your pharmacy.

Step Therapy

Some prescriptions that are included in the Curative Formulary listing do require Members use a clinically acceptable alternative medication prior to allowing a certain Prescription to

be dispensed. Step Therapy ensures that clinical guidelines are met. There may be exceptions in Step Therapy requirements if the patient has experienced allergies, ineffectiveness, or adverse events to the preferred drug.

If you are using a non-network Pharmacy, they may not be aware of the required Step Therapy and your claim may be denied due to non-adherence to the Step Therapy requirements. If you have any questions about which drugs are applicable to Step Therapy, please visit our website at www.curative.com/pharmacy or call Curative Member Services at 855-428-7284.

Step Therapy will not apply to prescriptions related to the diagnosis of Stage-Four Advanced Metastatic Cancer, associated conditions, and terminal illnesses.

If your Provider would like an exception to the Step Therapy requirement, they may submit a request to Curative at 855-428-7284. Curative will review and provide an answer within 72 hours of the request. If your prescribing Physician reasonably believes that denial of the Step Therapy Exception Request could cause you serious harm or death, the request is considered approved if we do not deny it within 24 hours of receiving the request. If we do deny, you have the right to request an expedited internal appeal and also have the right to request a review by an Independent Review Organization (IRO) as explained in the Claims Section of this Benefit Booklet.

Prior Authorization for Prescriptions

Some prescriptions require an approved Prior Authorization before they will be covered by Curative. Prior Authorizations are required to ensure the appropriate use, including safety and efficacy, of a drug. A list of the prescriptions that require Prior Authorization is available at www.curative.com/pharmacy or you can contact Curative Member Services at (855) 428-7284.

When a Network Pharmacy receives a prescription for a drug that requires a Prior Authorization, the prescription will not be covered by Curative until your Physician submits an authorization request form to Curative and it is approved. It is recommended that your Physician submit this authorization form at the time they are prescribing.

If you are obtaining a prescription from a non-network Pharmacy, they will not be aware that the Prescription required a Prior Authorization, therefore when you submit the claim a denial will be issued if your Physician did not submit and receive an approved Prior Authorization.

The right to appeal a Prior Authorization denial is included in the Utilization Management section of this Benefit Booklet.

See the Limitations and Exclusions section of this Benefit Booklet for more detail on drugs that may not be covered.

Denial Due to Formulary Limitation

If Curative denies a prescription drug that has been prescribed to you because the drug is not included on the drug formulary, and the prescribing physician has determined that the drug is medically necessary, Curative will treat the denial as an adverse determination and provide appeal rights to you in the same manner as any other adverse determination.

Limitations and Exclusions

In addition to limitations and exclusions noted in the What the Plan Covers section of this Benefit Booklet, your Curative Plan does not cover the following medical expenses:

1. Any services, supplies or drugs that are not medically necessary and essential to the diagnosis and direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.

2. Any experimental or investigational services, supplies, or drugs except for applicable clinical office visits and labs.

3. Any portion of a charge for a service, supply or drug that is in excess of the allowable amount as determined by Curative.

4. Services, supplies, and drugs that require a Prior Authorization that was not requested or was denied and not appealed and overturned will be paid at 50% of the Allowable Amount. For services received from a Network Provider, you will not be responsible for any portion of the Provider's charges not paid. For services received from Non-Network Providers, the Non-Network Provider may bill you for any difference between the Provider's charges and the amount paid by Curative. The underlying service must be a Covered Service and medically necessary.

5. Any benefits in excess of specified benefit maximums in this Benefit Booklet.

6. Claims submitted after 12 months from the date of service.

7. Any services, supplies or drugs provided in connection with an occupational sickness, or an injury sustained in the scope of and in the course of any employer whether or not benefits are, or could upon proper claim be, provided under a Worker's Compensation plan.

8. Any services, supply, or drugs for which a Member is not required to make payment or for which a Member would have no legal obligation to pay in the absence of this or any similar coverage, except services and supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.

9. Any services, supplies or drugs provided for injuries sustained as a result of war (declared or undeclared), insurrection, participation in a riot, or from a criminal felonious activity.

10. Services related to a disaster. In the event of a major disaster, services shall be provided insofar as practical, according to the best judgment of health professionals and within the limitations of facilities and personnel available, but neither the Plan, nor any health professionals shall have any liability for delay or failure to provide or to arrange for services due to lack of available facilities or personnel.

11. Court ordered services. Healthcare services provided solely because of the order of a court or administrative body are excluded. Charges for a provider to appear in court are also excluded.

12. Reimbursement for services, supplies or drugs provided by a non-contracted provider or facility shall be subject to benefits as provided in this Benefit Booklet and limited to the Curative allowable amount.

13. Coverage for any services, supplies or drugs furnished by a contracted facility or provider practicing outside of their scope of practice will be paid at a non-network benefit level.

14. Any services, supplies or drugs provided to a Member incurred outside of the United States, even if the Member traveled to the location for the purpose of receiving medical services, supplies, or drugs.

15. Any services, supplies or drugs provided or prescribed by a provider that is related to the Member by blood or marriage.

16. Service provided by a Christian Science or other faith or culturally based facility or practitioner.

17. Any charges resulting from failure to keep a scheduled visit with a physician or other professional provider; or for completion of any insurance forms; or for acquisition of medical records.

18. Reimbursement for same day duplicate services by different providers.

19. Any services, supplies or drugs provided before the patient is covered as a Member in this Plan or any services or supplies after the termination of the Member's coverage.

20. Any services, supplies or drugs provided for custodial care, long term care, respite care (except as noted under Hospice Care).

21. Any services, supplies and drugs provided for any medical social services (except as provided as an extended care expense), bereavement counseling (except as provided under Hospice Care), and vocational counseling.
22. Room and board charges incurred during a hospital admission for diagnostic or evaluation procedures if the tests could have been covered on an outpatient basis without adversely affecting the Member's physical condition or the quality of medical care provided.

23. Home Infusion Therapy unless those services would be routinely provided in a facility.

24. Private Duty Nursing services.

25. Nursing and Home Health Aide services.

26. Weight loss drugs, food products, and exercise programs or equipment.

27. Bariatric surgery is limited to 1 surgery per lifetime. For more on bariatric treatment refer to the What's Covered section in this Benefit Booklet.

28. Food and Nutritional items including, but not limited to, diet foods, enteral formula if less than 100% of your nutritional intake, or guest meals.

29. Any services, supplies or drugs supplied to increase or decrease height or alter the rate of growth, including surgical procedures or devices to stimulate growth (except for certain endocrine conditions).

30. Any services, supplies or drugs in connection with:

    - Routine foot care, including but not limited to the removal of warts, corns or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease; or
    - Foot care for flat feet and fallen arches.

31. Replacement prosthetic appliances except those necessitated by growth due to maturity of the Member.

32. Non-covered Durable Medical Equipment includes, but not limited to, air conditioner, air purifier, cryogenic machine, humidifier, physical fitness equipment, and whirlpool bath equipment.

33. Immunizations that are not routine and are for the purpose of travel.

34. Outpatient drugs except as provided under the Plan in the Prescription Drug Program in this Booklet. This includes any drugs dispensed by your provider for

outpatient use (including, but not limited to, compounded medications, dermatologic products, or physician developed product line unless included in the What's Covered section of this Benefit Booklet).

35. The use of the procedures or supplies for treatment of male sexual or erectile disfunction/impotence.

36. Over the Counter drugs and contraceptives prescribed by your provider that are not included on the Curative Formulary.

37. Over the Counter experimental devices.

38. Drugs that are not included in the Curative Formulary.

39. Non-FDA approved Drugs except those specifically noted in the What's Covered section of this Benefit Booklet, and drugs dispensed to treat a condition for which they are not approved by the FDA for a particular use.

40. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this Benefit Booklet.

41. Drugs which are illegal, unethical, imprudent, or not Medically Necessary.

42. Drugs used to promote hair growth or to replace hair, including, but not limited to Rogaine or Minoxidil.

43. Compound medications are not covered unless noted in the What's Covered section of this Benefit Booklet.

44. Prescription drugs that require but have not met the required Step Therapy.

45. Replacement of drugs that have been lost, stolen, destroyed, or misplaced with an exception for stolen drugs included in a police report.

46. Cosmetic drugs used to enhance appearance, including, but not limited to skin aging and wrinkle reduction drugs.

47. Cosmetic services and Plastic Surgery.

48. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.

49. Orthognathic surgery for Members 19 years of age and above.

50. All expenses related to Dental Care or oral surgery (except for corrective treatment of an an accidental injury to natural teeth; and Member must remain with Plan until

all treatment completed for continued coverage or any treatment relating to the teeth, jaws, or adjacent structures (for example, periodontium), including but not limited to:

- Cleaning of the teeth;
- Any services related to crowns, bridges , filings or periodontics;
- Rapid palatal expanders;
- X-rays or exams;
- Dentures or dental implants;
- Dental prostheses, or shortening or lengthening of the mandible or maxilla for Members over the age of 18, correction of malocclusion;
- Any non-surgical dental care involved in the treatment of Temporomandibular Joint (TMJ) pain dysfunction syndrome, such as oral appliances and devices;
- Treatment of dental abscess or granuloma;
- Treatment of gingival tissues (other than tumors);
- Surgery or treatment for overbite or underbite and any malocclusion associated thereto, including those deemed congenital or developmental anomalies;
- Orthodontics, such as splints, positioners, extractions of teeth, or repairing damaged teeth; and
- Odontogenic cysts.

51. Vision related services and supplies not noted in the What is Covered section of this Benefit Booklet.

52. Educational testing and therapy, motor or language skills, or services that are educational in nature or are for vocational testing or training (i.e. including, but not limited to, dyslexia, early childhood intervention (ECI), typing, language, or learning courses.)

53. Alternative / Optional Therapies (including, but not limited to, recreational therapy, exercise programs, hypnotherapy, music therapy, reading therapy, sensory integration therapy, vision therapy, vision training, orthoptic therapy, behavioral vision therapy, integration vision therapy, orthotripsy, chelation therapy, cryotherapy, massage therapy, hair replacement or removal regardless of indication.

54. Spinal adjustment and manipulation therapies.

55. Any services or supplies provided for the following treatment modalities including, but not limited to:

    - Intersegmental traction;
    - Surface EMGs;
    - Spinal manipulation under anesthesia; and

- Muscle testing through computerized kinesiology machines such as Issostation, Digital Myograph and Dynatron.

56. Biofeedback is not covered for any reasons except for urinary incontinence.

57. Extracorporeal Shock Wave Therapy (ESWT) except for treating kidney stones.

58. Physical Exams, Treatment and evaluations required or requested by employers, insurers (other than this Curative Plan), schools, camps, courts, licensing authorities, flight clearance and other third parties.

59. Athletic performance enhancing drugs.

60. Strength equipment or drugs.

61. Sports cords and TENS units or other Athletic Assist devices.

62. Disposable outpatient supplies - Any outpatient disposable supply or device, including but not limited to bandages, testing supplies (except for diabetes), blood pressure monitors, diapers, bedpans, support hose, compresses and other devices not intended for reuse.

63. Services and supplies used primarily for patient convenience.

64. Convenience services provided by a hospital (included, but not limited to, private rooms, guest beds, tv).

65. Personal comfort and convenience items, including, but not limited to, heating pads, air purifier, blood pressure cuffs.

66. Support garments including, but not limited to, compression support hose, compression socks, over the counter orthotic.

67. Home and mobility improvements including, but not limited to, widening doorways, ramps or home modification.

68. Medical costs for a transplant donor.

69. Transportation cost for personal transport and other than ambulance if not medically necessary.

70. Infertility treatment includes medical services, artificial insemination and all drugs associated with the treatment of infertility or any assisted reproductive technology or related treatment.

71. Storage of body fluids, including, but not limited to semen, ovum and body parts.

72. Reversal of voluntary sterilization; any cost related to surrogate parenting; infertility services required because of a gender change by the Member.

73. Elective Abortion, as defined by Section 245.002, Texas Health and Safety Code, other than an abortion performed due to a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.

74. Gene Therapy not noted in the What is Covered section of this Benefit Booklet.

75. Services related to Mental Illness and/or Substance Use Disorder that are provided by half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long term social needs, even if counseling is provided in such facilities. Curative requires that any facility providing healthcare for Mental Illness and/or a Substance Use Disorder treatment program be accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children.

76. Any services, supplies or drugs not specifically defined as eligible expenses in this plan.

Utilization Management

Continuity of Care – Network Providers

If a Network Provider leaves the Curative network and the provider is currently treating a Member at the time of the network termination, Curative will reimburse the provider at the same Network Provider rate if, at the time of the network termination, you are a “continuing care patient.” You have these continuity of care rights under state law. If you have questions regarding your continuity of care rights and opportunities, please call or text Curative Member Services at 855-428-7284.

Continuity of Care

Curative will provide notice to you if you are a “continuing care patient,” and may provide transitional care for up to 90 days, if:

- the contractual relationship between Curative and the provider or facility is terminated due to expiration or non-renewal; or

- benefits provided under the Plan with respect to the provider or facility are terminated because of a change in the terms of participation of such provider or facility under the Plan.

You are a “continuing care patient” with respect to a provider or facility if you:

- are undergoing a course of treatment from the provider or facility for a “serious and complex condition;”
- are undergoing a course of institutional or inpatient care from the provider or facility;
- are scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care, from such provider or facility with respect to such a surgery;
- are pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- are or were determined to be “terminally ill” (a medical prognosis that your life expectancy is six months or less) and are receiving treatment for such illness from such provider or facility.

If you are a continuing care patient and elect to have continued care, the Plan will continue such coverage with respect to the course of treatment furnished by the provider or facility, under the same terms and conditions as would have applied under the Plan had such network termination not occurred during the period beginning on the date on which the Plan provides the notice to the Member of continuity of care rights and ending on the earlier of—

- 90 days thereafter; or
- the date on which the Member is no longer a continuing care patient with respect to such provider or facility.

State Law - Continuity of Care

In addition, if a Network Provider leaves the Curative network and the provider is currently treating a Member at the time of the network termination, Curative will reimburse the provider at the same Network Provider rate it, at the time of the network termination, a Member whom the provider is currently treating has special circumstances, as determined by the treating provider and the provider requests that the Member be permitted to continue treatment under the provider’s care and agrees not to seek payment from the Member of any amount for which the Member would not be responsible if the provider were still an In-Network provider.

The continued care and payment for services under the terminated network agreement will continue until:

- the 90th day after the effective date of the termination;

- if the Member has been diagnosed as having a terminal illness at the time of the termination, the expiration of the nine-month period after the effective date of the termination; or
- if the Member is past the 24th week of pregnancy at the time of termination, through delivery of the child, immediate postpartum care, and the follow-up checkup within the six-week period after delivery.

Prior Authorizations

Curative requires advance approval (Prior Authorizations) for certain services. Prior Authorization establishes in advance the medical necessity of certain care and services covered under the Curative Health Plan. Prior Authorizations will ensure that care services will not be denied on the basis of medical necessity. Benefit coverage is subject to other applicable requirements including the network status of providers, limitations and exclusions, payment of premium and eligibility at the time care and services are provided.

The following types of services require Prior Authorization:

- All inpatient hospital admissions
- All outpatient surgical procedures
- Applied Behavioral Analysis
- Assistant Surgeon
- Non-Emergency Ambulance
- Biofeedback for urinary incontinence (Biofeedback is not covered for other indications)
- Drugs listed on the Pharmacy Prior Authorization Listing
- Molecular Genetic Lab Testing
- Radiation Therapy / Radiation Oncology
- Formula/Food Products/Liquid Nutrition
- Skilled nursing care in a skilled nursing facility
- Home health care
- Hospice Care
- Palliative Care
- Oncology Services (Chemotherapy, Radiation Therapy)
- Oral Surgery
- Observation
- Orthotics & Prosthetics
- Mastectomy
- MOHS procedures
- Rehabilitation Services (Physical, Speech and Occupational Therapies)
- Any durable medical equipment totaling over $750
- Transplants
- Dialysis
- Advanced Imaging
- Cochlear Implant
- Cardiology - All Tests and Procedures

- Joint and Spine Surgery
- Pain Management
- Psychological/Neuropsychological Testing
- Hyperbaric Therapy
- Sleep study
- Obesity Treatment
- Gender Affirmation Surgery and Treatment
- All inpatient treatment and behavioral health care, substance use disorder and serious mental illness (Acute Inpatient, Intensive Outpatient (IOP), Partial Hospitalization, Residential Treatment Center); and
- The following outpatient treatment of behavioral health care, substance use disorder and serious mental illness:
    - Electroconvulsive therapy
    - Partial Hospitalization
    - Intensive outpatient program

Other services may require Prior Authorization. Call the Curative Members Services at 855-428-7284 for additional information.

Care should also be Prior Authorized if you or your provider wants to:

- Extend your hospital stay beyond the approved days (you or your provider must call for an extension before your approved stay ends); or
- Transfer you to another facility or from a specialty unit within the facility.

Note: Prior Authorization for medical necessity of services does not guarantee the network level of benefits. Even if approved by Curative, non-network providers paid at the Curative allowable amount may balance bill for charges in excess of this amount, except as prohibited by law. You are responsible for these charges, which can be significant.

What happens if services are not Prior Authorized?

Curative will review the medical necessity of your treatment prior to the final benefit determination. If Curative determines the treatment or service is not medically necessary, coverage will be denied. This is also referred to as an Adverse Determination.

How to Prior Authorize

To satisfy prior authorization requirements, you and your providers must call Curative Member Services at 855-482-7284. The call for Prior Authorization should be made between 6:00 am and 6:00 pm Central Standard Time on business days and 9:00 and 12:00 Noon Central Standard Time on non-business days. Calls made after working hours or on weekends will be recorded and returned no later than the second working day after the call is received. A Clinical Care Coordinator (CCC) will follow up with your provider's office.

Prior Authorization for Inpatient Hospital Admissions

In the case of an elective inpatient hospital admission, the call for Prior Authorization should be made at least three calendar days before you are admitted unless it would delay emergency care. If you are admitted to a hospital as a result of an emergency, Prior Authorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

When an inpatient hospital is Prior Authorized, a length of stay is assigned. Your Curative Plan is required to provide a minimum length of stay in a hospital facility for the following:

- Maternity Care
  - 48 hours following an uncomplicated vaginal delivery
  - 96 hours following an uncomplicated delivery by Cesarean Section

- Treatment for Breast Cancer
  - 48 hours following a mastectomy
  - 24 hours following a lymph node dissection

Note: Your provider will not be required to obtain Prior Authorization from Curative for prescribing a length of stay less than 48 hours (or 96 hours) for maternity care. If you require a longer stay, your provider must seek an extension for the additional days by obtaining Prior Authorization from Curative.

Concurrent Review

Curative will review care and services during a hospital stay and if your provider recommends a longer stay than was first Prior Authorized, your provider may seek an extension for the additional days. Curative will respond to your provider request no later than 24 hours after receiving the request. Benefits will not be available for room and board charges for medically unnecessary days.

Urgent Prior Authorization Request

Providers can submit any Urgent Prior Authorization request by calling Curative Member Services at 855-428-7284 as noted on your ID card, through the Provider Portal, or a written request when the Member needs medical care or treatment for a condition that could seriously jeopardize the life, health, the ability to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition, would subject the claimant to severe pain that cannot be managed without treatment. Curative will respond to the request within one (1) hour by telephone or electronic transmission notifying the provider, followed by a letter within (3) working days notifying the patient and the provider.

Renewal of Prior Authorization

Your provider may request a renewal of a Prior Authorization at least 60 days before the date the Prior Authorization expires. If Curative receives a renewal request before the existing Prior Authorization expires, Curative will, if practicable, review the request and issue a determination indicating whether the Prior Authorization is renewed before the existing Prior Authorization expires.

Prior Authorization – Exempt Providers

Your provider may be exempt from the Prior Authorization requirement for specific services under Texas law. Curative will work with your provider to communicate any applicable exemptions.

ADVERSE DETERMINATIONS

An Adverse Determination is a decision that is made by us or our Utilization Review Agent that the health care services furnished or proposed to be furnished to a Member are not medical necessary or appropriate, or experimental or investigational. An Adverse Determination does not include denials due to the failure to request and receive Prior Authorization. An Adverse Determination includes determinations Curative makes to deny or not approve a prescribed drug that a physician has determined to be medically necessary for you.

Curative, or its contracted utilization review agent, will provide notice of Adverse Determinations as follows:

- For a Member hospitalized at the time of the Adverse Determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the Adverse Determination

- For a Member not hospitalized at the time of the Adverse Determination, within three working days in writing to the provider of record and the Member

- Within the time appropriate to the circumstances relating to the delivery of the services to the Member and the Member's condition - when denying post-stabilization care subsequent to emergency treatment as requested by a treating provider, notice will be provided to the provider no later than one hour after the time of the request.

Curative, or its contracted Utilization Review Agent, will provide notice of an Adverse Determination for a concurrent review regarding a prescription drug or intravenous infusions for which the patient is receiving benefits under the plan no later than the 30th day before the date on which the prescription drugs or intravenous infusion will be discontinued.

APPEAL PROCEDURES FOR AN ADVERSE DETERMINATION

How to Appeal an Adverse Determination

You have the right to appeal any Adverse Determination of a claim and receive a fair review.

An Appeal of an Adverse Determination (clinical or non-clinical) may be filed by you or a person authorized to act on your behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you, except to your authorized representative. To obtain an authorization form, you or your representative may contact Curative Member Services at 855-428-7284 or email medicalmanagementteam@Curative.com.

For Clinical Adverse Determinations made on the basis of lack of medical necessity, or when services are determined to be experimental, investigational or cosmetic, a health care provider may appeal on the Member's behalf.

If you believe all or part of benefits were incorrectly denied, you may have your determination reviewed. If you have any questions about the claim's procedures or the review process, write to Curative or call Curative Member Services at 855-428-7284.

Timing of Appeal Determinations

Curative shall render a determination of a retrospective appeal no later than 30 calendar days after the appeal was received.

Expedited Clinical Appeal

If you have an Adverse Determination that meets the definition for a Clinical Appeal, you may be entitled to appeal on an Expedited Basis. An Expedited Clinical Appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. The Member or their authorized representative may request an Expedited Clinical Appeal either orally or in writing. Before authorization of benefits for an ongoing treatment or continued hospitalization is terminated or reduced, Curative will provide you with notice not exceeding (1) one working day before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Notice of Internal Appeal Determination

Curative will notify the party filing the appeal, you and if a clinical appeal, any health care provider who recommended the services involved in the appeal, of its determination, filed by a written notice of the determination to all applicable parties.

Independent External Review

Standard External Review

You or your authorized representative may request an Independent External Review within 4 months after receiving an Adverse Determination of a Clinical Appeal be made by an Independent Review Organization (IRO). To obtain an authorization form, you may contact Curative Member Services at 855-428-7284.

Referral to and Review by an Independent Review Organization

When an eligible request for External Review is completed within the allowable time period, Curative will refer the matter to an Internal Review Organization (IRO) and the IRO will be accredited by URAC (Utilization Review Accreditation Commission).

IRO's Decision to Reverse an Adverse Determination

Upon receiving a notice of a final External Review reversing the Adverse Determination, Curative must immediately provide coverage for the claim

Expedited External Review

Curative must allow you or your authorized representative to make a request for an expedited External Review at the time you receive:

- An Adverse Benefit Determination, if it involves a medical condition of the claimant that which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an Expedited Internal Appeal; or

- An Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a Standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which you received emergency services, but have not been discharged from the facility.

Expedited Preliminary Review

Immediately upon receipt of the request for the Expedited External Review, Curative must determine whether the request meets the reviewability requirements set forth in the Standard External Review section above.

Expedited Referral to Independent Review Organization (IRO)

Upon determination that a request is eligible for an External Review following the preliminary review, Curative will submit the request to an IRO pursuant to the requirements set forth in the Standard External Review section above. Curative must provide and submit all necessary documents and information considered in making the Adverse Determination to the IRO electronically or by telephone or by facsimile or any other expeditious method.

- The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents above under the procedures for standard review. In reaching a decision, the IRO must review the claim independently and is not bound by any decision or conclusions reached during Curative's internal claims and appeals process.

Expedited Notice of Final External Review Decision

Curative's contract with the IRO must require the IRO to provide notice of their Final External Review decision, in accordance with the requirements set forth in the Standard External Review section above, as expeditiously as your medical condition or circumstances required. The IRO must provide written confirmation of their decision to Curative and you or your authorized representative.

Claims

Submitting a Medical Claim

You and your provider should submit, and Curative should receive all claims for benefits under this plan within 180 days of the date on which you received the service unless the network contract dictates differently or the date a primary payer finalizes their claim submission.

Filing A Claim

When you receive treatment or care from a network provider, you will not be required to file claims. The provider will submit the claims directly to Curative for you.

You may be required to file your own claims when you receive treatment or care from a non-network provider. At the time services are provided, ask your non-network provider whether they will file the claim for you.

Benefit payments will be made directly to network providers when they submit claims to Curative. If the claim is for a non-network provider, Curative may choose to pay either you

or your provider. If you receive the payment from Curative, it will be your responsibility to pay your provider for any billed services. If you have assigned your benefits to a provider via a valid assignment of benefits, Curative will pay the provider.

If allowed by law, any benefits available to you, if unpaid at your death, will be paid to your estate.

How to File a Medical Claim

Members submitting a claim directly to Curative must submit the claim no later than 1 year after the date of service. All benefits will be paid to the Member or the Member's assignee.

- Obtain the Claim Form: They are available for downloading from Curative on our website health.curative.com. Use a separate form for each Member and Provider.
- Complete all information requested on the Claim Form. Any missing information may cause a delay in processing your claim. Some key items that must be completed on the form are:

    - Patient's full name
    - Member ID Number
    - Current Address
    - Diagnosis (provided by your provider and may be included on an itemized bill from them)
    - Date of injury, illness, or pregnancy
    - Whether the patient has other health insurance coverage

- Attachments: You should include a copy of the itemized bill from your provider with your Claim Form. The itemized bill from your provider should include the following:

    - Name and address of the provider providing the services
    - Date of Service
    - Type of Service
    - Charges for Each Service
    - Patient's Full Name
    - Diagnosis

- Claim Submission: The claim form and itemized bills should be mailed to:

    Curative Claims Department
    P. O. Box 1786
    Austin, TX 78767

    Note: Claims not in English should be translated, if they are submitted without translation, processing may be delayed.

- Explanation of Benefits (EOB): The EOB will confirm if the expense is covered under your Curative health benefits and is eligible for payment. If so, you or the provider will receive a check. If your claim is denied, the EOB will state the reason(s) for the declination.

Claim Forms

Curative will furnish to the person making a claim or to the Member for delivery to a person making a claim the forms usually provided by Curative for filing a proof of loss.
If the forms for a proof of loss are not provided before the 16th day after the date Curative received notice of a claim under the plan, the person making the claim is considered to have complied with the requirements of the policy as to proof of loss on submitting, within the time set in the plan for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

Receipt of Claim

When a claim is submitted to Curative for processing it must contain all required information. If the claim is not complete, it will be denied noting the reason for the denial and sent to either you or your provider, if your provider submitted the claim, via an Explanation of Benefits (EOB). The claim must be resubmitted within 90 days after the denial with the additional information in order to be reprocessed. After the claim has been reprocessed, Curative will notify the Member by way of an Explanation of Benefits (EOB).

Prompt Payment of Benefits

All benefits payable under the plan will be paid no later than the 60th day after the date the proof of loss is received.

Payment/Reimbursement for Certain Publicly Provided Services

As required by Texas law, we will pay Benefits on behalf of a child to the *Texas Department of Human* Services, if:

- The parent who purchased the plan or who is required to pay child support by a court order or court-approved agreement is:
    - A possessory conservator of the child under a court order issued in the State of Texas, or
    - Not entitled to possession or access to the child.
- The *Texas Health and Human Services Commission* is paying Benefits on behalf of the child under Chapter 31 and 32, Human Resources Code.
- Curative is notified, through an attachment to the claim for Benefits at the time the claim is first submitted, that the Benefits must be paid directly to the *Texas Department of Human Services*.

Payment of Benefits to Conservator of a Minor

As required by Texas law, we will pay Benefits to a court appointed possessory or managing conservator of a child if the court appointed person includes the following information when submitting a claim to Curative:

- Written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made.
- A certified copy of a court order designating the person as a possessory or managing conservator of the child or other evidence designated by the rule of the Commissioner that the person is eligible for the Benefits as this section provides.

Right to Conduct Physical Examination or Autopsy

Pursuant to Texas law, Curative has the right and opportunity to conduct a physical examination of an individual for whom a claim is made when and as often as is reasonably required during the pendency of the claim under the plan. In the case of a death, Curative may require that an autopsy be conducted, unless the autopsy is prohibited by law.

Limitations on Legal or Equitable Actions

An action at law or in equity may not be brought to recover on Curative before the 61st day after the date written proof of loss is filed as required under the policy or after the third anniversary of the date on which written proof of loss is required under the plan to be filed.

Review Of Claims Determination

Claim Determinations

When Curative receives a properly submitted claim, it has the authority and discretion to interpret and determine benefits in accordance with the Plan Provisions. Curative will review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing.

You have the right to seek and obtain a full and fair review by Curative of any determination of a claim, any determination of a request for prior authorization, or any determination made by Curative in accordance with the benefits and procedures detailed in your medical plan.

If a Claim is Denied or Not Paid in Full

When reviewing and processing your claim, Curative may determine that all or part of your claim is not eligible for benefits for different reasons. Please read the Explanation of Benefits (EOB) summary prepared and sent to you through the Curative Member Portal, then review this Benefits Booklet to see whether you understand the reason for the determination. If you have any additional information that you believe could change the decision, send this additional information to Curative, and request a review of the decision as noted in the Claim Appeal Procedures.

If your claim is denied in part or whole, you will receive a notice in the Curative Member Portal with the following information:

- The reasons for the determination;
- A reference to the benefit plan provision on which the determination is based, or the contractual, administrative or protocol basis for the determination;
- A description of the additional information which may be necessary to submit an appeal and an explanation of why this information is necessary;
- Subject to privacy regulations and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable) and a statement detailing denial codes with their meanings and the standards used. Upon request, diagnosis and treatment codes with their meanings and the standards used are also available;
- An explanation of Curative's Appeal and External Review process and how to initiate;
- As applicable, a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If needed, a statement in non-English language(s) that the written notice of claim denial and certain other benefit information may be available upon request in such non-English language(s);
- If needed, a statement in non-English language(s) that indicates how to access the language services by Curative;
- The right to request reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy or such rule, guideline, protocol or similar criterion will be provided on request;
- If the denial is an adverse determination and is based on medical necessity, experimental or investigational treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's circumstances, or a statement that such explanation will be provided free of charge upon request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided upon request;
- In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claim. An urgent care/expedited

claim decision may be provided orally, so long as a written notice is provided to the claimant within 3 days of the oral notification; and

- Contact information for applicable office of health insurance consumer assistance.

CLAIMS & APPEALS

In addition to the requirements described in the “Claims” and “Utilization Management” sections of this Benefit Booklet, these federal requirements also apply to claim determinations. If Curative’s procedures for handling prior authorizations, as described in the “Claims” and “Utilization management” section provide additional protections or rights to you, those provisions will apply.

Notice of Decisions

After submission of a prior authorization request or claim, Curative will notify you within a reasonable time, as follows:

Prior Authorization Requests

For services requiring prior authorization, Curative will notify you of a favorable or adverse determination within a reasonable time appropriate to the circumstances, but no later than the third calendar day after receipt of the prior authorization request by Curative.

Urgent Care Prior Authorization Requests

An Urgent Care prior authorization request is about care that, if you do not receive it within a narrow window of time, you could: (a) seriously jeopardize your life or health or your ability to regain maximum function, or (b) cause yourself severe pain which (in the opinion of a physician who knows your health condition) could not be managed without the requested services.

Curative will determine whether a prior authorization request is for Urgent Care. This determination will be made on the basis of information furnished by or on your behalf. In making this determination, Curative will exercise its judgment, with deference to the judgment of a physician with knowledge of your condition. Accordingly, Curative may require clarification of the medical urgency and circumstances that support the prior authorization request for expedited decision-making.

Curative will notify you of a favorable or adverse determination as soon as possible, taking into account the exigencies particular to your situation, but not later than one hour after receipt of the prior authorization request by Curative.

Concurrent Care Determinations

Curative will review care and services during a hospital stay and if your provider recommends a longer stay than was first Prior Authorized, your provider may seek an extension for the additional days. Curative will respond to your provider request no later than 24 hours after receiving the request. Benefits will not be available for room and board charges for medically unnecessary days.

If a Prior Authorization has been issued for this hospitalization, Curative will only reduce or terminate when the physician or provider has materially misrepresented the proposed medical or health care service or has substantially failed to perform the proposed medical or health care services.

Post-Service Claims

A Post-Service claim is a claim for payment of benefits after services have been rendered. Curative will notify you of the benefit determination within a reasonable time, but not later than 30 days after receipt of the claim.

However, this period may be extended by an additional 15 days, if Curative determines that the extension is necessary due to matters beyond the control of the Plan. Curative will notify you of the extension before the end of the initial 30-day period, the circumstances requiring the extension, and the date by which a decision will be made.

If the reason for the extension is because of a failure to submit information necessary to decide the claim, the notice of extension will describe the required information.
Times for Decisions

The periods of time for claims decisions presented above begin when a claim is received by the Plan, in accordance with these claims procedures. However, the time periods described above for Curative to decide the claim or appeal will not run while Curative is waiting to receive information it has requested.

Times for Decisions

The periods of time for claims decisions presented above begin when a claim is received by the Plan, in accordance with these claims procedures. However, the time periods described above for Curative to decide the claim or appeal will not run while Curative is waiting to receive information it has requested.

Appeals of Adverse Determinations

You have the right to appeal any Adverse Determination of a claim and receive a fair review.

An Appeal of an Adverse Determination (clinical or non-clinical) may be filed by you or a person authorized to act on your behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you, except to your authorized representative. To obtain an authorization form, you or your representative may contact Curative Member Services at 855-428-7284 or email medicalmanagementteam@Curative.com.

For Clinical Adverse Determinations made on the basis of lack of medical necessity, or when services are determined to be experimental, investigational or cosmetic, a health care provider may appeal on the Member's behalf.

If you believe all or part of benefits were incorrectly denied, you may have your determination reviewed. If you have any questions about the claim's procedures or the review process, write to Curative or call Curative Member Services at 855-428-7284.

Time Period for Decisions on Appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent Care, Emergency Care, Denial of Prescription Drugs or Intravenous Infusions for which the patient is receiving benefits, Denial of Step Therapy exception requests prior authorization determinations. As soon as possible, but not later than the lesser of 72 hours or one working day after Curative has received the appeal request. (If oral notification is given, written notification will follow in hard copy or electronic format within the next three days.)

Prior Authorization Determinations. Within a reasonable period, but not later than 30 days after Curative has received the appeal request.

Post-Service Claims. Within a reasonable period, but not later than 30 days after Curative has received the appeal request.

Concurrent Care Decisions. As soon as possible, but not later than one working day after Curative has received the appeal request.

Appeal Denial Notices

Notice of a benefit determination on appeal will be provided to claimants by mail, postage prepaid, by facsimile, or by email, as appropriate, within the timeframes noted above.

A notice that a claim appeal has been denied will:

- State the specific reason or reasons for the adverse determination and the specific Plan provisions on which the determination is based.
- If the appeal denial relied on an internal rule, guideline, protocol, or other similar criterion, a copy of that rule, guideline, protocol, or other criterion or a statement that the claimant may receive a copy free of charge upon request.
- If the appeal denial is based on medical or dental necessity, experimental or investigational treatment, or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's circumstances, or a statement that such explanation will be provided free of charge upon request.

- A statement that the claimant on appeal is entitled to receive upon request and without charge, reasonable access to and copies of any document, record or other information relevant to his or her appeal.
- If applicable, a statement of the claimant's right to bring a civil action under ERISA Section 502(a) after exhaustion of the final appeal;

The notice of the claim appeal denial will also include:

- Information sufficient to identify the claim involved, including, to the extent available, the date of service, the provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- The denial code and its corresponding meaning (if available), and a description of the standard, if any, that was used in denying the appeal and a discussion of the decision.
- A description of the external review process after exhaustion of the final appeal, including information regarding how to initiate external review of a claim appeal denial.
- Contact information for any applicable office of health insurance consumer assistance or ombudsman established by the Department of Labor to assist individuals with the internal claims and appeals and external review procedures.
- Such other information as Curative determines is required by the ACA or other applicable law.

Exhaustion

Upon completion of the entire appeals process, a claimant will have exhausted his or her administrative remedies under the Plan. If Curative fails to complete a claim determination or appeal within the time limits set forth above, the claimant may treat the claim or appeal as having been denied, and the claimant may contact Curative to ask for confirmation that the claim has been denied, proceed to the next level in the review process, or (if applicable) bring a lawsuit under Section 502(a) of ERISA.

Voluntary External Review Appeal

If a claim is still denied after the claimant has followed Curative's appeal procedures, the claimant may have the option to file a voluntary appeal for external review by an independent review organization. This applies if the claim denial is based on a determination that involves (i) medical judgment, such as the service or treatment is not medically necessary or is an experimental or investigational service, (ii) a rescission of coverage (i.e., a retroactive cancellation of coverage for reasons other than the claimant's failure to timely pay contributions toward the cost of coverage), or (iii) a determination that surprise medical billing protections do not apply.

How the Voluntary Review Appeal Works

The external review process gives the claimant the opportunity to have certain coverage denials reviewed by independent physician reviewers. Under a voluntary external review:

- Curative sends the claim to an independent review organization (IRO) with which it has contracted to provide review services;
- The IRO then refers the case for review to a medical professional it has selected with appropriate expertise in the area in question;
- Once all necessary information is submitted, the external review requests will generally be decided within 45 days of the request. Expedited reviews are available when the claimant's provider certifies that a delay in service would jeopardize the claimant's health, life, or ability to regain maximum function or in cases where the final claim denial concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services and has not been discharged from the facility; and
- The decision of the independent external expert reviewer is binding on Curative and the Plan. The claimant will not be charged a professional fee for the review.

How to File for an External Review

The claimant generally must complete the standard internal appeal described above before requesting external review. The claimant must request an external review from Curative within four (4) months after receipt of the final denial notice under the standard appeal process. If no date corresponds to the date that is four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a weekend or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

Subject to verification procedures, the claimant's authorized representative may act on the claimant's behalf in filing and pursuing this review. If a voluntary external review appeal is filed, any applicable statute of limitations or other timelines will be "tolled" (suspended) while the appeal is pending. Whether or not a claimant seeks an external review will have no effect on the claimant's rights to any other benefits under the Plan or information about applicable rules.

Because an external review is voluntary, a claimant is not required to undertake an external appeal before pursuing legal action. Upon request, the claimant will be provided additional information about the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker.

If external review is not requested, the Plan will not assert that the claimant failed to exhaust administrative remedies due to that choice.

Subrogation, Reimbursement and Third-Party Recovery Provision

Subrogation

If the Curative Plan pays and provides benefits for you and your dependents, the plan is subrogated to all rights of recovery which you and your dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the plan has paid or provided. That means the plan may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer. For the purpose of this provision, subrogation means the substitution of one person or entity (the Plan) in the place of another (you and your dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the right of the other in relation to the debt or claim, and its rights and remedies.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the plan will have a right of reimbursement. If you and your dependent recover money from any person, organization, or insurer for any injury or condition for which the plan paid benefits, you or your dependent agree to reimburse the plan from the recovered money for the amount of benefits paid or provided by the plan. That means you or your dependent will pay to the plan the amount of money recovered by you through judgment, settlement, or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the plan.

Right to Recovery by Subrogation or Reimbursement

You and your dependent agree to promptly furnish to the Plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Plan in protecting and obtaining its reimbursement and subrogation rights. You, your dependent and attorney will notify the plan before settling any claim or suite so as to enable Curative to enforce our rights by participating in the settlement of the claim or suite. You and your dependent further agree not to allow the

reimbursement and subrogation rights of the Plan to be limited or harmed by any acts or failure to act on your part.

COORDINATION OF BENEFITS (COB)

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

Definitions

(A) A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only

coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under (a)(1) or (a)(2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

"This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

(C) "Allowable expense" is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care provider's or physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

(D) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a non preferred health care provider or physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(E) "Closed panel plan" is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

(F) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(A) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

(B) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both plans state that the complying plan is primary.

(C) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(D) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

(E) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a non contracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(F) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

(G) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any

other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

(H) Each plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(B) For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

(i) if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

(iv) if there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
(I) the plan covering the custodial parent;
(II) the plan covering the spouse of the custodial parent;
(III) the plan covering the noncustodial parent; then
(IV) the plan covering the spouse of the noncustodial parent.

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

(D) For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, (h)(5) applies.

(E) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.

(3) Active, Retired, or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is

the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

(A) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(B) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by an out-of-network provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

COMPLIANCE WITH FEDERAL AND STATE LAWS CONCERNING CONFIDENTIAL INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Curative will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give Curative any facts it needs to apply those rules and determine benefits.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Curative may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Curative will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Curative is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Plan Provisions

Eligibility

The eligibility date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when they become an employee or a dependent and is in a class eligible to be covered under the Plan.

Your eligibility date will be determined by the Plan in accordance with your Employer's established eligibility procedures.

Employee Eligibility

If you are eligible to participate in your Employer's Benefit Program, you are eligible for the benefits described in this Benefit Booklet.

For purposes of this Plan, the term Eligible Employee will also include those individuals who are no longer an employee of the Employer, but who are covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA). You may enroll for coverage for yourself (or for yourself and your dependents) on or before your benefit eligibility date, within 31 days of your eligibility date or during the annual enrollment period

Dependent Eligibility

If you are eligible for coverage, you may include your dependents. If you and your spouse or domestic partner are both eligible employees for your Employer's Plan, then your children may be covered as dependents of either parent, but not both. In addition, a spouse or domestic partner that is an eligible employee for your Employer's Plan may not be covered as a dependent.

The Plan defines dependents as:

- Your spouse or domestic partner;
- Your children under the age of 26 regardless of their marital status, including:
    - Biological children;
    - Stepchildren and adopted children;
    - Grandchildren you claim as dependents on your federal income tax filing;
    - Children for whom you are named a legal guardian or who are subject of a medical support order requiring such coverage; and
    - Certain children over age 26 who are determined to be medically incapacitated and are unable to provide their own support.

For a dependent that is eligible due to a medical support order, and who resides outside Curative's service area (but inside the United States, Curative will make necessary arrangement in compliance with applicable state law to ensure access to network and out-of-network benefits. Please call Member Services to notice Curative of the need to make the arrangements.

LIFE EVENT CHANGES

You have 31 days from the date of a qualifying life event to notify your employer and change your Plan elections. If you do not make the changes during the 31-day status change period, your changes cannot be made until the Annual Enrollment period for your Plan to be effective on the next Plan Year's effective date.

Qualified life events include:

- Marriage, Divorce, Annulment, Legal Separation or a Spouse's/Domestic Partner's death;
- Birth, Adoption, Medical Child Support Order, or Dependent's death;
- Significant change in residence if the change affects you or your dependent's current plan eligibility;
- Starting or ending employment, starting or returning from unpaid leave of absence, or change of job status affecting eligibility for benefits;
- Change in dependent eligibility; and
- Significant change in coverage or cost of other benefit plans available to you and your family.

Your benefit selection changes must be consistent with your change in status.

SPECIAL ENROLLMENT

Under the Health Insurance Portability and Accountability Act (HIPAA), you are allowed to enroll yourself and your eligible dependents outside of the annual enrollment period when certain events occur. Special enrollment rights exist when:

- You acquire a new dependent due to marriage, birth, adoption or placement for adoption;
- You declined coverage under the Plan during a previous enrollment period because you were covered under another group health plan (or group health insurance), but you subsequently lose your other coverage for any of the following reasons:
    - You or your dependents exhaust COBRA continuation coverage under another employer's group health plan (other than due to failure to pay contributions or for cause);
    - Employer contributions toward the other group health plan coverage terminate; or
    - You or your dependents lose eligibility under the other group health plan or health insurance coverage (other than due to your failure to pay contributions or for cause), including:
        - As a result of legal separation, divorce, cessation of dependent status, death, termination or reduction in hours of employment;
        - In the case of an individual HMO policy, loss of coverage because you no longer reside or work in the service area;
        - In the case of a group HMO, loss of coverage because you no longer reside or work in the service area, provided that no other benefit package is available to you; or
        - Your current employer decides to stop contributing for your coverage.
- You or your dependent becomes:
    - Ineligible for coverage under a Medicaid plan or a state child health plan, and as a result coverage is terminated; or
    - Eligible for a premium assistance subsidy for the Plan under Medicaid or a state child health plan.

When your special enrollment right results from acquiring a new spouse or dependent through marriage, birth or adoption, you may enroll your new spouse or dependent in the Plan. In addition, if you are not already enrolled in the Plan, you may enroll yourself during the special enrollment period. If your spouse is not already enrolled in the Plan and you have special enrollment rights because you acquire a new dependent, you may enroll your spouse during the special enrollment period. However, you may not enroll any other dependents who were already eligible for benefits but not previously enrolled in the Plan.

The request for a change in coverage must be made within 31 days of the special

enrollment event, unless the special enrollment event is you or your dependent becoming ineligible for coverage under a Medicaid plan or a state child health plan, or you or your dependent becoming eligible for a premiums assistance subsidy for the Plan under Medicaid or a state child health plan. For these special enrollment events, the request for a change in coverage must be made within 60 days of the date you lose coverage or become eligible for coverage, as applicable.

Termination of coverage

Coverage under the Curative Plan will terminate for you and your dependents if any of the following occur:

- Your portion of the premium cost-share is not received timely;
- The last day of the month in which you lose eligibility to participate in the plan;
- The plan is amended to terminate the coverage of the class of employees to which you belong; or
- A dependent ceases to meet the plan's definition of a dependent.

Coverage for a child of any age who is medically certified as disabled and dependent on the parent will not terminate upon reaching the limiting age shown in this Benefit Booklet if the child continues to be both disabled and dependent upon the employee as determined by the Plan as an incapacitated dependent.

As a condition to the continued coverage of a child as a disabled dependent beyond the limiting age, the Plan may require periodic certification of the child's physical or mental condition (but not more frequently than annually).

The coverage of all Members will be terminated if the plan is terminated in accordance with its terms.

Termination of Coverage - Fraud or Intentional misrepresentation of a material fact

We will provide at least 30 days notice to you that your coverage will end on the date we identify in the notice because you engaged in an act or omission that constituted fraud, or an intentional misrepresentation of a material fact. You may appeal this decision prior to the termination date set forth in the notice. The notice will include information on how to appeal. If you have engaged in an act or omission that constitutes fraud or an intentional misrepresentation of material, fact we may demand that you pay back all amounts we paid to you, or paid in your name, while coverage was incorrectly effective.

Extended coverage for total disability

Coverage when you are Totally Disabled on the date the entire Policy ends will not end automatically. We will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Ninety days from the date coverage would have ended when the entire Policy ends.

Coverage will not be extended by this provision if your coverage is being discontinued and replaced with coverage that is provided by a succeeding carrier and the coverage provides a level of benefits that is at least substantially equal to the level of benefits provided under this plan.

Continuation of employer's coverage (cobra)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) passed by Congress provides that when Members (Employees and their Dependents) lose their eligibility for health coverage due to any of the events listed below, they may elect to continue their health plan coverage. The continued coverage can remain in for a maximum period of either 18, 29 or 36 months depending on the reason that eligibility for health plan coverage terminated.

You may qualify for a 18-month continuation of coverage when:

- Reduction of employee work hours; or
- Employee retirement or termination of employment (voluntary or involuntary), except for termination for misconduct.

You may qualify for a 29-month continuation of coverage when:

- Any Member is determined by the Social Security Administration to be disabled at any time before the 60th day of COBRA coverage. The disability must last through the initial 18 month period of COBRA coverage, and the Member must provide proof of the disability determination to your employer (or their designated COBRA Administrator).

Note: The extension will not be granted if documentation of disability by the Social Security Administration is not provided during the initial 18-month eligibility period.

Multiple Qualifying Events

If your covered dependent experiences another qualifying event during the 18 months of COBRA continuation coverage, your covered dependent can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. The dependent qualified beneficiary may qualify for this 18-month extension of the continuation coverage period if the second qualifying event is:

- Death of the employee;
- Divorce or legal separation from the employee;
- Medicare eligible employee (employee becomes eligible for Medicare, leaving

dependents without coverage); or
- Children who lose coverage due to eligibility requirements.

To be considered a multiple qualifying event, such an event would have caused the qualified beneficiary to lose coverage had the first qualifying event not occurred. It is the responsibility of the dependent qualified beneficiary to notify your employer (or their designated COBRA Administrator) within sixty days of the multiple qualifying event.

Eligibility for Continuation of Coverage:

Members (employees and dependents) covered by the Plan at the time of the qualifying event are qualified beneficiaries and are eligible for continuation of coverage. Each may make an independent COBRA election. A child born or adopted by the employee during COBRA coverage is also eligible to be a qualified COBRA Member upon timely application.

How you can elect COBRA Continuation Coverage:

If the COBRA qualifying event is due to an employee's death, Medicare eligibility, or termination of employment (or reduction in hours), your employer (or their designated COBRA Administrator) will provide you with a COBRA election notice after your loss of coverage. The notice will be sent to eligible Members.

- If the qualifying event is for either a divorce of an employee or a child becoming ineligible for coverage, the Member(s) losing coverage should notify the employer within 60 days of the qualifying event. Then the COBRA election notice will be sent to either the spouse, domestic partner or child who is losing coverage.
- The notice must include the names of covered individuals and the reason for and date of the qualifying event. If a Member does not give notice within the required time period, the Member may not elect continuation coverage.

Eligible COBRA qualified beneficiaries will have 60 days after the later of the date of the COBRA election notice or their loss of coverage due to the qualifying event, or as otherwise provided in the COBRA election notices, to give written notice of their election to continue coverage.

Initial Payment:

When electing continuation coverage, you are not required to remit any payment with the election. You have 45 days from the date of election (post-mark date if mailed) to remit your initial payment. Benefits will be reinstated back to the date of termination from the plan after the payment has been received and processed. You will need to make sure that the payment amount is correct. If you have any questions regarding the amount and how to make the payment, please contact the employer or the designated COBRA Administrator.

Note: If payment is not received within the 45 days from your election date, you will not be eligible to continue coverage under the Plan.

Continuing Monthly Payments:

After you have made your first payment, you will be required to make payments for each month. Payments are due on the first day of the month with a 30-day grace period. If the payment is not received by the due date, the coverage will be suspended, and benefits may not be accessible during this time until payment is received. If the payment is received prior to the end of the grace period, coverage will be reinstated once payment has been processed.

If you fail to make the full payment before the end of the grace period, you will lose all rights to continuation of coverage under the Plan

Termination of Continuation of Coverage:

A service fee of 2% of the premium rate for Members is added to the premium and is payable by the continued Member. An extra premium of 50% may be added to the premium for Members who extend coverage from 18 months to 29 months due to disability. You are responsible for the full premium amount.

If you have any questions, please contact either the employer or the Member's continuation of coverage will terminate if any of the following occurs:

- The maximum qualifying time period expires;
- A continued Member obtains coverage after the date of election under any other health plan which does not contain an applicable exclusion for any Pre-existing Condition for the Member;
- A continued Member becomes covered by any Medicare benefits after the date of the election;
- The employer no longer provides health coverage from Curative for their employees; or
- The required payment to continue coverage is not made on a timely basis.

A Member on Continuation Coverage may also be terminated for fraud or intentional misrepresentation of material fact to the same extent the coverage for a similarly situated non-continued Member could be terminated.

Benefits for a Member on Continuation Coverage will be the same as those for active Members. Premium rates will be based upon the Employer's rates for an active employee and dependents. If the employer receives changes to their benefits or rates during the continuation period, the continued Member will receive the new benefits and the new rates will apply.

If continuation of coverage is not elected, your Plan coverage will end the last day of the month in which you were eligible and enrolled.

CONTINUATION OF COVERAGE UNDER STATE OF TEXAS LAW

You may elect State Continuation as described under the State of Texas Continuation Coverage provisions below.

Qualifying Events for State of Texas Continuation Coverage for Reasons other than Severance of the Family Relationship

A member whose coverage terminates due to any reason except involuntary termination for cause, and who has been continuously covered under the plan (including any similar group coverage the plan replaced) for at least three consecutive months immediately prior to termination, is entitled to continue coverage under state law. A person whose coverage terminates due to severance of the family relationship may either continue coverage as described immediately below, or if the person meets the requirements described in *Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship* may continue coverage as described there.

Notification Requirements, Election Period and Premium Payment for State of Texas Continuation Coverage Due to Reasons Other than Severance of the Family Relationship

The member must provide a written request for Continuation Coverage to the plan administrator within 60 days after the later of:

- The date Group coverage would otherwise terminate
- The date the Covered Person is given notice of the right to elect continuation.

The member must pay the premium for the continuation coverage to the employer within 45 days after the date of the initial election of coverage continuation and then on a monthly basis no later than the 30th day after the premium payment due date.

Terminating Events for State of Texas Continuation Coverage Due to Reasons Other than Severance of the Family Relationship

State of Texas Continuation Coverage due to reasons other than severance of the family relationship will end on the earliest of

- Nine months from the date state continuation coverage was elected, if the Covered Person is not eligible for Continuation of Coverage under Federal Law (COBRA)
- Six months from the date state continuation coverage was elected, if the state continuation coverage followed continuation coverage under Federal law (COBRA).
- The date coverage ends for failure to make timely payment of the Premium.

Qualifying Events for State of Texas Continuation Coverage Due to Severance of the Family Relationship

A member whose coverage terminates may elect state continuation coverage under the plan if:

- The member has been covered under the plan for at least one year, or is an infant under one year of age
- The member's coverage under the plan was terminated for one of the reasons set forth below
- Termination of the eligible member from employment
- Death, Divorce, or Retirement that severed the family relationship or terminated eligibility for a dependent

Notification Requirements, Election Period and Premium Payment for State of Texas Continuation Coverage Due to Severance of the Family Relationship

A member must provide written notice to the Group within 15 days of any severance of the family relationship that might qualify for the continuation - see *Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship*. The policyholder will immediately give written notice of the right to state continuation. Within 60 days of severance of the family relationship or a retirement that impacts a member's eligibility as a dependent, the dependent must give written notice to the policyholder of the intent to continue the coverage through state continuation. Coverage under the plan will remain in place during the 60-day election period if the necessary premium is paid. The member must pay the monthly premium for the coverage continuation to the employer each month. To avoid termination, the monthly continuation premium must be paid on or before the 30th day after the due date.

Termination Events for State of Texas Continuation Coverage Due to Severance of the Family Relationship

State of Texas Continuation Coverage due to severance of the family relationship will end on the earliest of the following dates:

- Three years from the date that the family relationship was severed or the date of the eligible member losing eligibility due to death or retirement.
- The date the continued member fails to timely pay the required premium.
- The date the continued member becomes eligible for substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program.

Glossary Of Terms

Accidental Injury means accidental bodily injury resulting, directly or independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

ADL (Activities of Daily Living) means the tasks of everyday living. Basic ADLs include eating, dressing, getting into and out of bed or chair, taking a bath or shower, and using the toilet.

Adverse Determination means a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational.

Allowable Amount means the maximum amount that will be paid by Curative for a medical service, supply, or drug. The allowable amount is the amount based upon usual and customary rates paid to similar providers or the negotiated rates with providers who have contracted with Curative.

Anniversary Date means the yearly return of the Employer's Annual Effective Date.

Annual Open Enrollment Period means an annual thirty-one (31) day period, beginning no less than thirty (30) days prior to the Anniversary Date of the Employer's health benefits program, during which:

- If the Employer has established and maintained more than one Plan for their Eligible Employees, an Eligible Employee who had elected another Plan, and maintained coverage under that Plan up to the beginning of the Annual Open Enrollment Period, can change to this Employer Contract.
- Eligible employees who decided not to enroll themselves and/or their Eligible Dependents for coverage under the Employer Contract during the Initial or Special Enrollment Periods can enroll.

Autism Spectrum Disorder means a neurobiological disorder that includes Autism, Asperger's syndrome, or Pervasive Development Disorder – Not Otherwise Specified.

Baseline Visit is the in-person meeting with a Curative Clinician to onboard you to the Curative Health Plan, understand your health goals and how we can best work with you to meet your current and future healthcare needs. The Baseline Visit will also include an Evaluation of Preventive recommendations indicated by the United States Preventive Services Task Force (USPSTF) and evaluate whether your immunizations are up to date, all designed to keep you healthy.

Behavioral Health Practitioner - means a Physician or a Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Substance Use Disorder.

Brand Name Drugs are medications developed, patented, and sold under a trademarked name which typically will not be available as a Generic Drug until the patent has expired.

Calendar Year means the period beginning on the original effective date of this policy and ending on December 31 of that year. For each following year it is the period beginning on January 1 and ending on December 31.

Child means a natural child, a stepchild, an adopted child (including a child for whom you or your spouse or domestic partner is a party in a suit in which the adoption of the child is sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, or any combination of those factors. A child of your child must be dependent on you for federal income tax purposes at the time of the enrollment of coverage for the child of your child is made under the Plan. A child not listed above whose primary residence is your household and to whom you are legal guardian or related by blood or marriage and who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States, is also considered a Dependent Child under the Plan.

Clinical Appeal means a request to change an Adverse Determination for care or services that were denied on the basis of lack of medical necessity, or when services are determined to be experimental, investigational or cosmetic. May be pre-service or post-service. Review

is conducted by a physician. Members or their authorized representatives may file a clinical appeal. Providers may also file a clinical appeal on the Member's behalf.

Clinical Care Coordinator means the Curative designated clinical staff member who reviews requests for Utilization Management review.

Clinical Trials means an experimental or investigational research study performed to evaluate a new medical treatment prior to FDA approval.

Complications of Pregnancy means: (a) conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (b) non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Coinsurance means the percentage of covered expenses that must be paid by you after the applicable Copay and Deductible amounts. This percentage is shown on the Summary of Benefits.

Coordinated Home Care means organized skilled intermittent patient care initiated by a hospital or other inpatient facility to facilitate the discharge and planning of its patients into home care under the orders of a qualified physician.

Copay (Copayment) means the amount You are required to pay to a Network Provider or other authorized provider in connection with the provision of Covered Health Services. The Copay amounts are indicated in the Summary of Benefits.

Covered Health Services or Covered Services means those medical and health care services and items specified and defined in the Benefit Booklet as being covered services but only when such services and items are medically necessary and when they are performed, prescribed, directed, or authorized in accordance with Our policies and procedures and this Benefit Booklet.

Crisis Intervention means a short-term process which provides intensive supervision and highly structured activities to the Member who is demonstrating an acute medical or psychiatric crisis of severe proportions, which substantially impairs the Member's thoughts, perception of reality, and judgment, or which grossly impairs behavior.

Crisis Stabilization Unit or Facility means a 24-hour residential program that is usually short-term in nature and provides intensive supervision and highly structured activities to persons who are demonstrating an acute psychiatric crisis of moderate to severe proportions.

Cryotherapy (or cold therapy) means the treatment of pain and/or inflammation by lowering the temperature of the skin over the affected area.

Custodial Care means care not given primarily for therapeutic value in the treatment of an Illness or Injury and is provided primarily for the maintenance of the Member and is essentially designed to assist in the activities of daily living (ADL). We and/or an independent medical review board will decide if a service or treatment is Custodial Care.

Deductible means the amount of out-of-pocket expense that must be paid for health care services by the Member before becoming payable by Curative. The family deductible means that a family of 3 or more will only need to meet a total of 2 Members' individual deductibles.

Dependent means your spouse, domestic partner, or any child covered under the Plan. For purposes of this Plan, the term Dependent will also include those individuals who no longer meet the definition of a Dependent but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the Texas Insurance Code. and who has become enrolled as a Member of Curative.

Diabetic Supplies and Equipment means equipment and supplies for the treatment of diabetes for which a physician or practitioner has written an order, including blood glucose monitors, including those designed to be used by or adapted for the legally blind; test strips specified for use with a corresponding glucose monitor; lancets and lancet devices; visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein; insulin and insulin analog preparations; injection aids, including devices used to assist with insulin injection and needleless systems; insulin syringes; biohazard disposal containers; insulin pumps, both external and implantable, and associated appurtenances, which include insulin infusion devices; batteries; skin preparation items; adhesive supplies; infusion sets; insulin cartridges;

durable and disposable devices to assist in the injection of insulin; and other required disposable supplies; repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump; prescription medications for controlling the blood sugar level; podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; glucagon emergency kits.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies shall be covered after the previous device's life expectancy fails or fails due to no fault of the Member if determined to be medically necessary and appropriate by a treating physician or other practitioner through a written order. All supplies, including medications, and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitution is approved by the physician or practitioner who issues the written order for the supplies or equipment.

Diabetic Self-Management Training means training including (i) Training provided after the initial diagnosis of diabetes, including nutritional counseling and proper use of Diabetes Equipment and Supplies; (ii) additional training authorized on the diagnosis of a significant change in Your symptoms or condition that requires changes to Your self-management regime; and (iii) periodic or episodic continuing education training as warranted by the development of new techniques and treatments for diabetes.

Digital Mammography means Mammography creating breast images that are stored as digital pictures.

Domestic Partner means a person who is not married to the enrolled employee but is in a committed relationship and plans to remain in the relationship. The domestic partner must be 18 years of age and reside with the member. The domestic partner may be the same or opposite gender or the member.

Effective Date means the date on which coverage begins for You and your dependents if they are enrolled in the Plan.

Eligible Employee means an employee who works on a full-time basis, working a normal work week for the number of hours designated by their employer to qualify as an eligible Member.

Eligible Expenses means either, Inpatient Hospital Expenses, Medical Expenses, Extended Care Expenses, DME, Prosthetics, or Pharmacy Expenses as described in this Benefit Booklet.

Emergency eans the health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson to believe that the individual's condition if left untreated could place their health in serious jeopardy, impair bodily functions, or result in serious disfigurement, and for a pregnant woman, result in serious jeopardy to the health of the fetus. Emergency care also pertains to behavioral health services. Curative covers medical emergencies wherever they occur in the United States. In case of an emergency, call 911 or go to the nearest emergency room.

Employer means the employer with 51 or more employees who signed the Employer Agreement with Curative, allowing this Employer's coverage to be provided.

Enrollment Forms mean the forms prescribed by Curative which the Member shall be required to complete and submit to the Employer for the purpose of enrolling them and any Eligible Dependents for coverage hereunder.

Experimental and Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical treatment of the condition being treated or any such items requiring Federal or other governmental agency approval not granted at the time services are rendered.

Facility means a health care or residential treatment center licensed by the state in which it operates to provide medical inpatient, residential, day treatment, partial hospitalization, or outpatient care.

Family means You and Your Dependents who are covered under this Plan.

Formulary is a list of over the counter, generic, brand-name and specialty prescription drugs, devices and supplies that are covered and dispensed by a Pharmacy. The listing is developed based on the efficacy and safety of the drugs.

Freestanding Emergency Medical Care Facility means a facility, structurally separate and distinct from a hospital that receives an individual and provides emergency care, as defined under Chapter 254, Health and Safety Code.

Gender Dysphoria means the feeling of discomfort or distress that occurs when gender identity differs from the gender assigned at birth.

Generic Drugs are medications that by law must have the same active ingredients and are subject to the same US Food and Drug Administration (FDA) standards for quality, strength, performance, and purity as their Brand Name counterpart. Generic drugs usually cost less than Brand Name drugs.

Home Health Care means the skilled health care services that are provided during a visit by a Home Health Agency to Members confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is: (1) Licensed in accordance with state law; or (2) Certified by Medicare as a supplier of Hospice Care.

Hospital means an acute care institution licensed by the State of Texas as a Hospital, and is accredited under the Joint Commission which is primarily engaged, on an inpatient basis, in providing medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, under supervision of a staff of Physicians and with 24-hour a day nursing and Physician service; provided, however, it does not include a nursing home or any institution or part thereof which is used principally as a custodial facility.

Identification Card (ID Card) means the card issued to the Curative Member indicating pertinent information applicable to their coverage. This card should be presented to your healthcare provider at time of services.

Intensive Outpatient Program means a freestanding or hospital-based program that provides services in a facility for a few days per week, for few hours per day, to treat mental illness, drug addiction, substance abuse or alcoholism, or Substance Use Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorder.

Imaging Center means a Provider that can furnish technical services with respect to diagnostic imaging services and is licensed by an agency of the State of Texas having legal authority to license, certify and approve.

Imaging Services including, but not limited to, CT Scan; MRI (Magnetic Resonance Imaging); PET Scan (Positron Emission Tomography).

In-Network Benefits means the coverage available under the plan for services, supplies and drugs that are provided by a Network Provider who has contracted with Curative.

Independent Review Organization (IRO) means an organization selected to review your medical care and benefit determination as provided under the Texas Insurance Code (also known as an IMR - Independent Medical Review).

Life-Threatening means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Mammography means the x-ray examination of the breast using equipment dedicated specifically for Mammography.

Maternity Care means care, and services provided for treatment of the condition of pregnancy.

Medical Copays and Deductibles means for services related to providers providing medical treatment. These do not reflect the Pharmacy benefit copays, deductible and annual maximum.

Medical Director means an accredited Physician designated by Curative to monitor appropriate provision of medically necessary Covered Health Services to Members in accordance with the Plan.

Medical Injectables means any medication that is infused via intravenous infusion (IV), injected intramuscularly (IM), where medical supervision is required, or must be administered at the point of care (i.e.: Dialysis Centers). These drugs will be defined by the Curative Pharmacy and Therapeutics Committee.

Medical Expenses means the Allowable Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Member, provided such items are:

- Furnished by or at the direction of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
- Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the discretion of a Physician, Behavioral Health Practitioner or Professional Provider if the listed service or supply is:

- Provided by a person employed by the directing Physician, Behavioral Health Practitioner or Professional Provider;
- Provided at the usual place of business of the directing Physician, Behavioral Health Practitioner or Professional Provider; and
- Billed by the directing Physician, Behavioral Health Practitioner or Professional Provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Medically Necessary/Medical Necessity means the health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider; and (d) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. No service is a Covered Service unless it is Medically Necessary.

Medicare means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or subsequently amended.

Member means a person who has enrolled in Curative as an Employee or Dependent and is eligible to receive Covered Health Services. This person sometimes is also referred to as a Participant, Enrollee or Patient

Neonatal Intensive Care Unit (NICU) means a special care nursery or intensive care nursery. Admission into NICU generally occurs but is not limited to when the Newborn is born prematurely, if difficulty occurs during delivery, or the Newborn shows signs of a medical problem after the delivery.

Network means identified Physician, Behavioral Health Practitioner, Professional Other Providers, Hospitals, Pharmacies, and other facilities that have entered into agreements with Curative as a network contracted provider or facility.

Network Provider means a Hospital, Physician, Behavioral Health Practitioner, Pharmacy, or other Provider who has entered into an agreement with Curative as a network contracted provider.

Neurocognitive Rehabilitation means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurophysiological Testing means an evaluation of the functions of the nervous system. (i.e. EMG-Electromyography, Intraoperative Neurological Monitoring)

Non-Clinical Appeal means a request to reconsider a previous inquiry, complaint or action by Curative that has not been resolved to the Member's satisfaction. This relates to administrative health care services such as enrollment, access, claim payment, etc. and may be pre-service or post-service. Review is conducted by a Non-Medical Appeal Committee. Only Members or their authorized representatives may file a non-clinical appeal.

Non-Network Provider Reimbursement means the amount Curative will consider for eligible medical care from non-contracted providers. We determine this amount based on the payment methodology established by Curative. You may be responsible for the balance due to the provider over the amount considered as the allowable amount covered by Curative.

Open Enrollment means the annual period each year in which You can make changes to Your Plan benefits.

Oral Anticancer Drugs Curative covers medically necessary Anticancer drugs that are used to treat cancer and are taken orally. They are typically part of the Specialty Drugs category and are categorized either traditional, targeted or hormonal. Refer to the Curative Formulary for the drugs that are covered in this category.

Organ Transplant means the harvesting of a solid and/or non-solid organ, gland, or tissue from one individual and reintroducing that organ, gland, or tissue into another individual.

Orthotics means prescribed medical devices that are applied to a part of the human body to correct a deformity, improve function, and relieve symptoms of a disease.

Out-of-Pocket Maximum means the total dollar amount a Member must pay each Calendar Year before We pay benefits at 100%. The Out-of-Pocket Maximum includes copayments. It does not include premiums, non-covered services, and balance billing amounts.

Palliative Care means specialized medical care focused to provide relief from the symptoms and illness with the goal of improving the quality

of life for a patient with chronic, complex, or terminal illnesses.

Physician means any person who is duly licensed and qualified to practice within the scope of a medical practice license issued under the laws of the State of Texas or in which state treatment is received. Physicians include a doctor of osteopathic medicine.

Plan, Your Plan, The Plan means the coverage of health care services available to You under the terms of this Benefit Booklet.

Plan Year means the annual period that begins on the anniversary of the Plan's Effective Date. See the Schedule of Benefits for details as to if Your Plan is administered on a Calendar Year or Contract Year basis.

Post-Acute Care means services provided after acute-care confinement and/or treatment that are based on an assessment of the patient's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or reestablishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Prescription Drug means any medicinal substance whose label is required to bear the legend "RX only" and FDA approved.

Prior Authorization means the review of the requested services for the medical appropriateness in advance of certain care and services under this Plan.

Prosthetics means prescribed devices meant to replace, wholly or partly, a lost limb or body part, such as an arm or a leg. Covered benefits may be limited to the appropriate model of prosthetic device that adequately meets the medical needs of the Members as determined by the Member's physician.

Provider means a Hospital, Physician, Behavioral Health Practitioner, Other Provider, or any other person, company or institution furnishing to a Member an item of service, supply or drug covered by the Curative Plan.

Partial Hospitalization /Psychiatric Day Treatment Facility means a free-standing facility that provides structured treatment for not more than eight hours in any 24-hour period after which the Member is allowed to leave. These facilities treat mental illness, drug addiction, substance abuse or alcoholism, or Substance Use Disorder or specialize in the treatment of co-occurring Mental Illness and Substance Use Disorder. The Joint Commission must accredit such facilities.

Remediation means the process(es) of restoring or improving a specific function.

Residential Treatment Center means a facility setting (including a Residential Treatment Center for Children and Adolescents) offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and 24-hour onsite nursing service. Curative requires that any facility providing Mental Health Care and/or a Substance Use Disorder treatment program be accredited as a residential treatment center by the Council on Accreditation, the Joint Commission or the American Association of Psychiatric Services for Children.

Rider means a supplement to Your Plan that describes any additional coverages, changes in Your coverage, or the terms of Your coverage under the Plan. We may provide Riders to You at the time You enroll in the Plan or at other times after that.

Self-Injectables means any medication that is injected subcutaneously or specifically designed and generally accepted to be self-injected and does not require direct medical professional oversight. These drugs will be defined by the Curative Pharmacy and Therapeutics Committee.

Skilled Nursing Facility means an institution which:

Is accredited under one program of the Joint Commission as a Skilled Nursing Facility or is recognized by Medicare as an Extended Care Facility:

- Is not a Rehabilitation Facility;
- Furnishes room and board and 24 hour-a-day skilled nursing care by, or under the supervision of a registered nurse (RN); and
- Is not a clinic, rest Facility, home for the aged, place for drug addicts or alcoholics, or a place for Custodial Care.

Special Enrollment Period means an enrollment period that is provided for employees and/or their dependents due to special circumstances as described in the Special Enrollment provision.

Telemedicine / Telehealth means a synchronous, interactive office visit with your provider through the use of

interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. The term does not include services performed using a telephone. Health care services will not be excluded based solely on the fact that they were provided through telemedicine / telehealth and not provided through a face-to-face consultation.

Total Disability (Totally Disabled) means the complete inability of that individual to perform all of the substantial and material duties and functions of the individual's occupation and any other gainful occupation in which the individual earns substantially the same compensation earned before the disability; and with respect to any other individual covered under a health plan, confinement as a bed patient in a hospital.

Toxic Inhalant means a volatile chemical under Chapter 484, Texas Health and Safety Code, or abusable glue or aerosol paints under Section 485.001, Texas Health and Safety Code.

Ultrasound, Breast means a procedure that may be used to determine whether a lump is a cyst or a solid mass.

Us, We or Our means Curative.

Utilization Review means a system for prospective and/or concurrent review of the Medical Necessity and appropriateness of Covered Health Services Your provider is currently providing or proposes to provide to You. Utilization Review does not include elective requests by You for clarification of coverage. The Utilization Review provides:

- Pre-treatment Review;
- Concurrent Review;
- Discharge Planning; and
- Retrospective Review

Virtual Urgent Office Visit means a synchronous, interactive, virtual office visit with a 24/7/365 On Demand Urgent Care Doctor through the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education.

Waiting Period means the period, if any, that must pass with respect to an individual before the individual is eligible to be covered for benefits under the Curative Plan.

You or Your means a covered Member.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Curative's toll-free telephone number for information or to make a complaint at:

1-855-428-7284

You may also write to Curative at:

P. O. Box 1786
Austin, TX 78767

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P. O. Box 149104
Austin, Texas 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES

Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Curative para obtener información o para presentar una queja al:

1-855-428-7284

Usted también puede escribir a Curative:

P. O. Box 1786
Austin, TX 78767

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P. O. Box 149104
Austin, Texas 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES

Si tiene una disputa con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA

Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

Curative Nondiscrimination and Assistance with Communication Notice

Curative does not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of sex, age, race, color, national origin, or disability.

Assistance is available at no cost to help you communicate with us. The services include, but are not limited to:

- Interpreters for languages other than English;
- Written information in alternative formats such as large print; and
- Assistance with reading the Curative website

To ask for help with these services, please call Curative Member Services at 855-428-7284.

If you think that we failed to provide language assistance or alternate formats, or you were discriminated against because of sex, age, race, color, national origin, or disability, you can send a complaint to:

Curative

P. O. Box 1786
Austin, TX 78767
Phone: 855-428-7284
Email: health@curative.com

You can also file a complaint with the US Department of Health and Human Services, the Office of Civil Rights:

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html
- Phone: 1-800-368-1017, 1-800-537-7697 (TDD)
- Mail: US Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, DC 20201

If you need help with your complaint, please call 855-428-7284.

Texas Department of Insurance Notice

You have the right to an adequate network of In-Network providers. If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

You have the right, in most cases, to obtain estimates in advance:

- from out-of-network providers of what they will charge for their services; and
- from your insurer of what it will pay for the services.

You may obtain a current directory of In-Network providers at the following website: www.curative.com/get-care or by calling Member Services at 855-428-7284 for assistance in finding available In-Network providers.

A facility-based physician or other health care practitioner may not be included in the health benefit plan's provider network. A health care practitioner may balance bill the enrollee for amounts not paid by the health benefit plan unless the health care or medical service or supply provided to the patient is subject to a law prohibiting balance billing.

If directory information is materially inaccurate and you rely on it, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

Curative Health Plan Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Curative respects the confidentiality of your health information. As part of our commitment to you and as required by state and federal law, we protect the privacy of your Protected Health Information (PHI). PHI is individually identifiable information about a person's health, health care or payments, including demographic information collected from you.

As required by law, we are providing this notice to inform you how we use PHI about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

What is Protected Health Information (PHI)?

PHI is information that identifies you, and relates to your past, present or future physical and mental health or conditions, the delivery of healthcare to you, or the past present, or future payment for your healthcare. PHI includes both medical information and individually identifiable information, including your name, address, telephone number, or Social Security number. We protect this information in electronic, written, or oral formats.

We understand the importance of protecting your PHI and restrict access to authorized workforce members who need that information for your treatment, for payment purposes and for health care operations. We will not disclose your PHI without your authorization unless it is necessary to provide your health benefits, administer your benefit Plan, support Plan programs and services, or as required or permitted by law. If we need to disclose your PHI, we will follow the policies described in the Notice to protect your privacy.

How We Use Your Protected Health Information (PHI)

Curative may disclose your PHI without your written authorization, if necessary, in order to provide your health benefits for the following purposes:

- Appointment Reminders - We may remind you of appointments that you have with your providers or Curative.

- **As Required by Law -** There are state and federal laws that may require your PHI released to others without your authorization. Some of the reasons may include, but are not limited to:
    - We may disclose PHI to a governmental, licensing, auditing, and accrediting agency for oversight activities.
    - We may share information for Public Health activities.
    - We may disclose PHI to a government authority regarding child abuse, neglect, or domestic violence.
    - We may share information relative to specialized government functions, such as military and veteran activities, national security and intelligence activities, and protective services for the President of the United States and others.
    - We may report information to a law enforcement agency if you are a victim of a crime or if we believe you are a victim of a crime.
    - We may disclose PHI to Disaster Relief Organizations or Agencies that seek your PHI to coordinate your care or notify family and friends of your location or condition in a disaster. (We will provide you with the opportunity to agree or object to such a disclosure whenever we can practically do so.)
    - We may release information to a coroner or medical examiner for the purpose of identifying a deceased person, determining the cause of death or other duties as required by law.

- **Business Associates -** We may disclose PHI to our business associates who perform functions for you on our behalf or provide us with services that support you if the PHI is necessary for those services.

- **Events and Fundraising -** We may contact you to provide you with information about events and activities, including fundraising programs. If we do contact you for these activities, the communication you receive will have instructions on how you may ask for us not to contact you again for such purposes.

- **Health Care Operations -** We may use and disclose your PHI for our health care operations supporting you. We use health information about you to develop better services for you.

- **Health or Safety -** We may disclose your PHI to prevent or lessen a serious and imminent threat to your health or safety or the health and safety of the general public or another person.

- **Health Benefits and Services -** We may contact you about benefits and services that we provide.

- **Individuals involved in your care or payment for your care -** Unless you object, we may disclose PHI to a family member, friend, or other person you identify that directly relates to that person's involvement in your care. We may disclose such information to such persons if we can infer from the circumstances that you would not object. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency, we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest.

Additionally, we may disclose information to your representative. If a person has the authority under law to make healthcare decisions for you, we will treat that representative the same way we would treat you with respect to your Protected Health Information. Parents and legal guardians are generally plan member representatives of minors unless the minors are permitted by law to act on their own behalf and make their own medical decisions.

- **Organ and Tissue Donation Requests –** We can share health information about you with organ procurement organizations.

- **Payments -** We may use and disclose your PHI to make coverage determinations; to make or obtain payment; and to determine and fulfill our responsibility to provide benefits. We may also disclose your PHI to another health plan or a health care provider to coordinate payment activities.

- **Research -** We may disclose your PHI for research purposes under specific rules determined by the confidentiality provisions of applicable law. In some situations, federal law allows us to use your PHI for research without your authorization, provided we get approval from a special review board. Such research will not affect your eligibility for benefits, treatment or welfare, and your PHI will continue to be protected.

- **Response to lawsuits and legal actions –** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

- **Treatment** - We may disclose your PHI to your healthcare provider for plan coordination; to help obtain services and treatment you may need; or to coordinate your health care and related services.

- **Treatment Alternatives -** We may contact you to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Underwriting -** We will not use or disclose your genetic information or your refusal to submit to a genetic test to reject, deny, limit, cancel, refuse to renew, increase the premiums for, or otherwise adversely affect eligibility for or coverage under the plan..

- **Workers' compensation –** We can use or share health information about you for workers' compensation claims.

Uses and Disclosures of Protected Health Information (PHI) with Your Written Authorization

News gathering activities - We may contact you to discuss whether or not you want to participate in a news story for plan-related publications or eternal news media. Your written authorization is required for this disclosure of PHI.

We will not use or disclose your PHI for any purpose other than those described in this Notice without your written authorization, unless authorized by state or federal law. Additionally, we are not allowed to sell or receive anything of value in exchange for your PHI without your written authorization. If you provide us authorization to use or disclose your PHI, you may revoke your authorization, in writing, at any time.

However, uses and disclosures made before your withdrawal are not affected by your action and we cannot take back any disclosures we may have already made with your authorization. If your withdrawal relates to research, researchers are allowed to continue to use the PHI they have gathered before your withdrawal if they need it in connection with the research study or follow-up to the study.

Know Your Rights regarding your Protected Health Information (PHI)

You have the following rights regarding PHI maintained by Curative about you:

- **Right to Amend Your Records -** If you feel that PHI we may have about you is incorrect or incomplete, you may request us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us in enrollment, payment, claims settlement and case or medical management record systems, or that is part of a set of records that is otherwise used by us to make a decision about you.
  Your request must be submitted in writing, with an explanation as to why the amendment is needed. If we accept your request, we will amend your records. If we cannot change what is in the record, then we will add your supplemental information to the records. We may deny or partially deny your request if you ask us to amend PHI that:

- we did not create (unless the person or entity that created the PHI is no longer available to make the amendment);
- is not part of the enrollment, payment, claims settlement, and case or medical management record systems maintained by or for us, or part of a set of records that we otherwise use to make decisions;
- is not part of the information which you would be permitted to inspect and copy; or
- is determined by us to be accurate and complete.
- If we deny or partially deny your request for amendment, you have the right to submit a written rebuttal and request the rebuttal be made a part of your medical record. We have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttals) be transmitted to any other party any time the involved portion of the medical record is disclosed.

- **Right to Inspect and Copy Your PHI -** You have the right to inspect and copy PHI about you that is maintained by us or for us in enrollment, payment, claims settlement, and case or medical management record systems, or that is part of a set of records that is otherwise used by us to make a decision. Your request to inspect or copy your PHI must be submitted to us in writing. We may charge you a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect or copy your records in certain limited circumstances. If we deny your request, you have the right to have your request reviewed by a licensed health care professional who was not directly involved in the denial of your request.

- **Right to Notice of Breach -** You have the right to receive written notice as soon as possible, but not later than 60 days, after any unauthorized use or disclosure that compromises the privacy and security of your PHI.

- **Right to Receive an Accounting of Disclosures -** You have the right to receive a list of disclosures we have made of your PHI in the 6 years prior to your request. This list will not include disclosures made for treatment, payment and health care operations purposes and certain other disclosures (such as any you asked us to make). Your request must be submitted in writing and state the time period for which you want to receive the accounting, which may not be longer than 6 years. You may receive the list in paper or electronic form. The first accounting you request in a 12-month period will be of no charge. We may charge you for responding to any additional requests in that same time period. We will inform you of any costs before you will be charged anything.

- **Right to Receive Confidential Communications -** You may ask to receive communications of your PHI from us in a certain way or at a certain location. You must make any such request in writing, and you must specify how or where we are to contact

you. While we will consider reasonable requests carefully, we are not required to agree to all requests. We will not ask you the reason for your request. We must accommodate reasonable requests by you to receive communications of PHI by alternative means or at alternative locations, if you clearly state that the disclosure of all or part of that information could endanger you.

- **Right to Receive Paper Copy of this Notice -** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

- **Right to Request Additional Restrictions -** You may request restrictions on our use and disclosure of your PHI for the treatment, payment, and health care operations. You also have the right to request a limit on the PHI we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. Your request for restriction must be submitted in writing and state the specific restriction requested. We are not required to agree to your request, except as required by law. If we do agree with your request for restriction, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency treatment or we are required or permitted by law to disclose it. We are allowed to end a non-mandated restriction if we tell you. f we end the restriction, it will affect PHI that was created or received only after we notify you.

- **Checking Your Identity for Your Protection -** For your protection, we may check your identity whenever you have questions about your treatment or payment activities. We will check your identity whenever you get requests to look at, copy or amend your records or to obtain a list of disclosures of your PHI.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing to our Privacy Officer address as follows:

Curative
ATTN: Privacy Officer
P. O. Box 1786
Austin, TX 78767

We may ask you to fill out and return to us a form that we will provide to you.

If Something is Wrong, Let Us Know Right Away

If you believe that Curative has violated your privacy rights, you may file a complaint with us by calling 855-428-7284 at any time or by sending your complaint to the address shown immediately above.

You may also file a written complaint with the Secretary of the US Department of Health and Human Services (HHS). Your complaint can be sent by mail to the HHS Office of Civil Rights (OCR). To file a complaint with the Secretary, write to:

US Department of Health and Human Services
200 Independence Avenue, SW
Room 509F HHH Bldg.
Washington DC 20201
Website: hhs.gov/ocr/privacy/hipaa/complaints/
Phone: 1-877-696-6775

We will not take any action against you if you exercise your right to file a complaint with us or the Secretary.

Changes to this Notice

We are required to abide by the terms of the Notice currently in effect. We may change our Privacy Practices and the terms of this Notice at any time as allowed by law. We may, at our discretion, make the new terms effective for all of your PHI that we maintain, including any PHI we created or received before we issued the new Notice. When we make significant changes in our Privacy Practices, we will change this Notice and post it to our website at www.curative.com.

Effective Date of Notice: July 2022