DEVON ENERGY CORPORATION

Employee Benefit Plan
And
Flexible Benefits Plan

SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2024

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IMPORTANT – PLEASE READ: This document and the booklets and other descriptive material provided to you by Devon and the various benefit providers are written in a manner that is intended to be easily understandable and to summarize the benefits available to you under the Plans. There may be other Plan materials (such as an insurance policy or other contractual agreement with a health care or other service provider) that contain more detailed information about Plan benefits. Every effort has been made to ensure that all these materials contain a consistent description of the Plans' benefits. However, if there is any conflict or inconsistency between these materials, it is Devon's responsibility as the Plan Administrator to interpret the conflicting provisions and determine what benefits will be provided under the Plans. ***Also, please keep in mind that the Plans, any changes to them, or any payments to you under its terms, does not constitute a contract of employment with Devon and does not give you the right to be retained in the employment of Devon.*** No one speaking on behalf of the Plans or Devon can alter the terms of the Plans. Although Devon intends to maintain the benefits described in this document for an indefinite period of time, Devon retains the right to amend or terminate any of the benefits described in this document as it relates to any employee, dependent, beneficiary or subclass thereof in whole or in part at any time and for any reason.

I. INTRODUCTION

Devon Energy Corporation ("Devon," the "Company" or "Plan Sponsor") sponsors the Devon Energy Corporation Employee Benefit Plan (the "Benefit Plan") and the Devon Energy Corporation Flexible Benefits Plan (the "Flexible Benefits Plan") (collectively, the "Plans"). The Plans work hand in hand to provide eligible employees and dependents with a comprehensive benefit program and may be referred to herein together as "the Plans." The Benefit Plan provides a wide variety of benefits to eligible employees, some of which are paid for by Devon and provided automatically and some of which are optional and require employee contributions. The Flexible Benefits Plan provides the pre-tax premium and flexible spending account benefits to eligible employees. Devon intends that the Flexible Benefits Plan qualify as a "cafeteria plan" within the meaning of Section 125(c) of the Internal Revenue Code of 1986, as amended (the "Code"), and that any premiums and contributions you pay for benefits under either Plan on a before-tax basis are excludable from your gross income for federal income tax purposes to the extent permitted by law. In some cases, your contributions may be paid on an after-tax basis as indicated in the Benefits Overview section below.

This document is the Devon Energy Corporation Employee Benefit Plan and Flexible Benefits Plan Summary Plan Description ("SPD") and describes the Plans as in effect on January 1, 2022. This document consists of this booklet, which provides information common to all elements of the Plans and detailed information about your medical benefits, and the descriptive material made available to you by Devon and third-party providers (such as insurance companies) for non-medical benefits. This document, together with the booklets and other descriptive materials you receive from Devon and third-party providers, constitutes the official SPD for the Plans. (A list of the descriptive materials that form part of the SPD can be found in **Appendix A**). Capitalized terms used herein shall have the meaning given to them in **Appendix B**. Because benefits under the Plans will be of importance to you and your family, you should retain this SPD as part of your permanent records.

Please contact HRConnect if you would like to request copies of Plan-related documents or have any questions you believe this document does not appropriately address.

Hours of Operation	**Contact Information**
Monday – Friday 7:00 a.m. – 5:00 p.m.	(855) 810-3555 HRConnect@dvn.com

II. BENEFITS OVERVIEW

Eligible employees will automatically receive the Core Benefits below. If you are eligible, you may also elect coverage under any or all the Optional Benefits listed below. Additional detail about the Core Benefits and Optional Benefits is provided in the section below entitled "Description of Benefits" and in **Appendices A through E** which provide important details about your coverage.

Core Benefits

The following benefits are provided by Devon at no cost to eligible employees. If you are eligible, you will be enrolled automatically.

- Basic term life/accidental death and dismemberment ("AD&D") insurance*
- Short-term disability insurance
- Long-term disability insurance
- Employee assistance program
- Business travel insurance

** While the term life insurance is provided to you at no cost, imputed income may be assessed if the dollar amount of your coverage exceeds $50,000 per year.*

Optional Benefits

The following benefits may be elected by eligible employees and the cost is either shared by Devon or will be paid entirely by you. Contributions are made on a before-tax or after-tax basis, as indicated.

Optional Benefit	**Who pays?**	**Pre-tax or After-tax?**
Medical benefits (includes prescription drug and telemedicine benefits)	Shared	Pre-tax
Dental benefits	Shared	Pre-tax
Vision benefits	You	Pre-tax
Voluntary life insurance	You	After-tax
Voluntary AD&D insurance	You	After-tax
Flexible spending accounts	You	Pre-tax
Tuition reimbursement	Devon	N/A

III. ELIGIBILITY

Eligible Employees

Who is an Eligible Employee? In general, you are eligible to participate in all the benefit options under the Plans as indicated below if you are a Regular Full-time Employee. A "**Regular Full-time Employee**" is an employee who is designated as a regular, full-time employee and who normally works at least 30 hours per week.

You are eligible to participate in some, but not all benefits under the Plans if you are a "**Part-time Employee**." Part-time employees are those employees for whom a schedule of not less than 20 hours per week and not more than 30 hours per week has been approved by Devon management. Part-time employees who regularly work less than 20 hours per week are not eligible for benefits under the Plans.

"**Interns**" are also eligible for some, but not all benefit options under the Plans regardless of the number of hours they work.

Keep in mind that some benefit options may have different terms, conditions or limitations affecting eligibility. You should refer to the separate descriptive material for more information. A new employee must work at least one full day to be eligible for Devon benefits.

Eligibility for Benefits

	Eligible?		
Benefit	Full-time	Part-time	Intern
Medical (includes prescription drugs and telemedicine benefits)	Yes	Yes	Yes No Employee Pre-tax contributions to an HSA
Dental	Yes	Yes	Yes
Vision	Yes	Yes	Yes

	Eligible?		
Benefit	Full-time	Part-time	Intern
Wellness Program and Incentives	Yes	Yes	No
Flexible Spending Accounts	Yes	Yes	No
Basic Life	Yes	Yes	No
Basic AD&D	Yes	Yes	Yes - $50,000 only
Voluntary Life and AD&D	Yes	Yes	No
Short-term Disability	Yes	No	No
Long-term Disability	Yes	No	No
Employee Assistance Program	Yes	Yes	No
Tuition Reimbursement	Yes	Yes	No
Business Travel Accident	Yes	Yes	Yes

Who is Ineligible? You are not eligible to participate in the Plans if you are not a Regular Full-time Employee, Part-time Employee or Intern. Persons classified by Devon in the following categories are ineligible for coverage under the Plans:

- independent contractors;
- temporary employees;
- leased employees; and

Persons classified in these categories remain ineligible for coverage even if subsequently reclassified as an employee by a governmental agency or court of law. In such case, eligibility for coverage may be available prospectively but shall not apply retroactively.

Eligible Dependents

Who is an Eligible Dependent? Regular Full-time and Part-time Employees can elect to provide medical (including prescription drug and telemedicine benefits), dental, vision and health care flexible spending account coverage for their eligible dependents who meet the eligibility requirements set forth in this section. An employee must be covered under the Plans to cover any eligible dependents under the Plans. For the definition of eligible dependents under the dependent care flexible spending account, voluntary life and voluntary AD&D benefits, please see those sections below in "Description of Benefits."

Legal Spouse - A spouse to whom the employee is legally married in any State or foreign jurisdiction. A spouse includes common law spouses provided the employee and his or her common law spouse: (i) meet the definition of common law marriage in the state they reside, (ii) complete the Devon affidavit of common law marriage, and (iii) provide (or agree to provide) a copy of a federal income tax return reporting marital status as married.

Eligible Domestic Partner – Your same-sex or opposite-sex domestic partner. You and your domestic partner must complete the Devon affidavit for domestic partnership and certify that:

- You are both at least 18 years old and mentally competent to enter into a valid legal contract;
- You are in a committed relationship and are jointly responsible for your common welfare and financial obligations;
- You are either jointly responsible for your assets and debts as provided by applicable law or have executed a written agreement or civil contract which defines your domestic partnership and your liabilities with respect to your assets and debts;
- You are not related by blood such that you would be prohibited from legal marriage in your state of residence;
- The domestic partnership began on the date specified;
- You are not legally married to, or the domestic partner of, anyone else;
- You are legally registered as domestic partners in your state of residence, if applicable; and
- If your domestic partnership terminates, the Company must receive notice within sixty (60) days of the change in status.

If your domestic partnership is terminated, your former domestic partner will no longer be eligible for coverage as an eligible domestic partner.

Note: **Imputed Income for Domestic Partners and the Domestic Partner's Dependent Children**

The amount of your contribution to provide benefits under the Plan for a domestic partner and his or her children will be the same as for a spouse and his or her children. However, the Internal Revenue Code treats spouses and children through marriage differently with respect to health benefits. The cost of coverage for a spouse, children and stepchildren is automatically exempt from taxes, but for a person who is not a spouse, child or a stepchild through marriage, a payment for health benefit coverage is not exempt from tax unless the person is a "dependent" as defined in the Internal Revenue Code.

Regardless of whether your domestic partner or his or her children is a dependent for federal income tax purposes, you will be subject to taxes on imputed income for the value of the coverage you choose for your eligible domestic partner and his or her children. Your contributions for health coverage will continue to be made on a pre-tax basis; however, you will see additional income imputed to you on your paystub. If your domestic partner and/or domestic partner's children are considered your own dependents for federal income tax purposes, you may be able to make adjustments on your own personal income tax return. Therefore, you should consult with your tax advisor for more information.

Dependent Child – The following categories of children are eligible for dependent coverage under the Plans until the end of the month in which the dependent reaches age 26:

- a biological child of the employee;
- an adopted child of the employee;
- a child placed for adoption with the employee; or
- a stepchild of the employee
- a domestic partner's child

Dependent children in this category are eligible for dependent coverage under the Plans until the end of the month in which they reach age 26 without regard to marital status, offer of other

coverage through employment, tax dependent status, student status, residence, or financial dependence on the employee.

- **Disabled Dependent Child** – If a dependent child was covered by the Plans on the end of the month in which the child reaches age 26, the child is permanently and totally disabled at that time, and a disabled dependent certification is approved by the claims administrator, the Plans shall continue to cover the child for the duration of the permanent and total disability.

  For purposes of this provision, a child is permanently and totally disabled if unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

- **Dependent Legal Ward** – A child for whom the employee has been appointed legal guardian by a court is an eligible dependent child provided all the following eligibility criteria are satisfied.

  - Residence – The child must have the same principal residence as the employee.

  - Age – The child must be:

  (a) less than nineteen (19) years of age, if the child is not a full-time student, as defined below, or less than twenty-four (24) years of age, if the child is a full-time student; or

  (b) any age, if the child was already covered by the Plans upon reaching age 19 or 24 (if a full-time student) and is permanently and totally disabled, as defined above.

  For purposes of this provision, a child is a full-time student if attending high school or post-secondary school (including accredited colleges and universities) for a minimum of 12 hours per semester (or the equivalent of 12 semester hours or more if the institution operates on a basis other than by semester). The definition of high school, accredited college or university does not include cosmetology, trade or other types of vocational schools.

  A child covered by the Plans who is a full-time student at an accredited post-secondary school and who takes a “Medically Necessary leave of absence” (“leave of absence”) may continue medical coverage for up to one year. A change in the child’s student status from full-time to part-time due to a serious Illness or injury may constitute a leave of absence. In such case, the dependent child on a leave of absence will be covered for one year from the first day of the leave of absence, or until the date on which the coverage otherwise would end under the Plans’ terms, whichever comes first.

  - Financially Dependent on Employee – The child must not provide more than half of his or her own support for the Calendar Year. In general, “support includes food, shelter, clothing, medical care and education.

- Citizenship or U.S. Residency – The child must be a citizen of the U.S., a national of the U.S., or a resident of the U.S. or a country contiguous to the U.S.

Additional Plan Rules Relating to Eligible Dependents

Verification Documentation. Devon reserves the right to request documentation to verify the eligibility of your dependents at any time. You will be required to provide documentation to verify eligibility whenever you add or drop a dependent or for any change in status event under the Plans. You may also be required to provide documentation during periodic open enrollment or during periodic dependent eligibility verification audits conducted by Devon.

Voluntary life insurance elections are made annually and are not eligible to change outside of open enrollment or qualified life events; with the exception of a mid-year change allowable due to premium cost increasing by a minimum of 100% due to a member's movement into new age banding.

No Foster Child Coverage. A foster child of the employee is not eligible for dependent coverage under the Plans.

Divorced Parents. For purposes of the medical benefits (including prescription drug), dental, vision and flexible spending accounts, in the case of a child who receives over one-half of his or her support during the Calendar Year from his or her parents (i) who are divorced or legally separated under a decree of divorce or separate maintenance, (ii) who are separated under a written separation agreement, (iii) who live apart at all times during the last six months of the year, (iv) who have agreed that the custodial parent will not claim the child as an income tax exemption, and (v) where such child is in the custody of one or both parents for more than one-half of the year, such child will be considered the dependent of both parents, regardless of the child's place of residence or the amount of support provided by either parent. Contact your tax advisor or refer to IRS Publication 502 (Medical and Dental Expenses) or Publication 503 (Child and Dependent Care Expenses) for more information.

IV. PARTICIPATION

When Does Participation Begin?

Core Benefits. If you are an eligible employee, you will be automatically enrolled in the Core Benefits under the Plans as of your first day of employment.

Optional Benefits. If you are an eligible employee, you have thirty (30) days from your first day of employment to elect to participate in one or more Optional Benefits under the Plans by completing the election process established by Devon. Thereafter, you may elect to participate in Optional Benefits only (1) if you have a change in status, as described below under "Changing Your Election," or (2) during an open enrollment period.

Failure to Make an Initial Election. If you fail to make an election for Optional Benefits upon your initial eligibility for coverage, you will be deemed to have elected no Optional Benefits and you will receive only the Core Benefits. Therefore, it is extremely important that you complete the election process within the initial period prescribed by the Plan Administrator.

Failure to Make an Election During Open Enrollment. As an Eligible Employee, you generally must take action during the open enrollment period if you want to change any benefit elections for you or your Eligible Dependents, or if you want to enroll or drop your dependents from coverage. Except for the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account, the coverage you elect will generally continue to be in effect for subsequent Plan Years unless you revoke your elections during a subsequent open enrollment period, or a benefit option is no longer offered.

For the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account, you must make a new election each open enrollment if you want to contribute for the following Plan Year. Your contribution election from the previous Plan Year will not carry over into the next Plan Year. If you fail to make a contribution during open enrollment you will not be able to enroll in the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account for the remainder of the Plan Year unless you qualify for special enrollment or experience a qualified change in status event which is described in the "Change in Status and Special Enrollment Rights" sections below. **It is important that you refer to your annual open enrollment materials each year to confirm whether you must make an affirmative election that year.**

Actively at Work. Please note that some coverages may require you to be "actively at work" for coverage to begin or for changes to take effect. "**Actively at Work**" means the active expenditure of time and energy in the service of Devon, except that an employee shall be deemed to be actively at work on each day of a regular paid time off or on a regular non-working day, provided he was actively at work on the last preceding regular working day. However, with respect to coverage under a medical benefit option, you will be treated as actively at work on any day you are absent due to a health factor.

Replacement Coverage. If the medical benefit under which you are covered ceases to be offered as an option, you will be given an opportunity to elect suitable replacement coverage or you could elect to waive medical coverage under the Plans. If you do not make an election either to enroll for replacement coverage or to waive medical coverage, you will automatically be enrolled in coverage that the Plan Administrator determines is most like the coverage being lost and you will be responsible for the cost of that coverage.

Participation Following Cessation of Eligibility

In general, if you terminate employment or otherwise cease to be an eligible employee and you again become an eligible employee, you will be eligible to participate in the Plans immediately upon again becoming an eligible employee, provided you make any required elections and complete all required enrollment materials within 30 days of becoming eligible. If the period between your cessation of eligibility and re-commencement of participation is less than 30 days, your prior benefit elections will be restored, and you will not be permitted to make new elections.

If the period between your cessation of eligibility and re-commencement of participation is 30 days or more, you will be treated as a new hire.

With respect to the health care flexible spending account, your participation will be reinstated if you return to work during the same Calendar Year. Your health care flexible spending account will be reinstated at the same payroll deduction level and you will be permitted to resume submitting reimbursements to the extent your account had not been exhausted prior to your termination. However, you will not be eligible to make a new election or increase contributions until the following year.

Changing Your Election Mid-Year

Generally, federal law prohibits changes to your coverage election during the Plan Year. However, you may make a change to your election if you have a "change in status" (as described below) and the election change is because of and consistent with the change in status. More restrictive election change rules may apply to the flexible spending accounts. For example, the only election change permitted to the Health Care Flexible Spending Account following a change in status is to either begin deferrals to a new account or to increase or decrease deferrals to your current account.

To change your coverage elections, you have sixty (60) days to notify HRConnect of the change in status and provide any proof of the change as may be required.

> **Failure to Provide Timely Notice or Necessary Documentation**: If you fail to provide notice or the necessary supporting documentation within the applicable timeframe, your request to change your election will be denied and you will not be allowed to make changes until the next open enrollment period or sooner if you experience another qualified change in status and provide timely notice and documentation. This includes adding dependents due to marriage, birth or adoption.

The following chart provides a snapshot of the most common change in status events and required documentations listed below.

QUALIFIED CHANGE IN FAMILY STATUS FOR MEDICAL BENEFITS AT A GLANCE							
Change in Status	**Add Employee**	**Add Spouse**	**Add Child**	**Drop Employee**	**Drop Spouse**	**Drop Child**	**Required Documents**
Marriage	YES	YES	YES	YES	YES	YES	Marriage certificate
Common Law Marriage/Domes-tic Partner	YES	YES	YES	YES	YES	YES	State common law certification/ Domestic Partner certification
Divorce, legal separation, or termination of a domestic partnership	YES	NO	YES	YES	YES (if not your dependent)	YES	Divorce decree, legal separation document or notice of termination
Birth or adoption	YES	YES (Spouse)	YES	YES	YES	YES	Birth certificate or adoption papers
Guardianship	YES	NO	YES	YES	YES	YES	Legal papers
Qualified Medical Child Support Order ("QMCSO")	YES	NO	YES	NO	NO	YES	QMCSO
Spouse's employment terminated or significant change in coverage	YES	YES	YES	NO	NO	NO	Proof of loss of coverage (COBRA notice / notice from prior employer)
Spouse now covered by own employer	NO	NO	NO	YES	YES	YES	Proof of benefit coverage from employer
Dependent no longer eligible	NO	NO	NO	NO	NO	YES	N/A
Death of spouse or Domestic Partner	YES	NO	YES	YES	YES	YES	Death certificate
Death of eligible dependent	NO	NO	NO	NO	NO	YES	Death certificate

Change in Status

You may change or revoke your benefit election during the Plan Year if you experience a change in status that would lead to the loss or gain of eligibility under the Plans. A change in status includes:

a change in your legal marital status (such as marriage, death of spouse, divorce, legal separation or annulment) or addition or termination of domestic partner relationship;

a change in the number of your dependents (such as birth of a child, adoption or placement for adoption of a dependent, or death of a dependent);

any of the following events that change the employment status of you or your Dependent and result in the loss of coverage or eligibility for benefits, including a:

- termination or commencement of employment;
- a commencement of or return from an unpaid leave of absence (but only if you are ineligible for benefits during the unpaid leave);
- a change in worksite (but only if available benefits are different);
- switching employment classifications from salaried to hourly-paid or part-time or intern to full-time (or vice versa)
- incurring a reduction or increase in hours of employment (but only if the reduction or increase in hours affects your benefit eligibility);
- any other similar change which makes the individual become (or cease to be) eligible for an employee benefit; or

an event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a benefit (such as attaining a specified age); or

your eligibility to enroll in coverage through the government-sponsored health insurance marketplace during a special or annual enrollment period, provided you certify to Devon that you and any covered dependents will obtain minimum essential coverage on the health insurance marketplace immediately upon cancellation of coverage under this Plan.

The election change must be because of and correspond with the change in status event as determined by Plans. Generally, a desired election change will be found to be consistent with a change in status event if the event affects eligibility for coverage under the Plans. All election changes become effective prospectively. No retroactive changes are permitted.

You have sixty (60) days to notify the Plan Administrator of a change in status event. If you fail to notify the Plan Administrator of a change in status within sixty (60) days of the event, you will lose your right to make any benefit changes until the next annual open enrollment period or until you or your dependent experience another change in status.

Special Enrollment Rights

You may also revoke or change your benefit election during the Plan Year if you experience a Health Insurance Portability and Accountability Act (“HIPAA”) special enrollment right that would lead to the loss or gain of eligibility under the Plans. Some of the HIPAA special enrollment rights are duplicative of the change in status rules described above. You and/or dependents will have a HIPAA special enrollment right if you and/or dependent:

were covered under a group health plan or had health insurance coverage at the time coverage was previously offered; and

lost your coverage under the other group health plan or health insurance coverage for reasons such as:

- termination of COBRA continuation coverage;
- legal separation;
- divorce/marriage;
- Affirmation/dissolution of domestic partnership
- death/birth of a child (including adoption or placement for adoption);
- termination of employment; or
- reduction in hours of employment.

You have sixty (60) days to notify the Plan Administrator of a HIPAA special enrollment right. If you fail to notify the Plan Administrator of a HIPAA special enrollment right within sixty (60) days of the event, you will lose your right to make any benefit changes until the next open enrollment period or until you or your dependent experience another change in status.

Special Rule Relating to Medicaid and Children's Health Insurance Program ("CHIP"). You may also change your benefit election during the Plan Year if you or your dependent lose Medicaid or CHIP coverage or become eligible for a premium assistance subsidy under Medicaid or CHIP. You have sixty (60) days after the loss of such coverage or the eligibility determination date for such coverage to request enrollment. A notice explaining your rights with respect to premium assistance is attached as **Appendix H.**

When Does Participation End?

Generally, your participation under the Plans will terminate automatically as of the earliest of the following:

- the date on which the Plans, or any coverage that is part of the Plans terminates;
- the date on which your coverage terminates due to your failure to satisfy the eligibility criteria for a benefit under the Plans; Life, Disability, Tuition Reimbursement & Business Travel
- the date on which your election to receive benefits under this Plans terminates, is revoked due to a change in status or expires;
- for medical, dental and vision benefits, the last day of the month in which you cease to be an active employee for any reason (unless you are on approved leave of absence);
- 48 months following approval of Long-Term Disability or as soon as Medicare Parts A & B are approved; whichever occurs first.
- for all other benefits, the date on which you cease to be an active employee for any reason (unless you are on approved leave of absence);
- the date you fail to make any required contributions when due; or
- the date of your death.

Special rules apply for certain leaves of absence, including for disability, military leave or family and medical leave. Please refer to page 12 of this SPD and/or contact HRConnect if you have questions about participation while on a leave of absence.

The coverage for your covered dependents will generally terminate on the earlier of the date your coverage terminates or the covered dependent no longer satisfies the eligibility criteria or the definition of dependent as described in this SPD or the insurance booklets associated with the benefit. If, however, the coverage for your covered dependents terminates due to your death, the medical benefit coverage of your covered dependents will end six months after your date of death. Additionally, if you are disabled and receiving long-term disability benefits, the medical benefits coverage of your covered dependents terminates the last day of the month in which you cease to be an active employee.

Coverage for your dependent will terminate prospectively if it is found that your dependent is ineligible for coverage. Coverage for your dependent may terminate retroactively, upon thirty (30) days' notice if your covered dependent obtained coverage by fraud or intentional misrepresentation.

Termination of Coverage in the Event of Fraud. Notwithstanding any of the above, your participation in the Plans may also terminate if you or your covered dependents:

- provide false information or make a misrepresentation in connection with a claim for benefits;
- permit a non-eligible person to use a membership or other identification card for the purpose of wrongfully obtaining benefits;
- obtain or attempt to obtain benefits by means of false, misleading or fraudulent information, acts or omissions; or
- fail to provide documents requested by the Plans to verify representation made by you in connection with eligibility or continued eligibility for benefits for yourself or your dependents.

If your participation or your covered dependent's participation in the Plans is terminated due to any of the reasons described above, you and your dependent shall not be eligible to re-enter the Plans again until the next open enrollment period or unless you or your dependent experience a special enrollment right during the Plan Year.

Authorized Leaves of Absence

Devon may continue coverage during certain periods of absence, such as absence by reason of sickness, disability, or other authorized leave of absence (including military leaves), in accordance with its personnel policies and practices and to the extent prescribed by law. Devon's personnel policies and practices describe the different types of leaves of absence, how long benefits are continued during a leave of absence, what employee contributions are required during the leave and how those contributions are made, and what your rights and obligations are under those policies and applicable federal and state law. Employees and former employees on disability leave and receiving long-term disability benefits will no longer be eligible for coverage under the Plans after 48 months from the date of approved long-term disability or upon approval of Medicare Parts A & B (whichever occurs first), or if they are no longer disabled or their long-term disability benefit is terminated for any reason.

If you are permitted to revoke an existing election while on a leave of absence, you will not be entitled to receive payment on any claims incurred following your election to revoke participation. Upon return from such leave, you may choose to be reinstated in the Plans on the same terms as prior to taking leave, but you may not retroactively elect coverage for claims incurred following your election to revoke participation.

V. PAYING FOR YOUR COVERAGE

If you elect to purchase Optional Benefits under the Plans or contribute to a flexible spending account, you are required to contribute a portion of your compensation for such coverage. The contribution you are required to pay is determined by Devon each year, may differ depending upon your eligible employment category and may be adjusted during the year to reflect any increases or decreases.

The maximum amount deducted from your pay may not exceed the total of after-tax and pre-tax contributions for Core and Optional Benefits you elect under the Plans.

After-tax Contributions. Your contributions for voluntary life and voluntary AD&D insurance will be deducted from your pay on an after-tax basis.

Pre-tax Contributions. Your contributions for medical coverage (including prescription drug), dental, vision and any contributions you elect to make to a flexible spending account will be deducted from your pay before federal income taxes, state income taxes or Social Security taxes are withheld (some local income/wage taxes may apply), meaning that you purchase coverage with more valuable before-tax dollars. Therefore, you will be taxed on a slightly lower gross income and your taxes will be lower. Because your before-tax contributions are not subject to Social Security taxes, your Social Security benefit at retirement may be slightly reduced if your earnings are under the Social Security Taxable Wage Base $142,800 for 2022. However, the loss in Social Security benefits should be more than offset by the tax savings under the Plans.

Imputed income for Domestic Partner coverage. For employees covering a domestic partner and/or domestic partner child(ren), any pre-tax contributions you make for medical (including prescription drug), dental and vision coverage will be imputed to you as income. Devon will calculate the benefit value for domestic partner benefits and report the value as income to the employee on his or her bi-weekly payroll stub. For more information on the tax consequences of covering domestic partners and/or domestic partner child(ren), see the explanatory note after the definition of domestic partner in the Eligibility section.

VI. DESCRIPTION OF BENEFITS

This section briefly summarizes the benefits available under the Plans and describes some important rules regarding your annual elections. If you have any questions about the enrollment process or any of the options available to you, please contact HRConnect.

Medical (including prescription drug and telemedicine), Dental and Vision Benefits

Medical Benefits. If you elect medical benefits, you will be responsible for contributing toward the coverage you elect. Your contributions will be deducted from your pay on a pre-tax basis, if eligible

In addition, Full-time and Part-time Employees also have an opportunity to earn a wellness incentive each year by completing wellness-related activities. The amount of the wellness incentive will be determined by Devon and communicated to employees each year. Interns may participate in wellness-related activities but cannot earn related wellness incentive.

Medical Option: PPO Summary Schedule of Medical Benefits for the PPO (including prescription drug and telemedicine), effective Jan. 1, 2024. Updated information, if available, is posted on HRConnect and in the current year's Benefits Guide.

Medical provisions (administered by BCBS of Illinois)	
Deductible (combined with prescription drug)	
Employee-only coverage	$2,000 in network ($4,000 out of network)
Any other coverage level	$4,000 in network ($8,000 out of network)
Out-of-pocket maximum (combined with prescription drug)	
Employee-only coverage	$4,650 in network ($9,300 out of network)
Any other coverage level	$9,300 in network ($18,600 out of network)
After deductible, plan pays	
In network	80%
Out of network	60%
After deductible plan pays (Oklahoma only)	
In network - Blue Preferred	80%
In network - Blue Choice	70%
Out of network	60%
*Preventive care	
In network	Plan pays 100% (no deductible)
Routine care	
Non-emergency use of emergency room	$250 per occurrence
Tobacco surcharge	$50 per month, per employee and/or spouse
*Preventive Care is further described in **Appendix C**. Examples include: • Annual physical exam • Routine colonoscopies	

• Blood pressure screening • Well woman visits, including cervical cancer screenings and routine mammograms • Contraception • Immunizations • Childhood vision and hearing screenings (ages 5-19) • Tobacco cessation programs	

Prescription drug provisions (administered by CVS Caremark)	
Deductible (combined with medical)	
Employee-only coverage	$2,000 in network, $4,000 out of network
Any other coverage level	$4,000 in network, $8,000 out of network
Out-of-pocket maximum (combined with medical)	
Employee-only coverage	$4,650 in network, $9,300 out of network
Any other coverage level	$9,300 in network, $18,600 out of network
Preventive care	
Preventive* prescription drugs	Plan pays 100%
Retail pharmacy (up to 30-day supply)	
Preventive maintenance drugs	You pay:
Generic	$10 copay
Preferred brand	30% ($40 min, $125 max)
Non-preferred brand	40% ($60 min, $185 max)
Maintenance and non-maintenance drugs	**After deductible**, you pay:
Generic	$10 copay
Preferred brand	30% ($40 min, $125 max)
Non-preferred brand	40% ($60 min, $185 max)
Mail-order pharmacy (up to 90-day supply)	

Preventive maintenance drugs	You pay:
Generic	$20 copay
Preferred brand	30% ($80 min, $250 max)
Non-preferred brand	40% ($120 min, $370 max)
Maintenance drugs	**After deductible**, you pay:
Generic	$20 copay
Preferred brand	30% ($80 min, $250 max)
Non-preferred brand	40% ($120 min, $370 max)

** As designated under the Affordable Care Act (ACA)*

Preventive prescription drugs are medications designated by federal government guidelines under the Affordable Care Act as preventive. They are not subject to the Deductible, and you will not pay copays or coinsurance for them. They are covered at 100%.

Preventive maintenance prescription drugs are medications you take regularly that CVS Caremark believes meet the IRS definition of preventive for purposes of HSA-eligibility when enrolled in a high-deductible health plan. They are not subject to the Deductible. However, you will pay copays or coinsurance for them.

Maintenance prescription drugs are medications you take regularly that CVS Caremark believes do not meet the IRS definition of preventive for purposes of HSA-eligibility when enrolled in a high-deductible health plan. They are subject to the Deductible, and you will pay copays or coinsurance for them.

1. a. DETAILED SCHEDULE OF PPO MEDICAL BENEFITS FOR NON-OKLAHOMA MEMBERS

The PPO medical benefit under the Benefit Plan covers certain Medically Necessary treatments administered by licensed medical practitioners. Devon expects and encourages you to review this SPD and its appendices which describe your benefit package, including detailed information about your medical benefits. ***We encourage all Participants to be selective medical consumers and assume a major role in keeping the cost of medical services at a minimum.***

A list of definitions that apply to all medical benefits is provided at **Appendix B**. A more detailed list of covered medical expenses, exclusions from coverage and information about the cost management program are attached in **Appendix C**.

The benefit is structured as a Preferred Provider Organization ("PPO") high-deductible health plan with various medical providers. Enhanced benefits are available for most services rendered by a PPO provider. Except for recommended preventive care services which are provided to you at no cost, the PPO medical plan pays no benefit until you have satisfied the individual or family deductible, as applicable. The Benefit Plan will also pay in accordance with the PPO benefits for eligible expenses incurred for related Non-PPO Ancillary Services which are rendered in a PPO network Hospital.

Health Savings Account

If you are a Regular Full-time or Part-time Employee and elect the PPO, you will be offered the opportunity to establish a health savings account (HSA).* An HSA is an individual trust or custodial account, separately established and maintained by you with a qualified trustee/custodian. You may elect to contribute funds to your HSA each pay period on a pre-tax basis up to the legally permissible limit. While HSA contributions are made possible under the terms of the Plan, the HSA itself is not part of the Plan, is not covered by ERISA, and is not sponsored or endorsed by Devon. Devon cannot guarantee that you are eligible to establish an HSA. You should be sure you are HSA-eligible before electing this option.

If you are a Regular Full-time or Part-time employee and participate in the medical plan, but are ineligible to establish an HSA due to Medicare enrollment, Devon may establish a health reimbursement account (HRA) for you and make an employer contribution into your HRA annually based on wellness-related activities completed in the prior year.* You may not elect to contribute additional funds to an HRA. For more information about the HRA, see the "**Wellness Programs**" section of this SPD.

**Interns who elect the PPO are not eligible to receive HSA or HRA employer contributions..*

LIFETIME MAXIMUM BENEFIT: Per Covered Participant **NONE**

HSA EMPLOYER CONTRIBUTION:

Devon will contribute to an HSA on your behalf based on your annual activity in the current year. HSA deposits will be made in the following calendar year. The maximum employer contribution in 2024 (for 2023 activity) is below, effective Jan. 1, 2024**. Updated information for a calendar year other than 2024, if available, is posted on HRConnect and in the current year's Benefits Guide.**

Per Individual:

Potential Wellness Incentive $1,250

Employee & Child(ren):

Potential Wellness Incentive $2,250

Employee & Spouse; Employee & Family:

Potential Wellness Incentive ……..$2,500

DEDUCTIBLE PER CALENDAR YEAR:

Per Individual:

PPO $2,000
Non-PPO $4,000

Per Family:

PPO $4,000
Non-PPO..... $8,000

BENEFIT PERCENTAGE (payable by the Benefit Plan):

PPO ..... 80% unless stated otherwise
Non-PPO ..... 60% unless stated otherwise

OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR:

Per Individual:

PPO $4,650
Non-PPO..... $9,300

Per Family:

PPO $9,300
Non-PPO..... $18,600

Non-emergent use of Emergency Room will result in a $250 charge per occurrence. Tobacco use surcharge is $50 per month for employee and/or spouse.

Your eligible expenses accumulate toward separate out-of-pocket maximums depending on whether you use PPO or Non-PPO services. The PPO out-of-pocket amounts for eligible medical and prescription drug expenses will accumulate toward the PPO out-of-pocket maximum each Calendar Year. However, if you use Non-PPO services, eligible medical expenses will accumulate toward a separate Non-PPO out-of-pocket maximum each Calendar Year.

The out-of-pocket maximum generally includes any applicable copays, coinsurance and deductibles. Charges over the eligible charge or maximum allowance; charges for non-covered services; and preauthorization penalties only do not accumulate toward out-of-pocket maximums. After the out-of-pocket maximum has been reached, the Benefit Plan pays **100%** of eligible expenses incurred by the individual during the balance of the Calendar Year or for any covered family member after the family out-of-pocket maximum has been reached.

ALLERGY TESTING, INJECTIONS, AND SERUMS

PPO ..... 80% after Deductible
Non-PPO..... 60% after Deductible

CHIROPRACTIC SERVICES:

PPO ..... 80% after Deductible
Non-PPO ..... 60% after Deductible
Calendar Year Visit Limit ..... 15 Visits

DIAGNOSTIC X-RAY AND LABORATORY SERVICES (outpatient):

Hospital Outpatient Basis/Independent Facility:

PPO ..... 80% after Deductible
Non-PPO ..... 60% after Deductible

Performed in a Physician's Office:

PPO ..... 80% after Deductible
Non-PPO ..... 60% after Deductible

HEARING EXAMS AND HEARING AIDS:

Routine Hearing Exams

PPO ..... 80% after Deductible
Non-PPO ..... 60% after Deductible

Hearing Aids

PPO ..... 80% of Allowable Charge after Deductible
Non-PPO ..... 60% of Allowable Charge after Deductible
3-Year Maximum ..... One Set

Cochlear implants are limited to two sets per lifetime.

HOSPITAL EXPENSES:

Room and Board Charges (common semi-private charge):

PPO ..... 80% after Deductible
Non-PPO ..... 60% after Deductible

Intensive Care Unit (Usual and Customary Charges or Negotiated Fees):

PPO ..... 80% after Deductible
Non-PPO ..... 60% after Deductible

Private Room Accommodations:

PPO ..... 80% after Deductible
Non-PPO ..... 60% after Deductible
Medically Necessary Private Room Isolation ..... Actual private room charge
Hospital with Private Rooms only ..... Actual private room charge

INFERTILITY DIAGNOSIS AND TREATMENT:

Medical & Prescription treatment combined

Lifetime Maximum Benefit $20,000

MENTAL ILLNESS:

Inpatient Physician/Confinement Charges/PPO..... 80% after Deductible
Inpatient Physician/Confinement Charges/Non-PPO ..... 60% after Deductible
Outpatient Charges/PPO ..... 80% after Deductible
Outpatient Charges/Non-PPO ..... 60% after Deductible
Residential Treatment Facilities/PPO ..... 80% after Deductible
Residential Treatment Facilities/Non-PPO..... 60% after Deductible

***Refer to the "COST MANAGEMENT PROGRAM" section of Appendix C for more details, as well as information concerning federal law as it pertains to certification of admissions** in connection with childbirth.

ORGAN TRANSPLANTS:

Lifetime Maximum Benefit..... **NONE**

PHYSICIAN OFFICE VISITS:

PPO – All Physician Office Visits ..... 80% after Deductible
Non-PPO – All Physician Office Visits ..... 60% after Deductible

PREADMISSION/PREOPERATIVE TESTING ..... **Subject to Deductible**

PREGNANCY EXPENSES (includes pregnancy and Complications of Pregnancy) ***

All Covered Female Participants..... Same as any other Illness

*****Refer to "Hospital Care (Inpatient)" under the "COVERED MEDICAL EXPENSES" section of Appendix C for information concerning federal law as it pertains to coverage and certification of Hospital admissions in connection with childbirth.**

SKILLED NURSING FACILITIES:

PPO ..... 80% after Deductible
Non-PPO..... 60% after Deductible

Charges for room and board are limited to ½ the average semi-private room charge of the previous confinement. However, benefits are only provided when confinement begins within 14 days after the end of a Hospital confinement due to the same or related conditions that caused the Hospital confinement.

SPEECH THERAPY:

PPO ..... 80% after Deductible
Non-PPO..... 60% after Deductible
Annual Maximum Benefit ..... 50 visits

SUBSTANCE ABUSE CONDITIONS:

Inpatient Physician/Confinement Charges/PPO ..... 80% after Deductible
Inpatient Physician/Confinement Charges/Non-PPO..... 60% after Deductible
Outpatient Charges/PPO ..... 80% after Deductible
Outpatient Charges/Non-PPO ..... 60% after Deductible

Residential Treatment Facilities/PPO ..... 80% after Deductible
Residential Treatment Facilities/Non-PPO..... 60% after Deductible

SURGICAL EXPENSES:

Hospital-Inpatient Facility and Surgeon Charges:

PPO ..... 80% after Deductible
Non-PPO..... 60% after Deductible

Hospital-Outpatient/Outpatient Surgical Facility, Facility and Surgeon Charges:

PPO ..... 80% after Deductible
Non-PPO..... 60% after Deductible

Performed in a Physician's Office:

PPO ..... 80% after Deductible
Non-PPO..... 60% after Deductible

Assistant Surgeon ..... Up to 25% of usual and customary surgical charge or the Negotiated Fee for the surgical charge

1. b. DETAILED SCHEDULE OF PPO MEDICAL BENEFITS FOR OKLAHOMA MEMBERS

The PPO medical benefit under the Benefit Plan covers certain Medically Necessary treatments administered by licensed medical practitioners. Devon expects and encourages you to review this SPD and its appendices which describe your benefit package, including detailed information about your medical benefits. ***We encourage all Participants to be selective medical consumers and assume a major role in keeping the cost of medical services at a minimum.***

A list of definitions that apply to all medical benefits is provided at **Appendix B**. A more detailed list of covered medical expenses, exclusions from coverage and information about the cost management program are attached in **Appendix C**.

The benefit is structured as a Preferred Provider Organization ("PPO") high-deductible health plan with various medical providers. Enhanced benefits are available for most services rendered by a PPO provider. Except for recommended preventive care services which are provided to you at no cost, the PPO medical plan pays no benefit until you have satisfied the individual or family deductible, as applicable. The Oklahoma network includes medical providers in the Blue Preferred and Blue Choice networks. Choosing healthcare by providers in the Blue Preferred network will result in a lower out-of-pocket cost. The Benefit Plan will also pay in accordance with the PPO benefits for eligible expenses incurred for related Non-PPO Ancillary Services which are rendered in a PPO network Hospital.

Health Savings Account

If you are a Regular Full-time or Part-time Employee and elect the PPO, you will be offered the opportunity to establish a health savings account (HSA).*An HSA is an individual trust or custodial account, separately established and maintained by you with a qualified trustee/custodian. You may elect to contribute funds to your HSA each pay period on a pre-tax basis up to the legally permissible limit. While HSA contributions are made

possible under the terms of the Plan, the HSA itself is not part of the Plan, is not covered by ERISA, and is not sponsored or endorsed by Devon. Devon cannot guarantee that you are eligible to establish an HSA. You should be sure you are HSA-eligible before electing this option.

If you are a Regular Full-time or Part-time Employee and participate in the medical plan, but are ineligible to establish an HSA due to Medicare enrollment, Devon may establish a health reimbursement account (HRA) for you and make an employer contribution into your HRA annually based on wellness-related activities completed in the prior calendar year.* You may not elect to contribute additional funds to an HRA. For more information about the HRA, see the "**Wellness Programs**" section of this SPD.

**Interns who elect the PPO are not eligible to receive HSA or HRA employer contributions.*

LIFETIME MAXIMUM BENEFIT: Per Covered Participant **NONE**

HSA EMPLOYER CONTRIBUTION:

Devon will contribute to an HSA on your behalf based on your annual activity in the current year. HSA deposits will be made in the following calendar year. The maximum employer contribution in 2024 (for 2023 activity) is below, effective Jan. 1, 2024. **Updated information for calendar years other than 2024, if available, is posted on HRConnect and in the current year's Benefits Guide.**

Per Individual:

Potential Wellness Incentive $1,250

Employee & Child(ren):

Potential Wellness Incentive $2,250

Employee & Spouse, Employee & Family:

Potential Wellness Incentive $2,500

DEDUCTIBLE PER CALENDAR YEAR:

Per Individual:

PPO $2,000
Non-PPO $4,000

Per Family:

PPO $4,000
Non-PPO..... $8,000

BENEFIT PERCENTAGE (payable by the Benefit Plan):

Blue Preferred PPO ..... 80% unless stated otherwise
Blue Choice PPO ……70% unless stated otherwise
Non-PPO ..... 60% unless stated otherwise

OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR:

Per Individual:

PPO $4,650
Non-PPO..... $9,300

Per Family:

PPO $9,300
Non-PPO..... $18,600

Non-emergent use of Emergency Room will result in a $250 charge per occurrence. Tobacco use surcharge is $50 per month for employee and/or spouse.

Your eligible expenses accumulate toward separate out-of-pocket maximums depending on whether you use PPO (Blue Preferred or Blue Choice) or Non-PPO services. The PPO out-of-pocket amounts for eligible medical and prescription drug expenses will accumulate toward the PPO out-of-pocket maximum each Calendar Year. However, if you use non-PPO services, eligible medical expenses will accumulate toward a separate Non-PPO out-of-pocket maximum each Calendar Year.

The out-of-pocket maximum generally includes any applicable copays, coinsurance, and deductibles. Charges over the eligible charge or maximum allowance; charges for non-covered services; and preauthorization penalties only do not accumulate toward out-of-pocket maximums. After the out-of-pocket maximum has been reached, the Benefit Plan pays **100%** of eligible expenses incurred by the individual during the balance of the Calendar Year or for any covered family member after the family out-of-pocket maximum has been reached.

ALLERGY TESTING, INJECTIONS, AND SERUMS

Blue Preferred PPO…….80% after Deductible
Blue Choice PPO…….70% after Deductible

Non-PPO ……..... 60% after Deductible

CHIROPRACTIC SERVICES:

Blue Preferred PPO…… 80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO ……...60% after Deductible
Calendar Year Visit Limit .....15 Visits

DIAGNOSTIC X-RAY AND LABORATORY SERVICES (outpatient):

Hospital Outpatient Basis/Independent Facility:

Blue Preferred PPO…… 80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO …….. 60% after Deductible

Performed in a Physician's Office:

Blue Preferred PPO…… 80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO ……60% after Deductible

HEARING EXAMS AND HEARING AIDS:

Routine Hearing Exams

Blue Preferred PPO…… .80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO …….. 60% after Deductible

Hearing Aids

Blue Preferred PPO…… 80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO …….. 60% after Deductible
3-Year Maximum ……. One Set

Cochlear implants are limited to two sets per lifetime.

HOSPITAL EXPENSES:

Room and Board Charges (common semi-private charge):

Blue Preferred PPO…… 80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO ……...60% after Deductible

Intensive Care Unit (Usual and Customary Charges or Negotiated Fees):

Blue Preferred PPO…… 80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO ……...60% after Deductible

Private Room Accommodations:

Blue Preferred PPO…… 80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO ……60% after Deductible

Medically Necessary Private Room Isolation ..... Actual private room charge
Hospital with Private Rooms only ..... Actual private room charge

INFERTILITY DIAGNOSIS AND TREATMENT:

Medical & Prescription treatment combined

Lifetime Maximum Benefit $20,000

MENTAL ILLNESS:

Inpatient Physician/Confinement Charges/Blue Preferred PPO..... 80% after Deductible
Inpatient Physician/Confinement Charges/Blue Choice……..... 70% after Deductible
Inpatient Physician/Confinement Charges/Non-PPO …..……60% after Deductible

Outpatient Charges/Blue Preferred PPO……..80% after Deductible
Outpatient Charges/Blue Choice PPO……..70% after Deductible
Outpatient Charges/Non-PPO ……60% after Deductible

Residential Treatment Facilities/Blue Preferred PPO…… 80% after Deductible
Residential Treatment Facilities/Blue Choice PPO…… 70% after Deductible
Residential Treatment Facilities/Non-PPO……60% after Deductible

***Refer to the "COST MANAGEMENT PROGRAM" section of Appendix C for more details, as well as information concerning federal law as it pertains to certification of admissions in connection with childbirth.**

ORGAN TRANSPLANTS:

Lifetime Maximum Benefit..... **NONE**

PHYSICIAN OFFICE VISITS:

Blue Preferred PPO…… 80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO ……60% after Deductible

PREADMISSION/PREOPERATIVE TESTING ..... **Subject to Deductible**

PREGNANCY EXPENSES (includes pregnancy and Complications of Pregnancy) ***

All Covered Female Participants..... **Same as any other Illness**

*****Refer to "Hospital Care (Inpatient)" under the "COVERED MEDICAL EXPENSES" section of Appendix C for information concerning federal law as it pertains to coverage and certification of Hospital admissions in connection with childbirth.**

SKILLED NURSING FACILITIES:

Blue Preferred PPO…… 80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO ……60% after Deductible

Charges for room and board are limited to ½ the average semi-private room charge of the previous confinement. However, benefits are only provided when confinement begins within 14 days after the end of a hospital confinement due to the same or related conditions that caused the hospital confinement.

SPEECH THERAPY:

Blue Preferred PPO…… 80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO ……60% after Deductible
Annual Maximum Benefit ..... 50 visits

SUBSTANCE ABUSE CONDITIONS:

Inpatient Physician/Confinement Charges/Blue Preferred PPO……80% after Deductible
Inpatient Physician/Confinement Charges/Blue Choice PPO……70% after Deductible
Inpatient Physician/Confinement Charges/Non-PPO……60% after Deductible

Outpatient Charges/Blue Preferred PPO…….. 80% after Deductible
Outpatient Charges/Blue Choice PPO ……..70% after Deductible
Outpatient Charges/Non-PPO……..60% after Deductible

Residential Treatment Facilities/Blue Preferred PPO…….……80% after Deductible
Residential Treatment Facilities/Blue Choice PPO…….....70% after Deductible
Residential Treatment Facilities/Non-PPO…….60% after Deductible

SURGICAL EXPENSES:

Hospital-Inpatient Facility and Surgeon Charges:

Blue Preferred PPO…… 80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO ……60% after Deductible

Hospital-Outpatient/Outpatient Surgical Facility, Facility and Surgeon Charges:

Blue Preferred PPO…… 80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO ……60% after Deductible

Performed in a Physician's Office:

Blue Preferred PPO…… 80% after Deductible
Blue Choice PPO……..70% after Deductible
Non-PPO ……60% after Deductible

Assistant Surgeon ..... Up to 25% of usual and customary surgical charge or the Negotiated Fee for the surgical charge

Balance Billing and Other Protections

Federal requirements, including, but not limited to, the Consolidated Appropriations Act, may impact Your benefits. BCBSIL will apply federal requirements to your benefit plan, where applicable.

For some types of out-of-network care, your health care Provider may not bill you more than your in-network Copayment/Coinsurance. If you receive the types of care listed below, your Copayment/Coinsurance will be calculated as if you received Covered Services from a Participating Provider. Those Copayment/Coinsurance amounts will apply to any in-network Deductible and out-of-pocket maximums.

- Emergency Care from non-Participating facilities or Providers;
- Care furnished by non-Participating Providers during your visit to a Participating facility; and
- Air ambulance services from non-Participating Providers when the Plan covers in-network air ambulance services.

There are limited instances when a non-Participating Provider of the care listed above may send you a bill for up to the amount of that Provider's billed charges. You are only responsible for payment of the out-of-network Provider's billed charges if, in advance of receiving services, you signed a written notice that informed you of:

- The Provider's out-of-network status;
- In the case of services received from a non-Participating Provider at a Participating facility, a list of Participating Providers at the facility who could offer the same services;
- Information about whether Prior Authorization or other Utilization Management limitations may be required in advance of services; and
- A good faith estimate of the Provider's charges.

Your Provider cannot ask you to be responsible for paying billed charges for certain types of services, including emergency medicine, anesthesiology, pathology, radiology, and neonatology, and other specialists as may be defined by applicable law.

2. DETAILED SCHEDULE OF PPO PRESCRIPTION DRUG BENEFITS

Your PPO medical benefit coverage includes prescription drug benefits administered by CVS Caremark for you and your eligible dependents. A list of definitions that apply to this section is provided in **Appendix B.** A detailed list of covered prescription drug expenses and exclusions from coverage is attached as **Appendix D.**

Except for drugs that are considered recommended preventive drugs which are provided to you at no cost and preventive maintenance drugs for which you pay a copay (discussed below), the PPO medical plan pays no benefit until you have satisfied the individual or family deductible, as applicable. After the Deductible is satisfied, outpatient prescription drugs will be covered in the following manner through the prescription drug coverage:

Pharmacies:

Copay per Prescription (30-day supply maximum per prescription):

Preventive Drug.....$0 copay, no Deductible
Preventive Maintenance Drug ..... Applicable copay or coinsurance, no Deductible
Maintenance Drug ..... Applicable copay or coinsurance after Deductible
Generic Drug .....$10 copay after Deductible
Preferred Drug ..... 30% ($40 min - $125 max) after Deductible
Non-Preferred Drug ..... 40% ($60 min - $185 max) after Deductible

Mail Order or 90-day supply at retail:
Copay per Prescription (90-day supply maximum per prescription):

Preventive Drug.....$0 copay, no Deductible
Preventive Maintenance Drug ..... Applicable copay or coinsurance, no Deductible
Maintenance Drug .....…….Applicable copay or coinsurance after Deductible
Generic Drug .....$20 copay after Deductible
Preferred Drug ..... 30% ($80 min - $250 max) after Deductible
Non-Preferred Drug ..... 40% ($120 min - $370 max) after Deductible

Preventive prescription drugs are medications designated by federal government guidelines under the Affordable Care Act as preventive. They are not subject to the deductible, and you will not pay copays or coinsurance for them. They are covered at 100%.

Preventive maintenance prescription drugs are medications you take regularly that CVS Caremark believes meet the IRS definition of preventive for purposes of HSA-eligibility when enrolled in a high-deductible health plan. They are not subject to the Deductible. However, you will pay copays or coinsurance for them.

Maintenance prescription drugs are medications you take regularly that CVS Caremark believes do not meet the IRS definition of preventive for purposes of HSA-eligibility when enrolled in a high-deductible health plan. They are subject to the Deductible, and you will pay copays or coinsurance for them.

The Benefit Plan requires generic substitution, if available. Once the Deductible is met, if a Covered Participant chooses a Preferred or Non-Preferred Drug instead of its generic substitute, the participant not only pays the applicable copay, but also the difference in cost between the two drugs.

Drugs and medicines prescribed by a licensed Physician and dispensed by a licensed pharmacist are covered by the Benefit Plan. Outpatient prescription drugs will be covered subject to the applicable Deductible and/or copay amounts, Benefit Percentages, and any limitations as stated in the Benefit Plan.

Information regarding whether the prescription drug coverage is “creditable coverage” when compared to Medicare Part D is attached as **Appendix I**.

3. DETAILED SCHEDULE OF DENTAL BENEFITS

If you elect dental benefits, you will be responsible for contributing toward the coverage you elect. Your contributions will be deducted from your pay on a pre-tax basis.

Summary Schedule of Dental Benefits	**PPO Provider**	**Premier Provider**
Annual Deductible **(Per covered participant)**	**$50**	**$100**
Annual Benefit Maximum	**$2,000** (Excludes preventive services and wisdom tooth extraction)	**$2,000** (Excludes preventive services and wisdom tooth extraction)
Preventive (up to 2 cleanings per year)	Benefit Plan pays 100% (no Deductible)	Benefit Plan pays 90% (no Deductible)
Basic Services (fillings, simple extractions, oral surgery)	Benefit Plan pays 80% after Deductible	Benefit Plan pays 70% after Deductible
Major Services (inlays and on lays, crowns, dentures, caps, extraction of wisdom teeth*)	Benefit Plan pays 50% after Deductible	Benefit Plan pays 50% after Deductible
Orthodontics	Benefit Plan pays 50% after Deductible $2,000 Lifetime Maximum	Benefit Plan pays 50% after Deductible $2,000 Lifetime Maximum

** Extraction of wisdom teeth may also be covered under the Plan's medical coverage. Consult with your dentist for the proper coverage.*

Your dental benefit coverage is provided by Delta Dental and includes dental benefits for you and your dependents. Dental coverage under the Benefit Plan is limited to the necessary, Usual and Customary Charges, subject to the application of maximum benefit, Deductible and Benefit Percentage provisions of this section. A list of definitions that apply to this section is provided at **Appendix B.**

MAXIMUM BENEFIT PER CALENDAR YEAR **$2,000**

LIFETIME MAXIMUM BENEFIT FOR ORTHODONTIC TREATMENT per covered individual **$2,000**

PRE-TREATMENT PROCEDURES - If charges which would be payable for a proposed course of dental care will exceed a total of $250.00, written notice outlining such course and including charges should be forwarded to the Claims Administrator for assessment and certification prior to the commencement of any work or treatment. The Claims Administrator will determine and certify in writing the maximum amount of work or treatment and charges for which payment will be made. This certification is not a guarantee of payment. *Any pre-certification of charges previously issued to a Covered Participant will be of no effect after the date such person's coverage under the Benefit Plan terminates*.

"SERVICES INCURRED" AND "SERVICES PERFORMED" - Charges shall be allocated to a Calendar Year and to the Deductible or maximum applicable to such year, in accordance with the date such charge is deemed "incurred." All charges which are "incurred" with respect to any treatment plan shall be deemed "incurred" on the date the service is actually "performed."

4. DETAILED SCHEDULE OF VISION BENEFITS

Vision Benefits. Your vision benefit coverage is fully insured by VSP. If you elect vision benefits, you will be responsible for contributing toward the coverage you elect. Full-time, Part-time employees and Interns have two options – Basic or Premier coverage. Your contributions will be deducted from your pay on a pre-tax basis.

Summary of Vision Benefits	Basic	Premier
Benefit Frequency (exam/lenses/frames)	exam/lenses – every calendar year frames – every other calendar year for adults, every year for children	every calendar year*
Well Vision Exam	$0 copay	$0 copay
Materials	$20 copay	$20 copay
Single Vision Lenses, Lined Bifocal, Lined Trifocal	Covered after copay	Covered after copay
Wide Selection Frames Featured Frames	$150 allowance $170 allowance	$220 allowance $240 allowance
Contact Lens Materials and Exam (fitting and evaluation)	$150 allowance	$220 allowance
Glasses and Contacts in Same Year Permitted?	No	Yes

** The basic plan covers either contact lenses in lieu of glasses but not both. The premier plan covers both contact lenses and glasses.*

Vision benefit coverage for Regular Full-time, Part-time Employees and Interns includes vision benefits for you and your dependents. Your vision benefits reimburse 100% of the cost of annual eye exams (including retinal imaging) and a significant portion of costs associated with glasses (including frames and lenses) and contact lenses as provided in the chart above.

The initial purchase of lenses required after cataract surgery is covered under the regular medical benefit provisions of the Benefit Plan.

5. WELLNESS PROGRAMS

From time to time the Plan may offer wellness programs designed to promote the health and well-being of all employees. These wellness programs may provide financial incentives/disincentives such as a tobacco use surcharge or HRA or HSA contribution to engage in activities that encourage healthy lifestyle changes, provide you with information about your current health condition by undergoing health screenings or answering questionnaires, give you the opportunity to receive health "coaching" and participate in disease management programs, provide on-line education tools, etc. These wellness programs are designed to help mitigate risks and allow you to be more involved in your healthcare, which may lead to a healthier employee population with lower healthcare costs, ultimately saving you and Devon money. Any information collected as part of a wellness program will be de-identified and may be analyzed and considered when developing future wellness programs and making future plan design changes affecting all participants. The terms of any wellness programs will be communicated to you separately as part of open enrollment material or other communication. Devon is committed to helping you achieve your best health. Participation in the wellness program is available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program or need a reasonable accommodation due to disability, you might qualify for an opportunity to earn the same reward by different means. Contact wellness@dvn.com and we will work with you (and, if you wish, with your doctor) to find an activity with the same reward that is right for you considering your health status. Any wellness program and related financial incentive offered under the Plan shall comply with the requirements and limitations of HIPAA, PPACA, EEOC and related guidance.

Each enrolled employee in the Benefit Plan will be given an opportunity to complete wellness-related activities throughout the year. Participation in this process helps participants understand their own health risks and helps Devon keep the cost of medical coverage down by identifying areas where participants may benefit from proactive preventive health services.

Completion of the wellness activities is completely voluntary and Regular Full-Time and Part-Time employees receive wellness incentives based upon their level of participation. However, to encourage participation, there is no cost to the employee enrolled in Devon's medical plan to complete the in-network preventive annual physical exam including biometric screening lab work and Regular Full-time and Part-Time Employees receive a wellness incentive for participating in this confidential and valuable health review. If you participate in the PPO medical plan, Devon will deposit the designated wellness incentive into your HSA. If you participate in the PPO but are ineligible for an HSA due to Medicare enrollment, Devon will credit a health reimbursement account (see below) with the designated wellness incentive. You should refer to your annual enrollment materials for details about the wellness incentive opportunity each year. Interns may participate in the wellness activities but are not eligible to earn a wellness incentive.

The annual physical exam and biometric screening lab work should be performed by your own doctor but will only be paid at 100% if your doctor codes the visit as preventive and is in-network.

HEALTH REIMBURSEMENT ACCOUNT

Devon may establish an HRA for you if you participate in the PPO medical benefit but are ineligible for an HSA due to Medicare enrollment. An HRA is an employer-funded account that you can use to pay for qualified medical expenses. You may not make additional contributions to an HRA. If you have a residual amount in your HRA at the end of the Plan Year, it will carry over and be available for reimbursements the following year. However, if your employment ends or you are no longer eligible for Devon benefits, your participation in the HRA terminates and you will have three months from the end of the Plan Year in which to submit claims. If you

participate in the HRA and the Health FSA, your eligible claims will first run through the Health FSA and then the HRA account. You are not eligible to receive employer contributions or make pre-tax payroll contributions to an HSA if you have funds available to you in an HRA.

Other Benefits

The following is intended to provide only a summary of the other benefits under the Plans. Additional, more detailed information about each of the following benefit options below, including insurance booklets, benefit limitations and beneficiary forms is available on HRConnect or by contacting the Devon Employee Benefits Department. See the section entitled "Plan Information – Claims Administrator" for provider contact information. It is important that you refer to the provider-specific information for a complete description of the following benefits.

1. Basic Life/AD&D Coverage

Basic life insurance and accidental death and dismemberment insurance coverage are provided to you by Devon at no cost to you. Eligible Regular Full-time and Part-time Employees are provided with coverage of two times base annual salary up to a maximum of $1 million dollars. Eligible interns are automatically enrolled in a $50,000 accidental death and dismemberment benefit.

Note: The first $50,000 of basic life insurance coverage is tax-free. However, under current federal tax laws, if you have basic life insurance coverage in excess of $50,000, the amount in excess of $50,000 results in taxable income to you. Although this income is not actually received by you in your paycheck, it is taxable to you and must be reported as such on your Form W-2.

2. Voluntary Life Insurance

Voluntary life insurance coverage, including coverage for your spouse, domestic partner and/or dependent children is available to Regular Full-time and Part-time Employees. Interns are not eligible to elect voluntary life insurance. If you elect to receive voluntary life insurance under the Plans, you will be responsible for paying for the coverage you elect on an after-tax basis. For purposes of dependent child coverage under the voluntary life insurance coverage, eligible dependent children are up to age 26. A dependent child may not be covered by more than one employee. For additional limitations on dependent coverage, please see the certificate of coverage. Voluntary life insurance elections are made annually and are not eligible to change outside of open enrollment or qualified life events; with the exception of a mid-year change allowable due to premium cost increasing by a minimum of 100% due to a member's movement into new age banding.

3. Voluntary AD&D Insurance

Voluntary AD&D coverage, including coverage for your spouse, domestic partner and/or dependent children, and/or domestic partner child(ren) is available to Regular Full-time and Part-time Employees. Interns are not eligible to elect voluntary AD&D coverage. If you elect to receive voluntary AD&D insurance under the Plans, you will be responsible for paying for the coverage you elect on an after-tax basis. For purposes of dependent child coverage under the voluntary

AD&D insurance, eligible dependent children are up to age 26. A mentally or physically disabled dependent child incapable of self-sustaining employment and chiefly dependent on you for support may also qualify as a dependent child if proof of incapacity and dependency is submitted prior to attainment of age 26. A dependent child may not be covered by more than one employee. For additional limitations on dependent coverage, please see the certificate of coverage.

4. Short-Term Disability Coverage

Short-term disability benefits replace a portion of your income if you become disabled and are unable to work. This coverage is provided to Regular Full-time Employees at no cost as a salary continuation by Devon. Part-time Employees and Interns are not eligible for short-term disability coverage. The benefit begins on the 5th day of your disability and expires when you are no longer disabled or after 180 days, whichever occurs first.

5. Long-Term Disability Coverage

Long-term disability coverage replaces a portion of your income if you become disabled and are unable to work. This coverage is provided to Regular Full-time Employees at no cost. Part-time Employees and Interns are not eligible for long-term disability coverage. Your long-term disability compensation will be equal to 60% of your monthly compensation up to a maximum benefit per month. The benefit begins on the 181st day of your disability and expires when you are no longer disabled or your attainment of Social Security retirement age, whichever occurs first.

6. Flexible Spending Accounts

Flexible spending accounts ("FSAs") provide valuable benefits designed to give Regular Full-time and Part-Time Employees a tax-effective way to reimburse yourself on a tax-free basis for certain health care and dependent care expenses. Interns are not eligible to participate in the FSAs. If you elect to establish one or more FSAs, the contributions you elect will be deducted from your pay on a before-tax basis. The flexible spending accounts under the Flexible Benefits Plan are administered by Flores & Associates.

The following description is only a highlight of the benefit, restrictions and limitations. Additional information, instructions and claims forms are available from the claims administrator at *www.Flores247.com*.

The following general rules apply to both types of flexible spending account.

Use it or lose it. Plan your expenses carefully. If you do not incur eligible expenses by December 31, non-reimbursed funds are forfeited. You may not carry over balances from year to year or receive a refund of unused amounts. You may submit claims until March 31 of the following year for expenses incurred during the preceding Calendar Year. Devon uses any unclaimed money to offset the administrative costs of the Plans.

Separate Accounts. You may not use money from the health care flexible spending account to pay for dependent care expenses, or money from the dependent care flexible spending account to pay for health care expenses. If you wish to pay for health care and dependent care expenses on a pre-tax basis, you must elect and contribute to both accounts.

Spending Account or Tax Deduction, or Tax Credit, not Both. You may not claim a tax deduction or tax credit for any expenses reimbursed through a flexible spending account.

<u>Restrictions on Contributions by Highly Compensated Employees</u>. Both spending accounts must meet stringent IRS tests that compare the benefits of employees who are highly compensated with all other employees. If these tests are not met, the amount contributed by the highly paid group of employees may be taxed and/or reduced.

Domestic Partner Expenses: Expenses of a domestic partner or children of domestic partners are generally not eligible for reimbursement under your flexible spending accounts.

Health Care Flexible Spending Account

The Health Care Flexible Spending Account ("Health Care FSA") may be used to pay any health care expense that would qualify for a medical deduction under IRS rules, except for premiums paid for other health plan coverage (including Medicare or plans maintained by the employer of your spouse or dependent) and certain long-term care expenses. Generally, the expenses covered must be "Medically Necessary" or prescribed by a licensed Physician to qualify. Expenses must be incurred on behalf of you, your spouse and any dependent. You may contribute up to $3,200 to a Health Care FSA effective Jan. 1, 2024. **Updated information for calendar years other than 2024, if available, is posted on HRConnect and in the current year's Benefits Guide.**

The Health Care FSA is a limited excepted benefit under Code Section 9831.

Eligible Expenses

Health care expenses generally include, but are not limited to:

- Deductibles and copays;
- medical, dental, prescription drug and vision expenses not covered by any insurance or a benefit plan; and
- prescribed medication
- feminine hygiene products

Expenses eligible for reimbursement include only those expenses for medicines or drugs if the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin.

Ineligible Expenses

In general, any expenses that cannot be claimed as medical expenses for income tax purposes are not reimbursable. Ineligible expenses include, but are not limited to:

- expenses incurred by a domestic partner or children of a domestic partner, unless such individuals otherwise qualify as IRS tax dependents
- premiums for health insurance;
- certain long-term care expenses;
- cosmetic surgery (except in limited circumstances);
- electrolysis;
- health club dues not related to a specific medical condition;
- dental bonding and bleaching;
- services for which any insurance reimburses you; and
- services rendered before you become a participant in the Flexible Benefits Plan and after your participation has ended.

Refer to *www.Flores247.com* for more information on eligible and ineligible expenses.

Claims. Claims for reimbursement, including substantiation of the expense, must be submitted timely by March 31 following the end of the Plan Year in which the expense was incurred in accordance with the claim instructions at *www.Flores247.com*.

HSA. You are not eligible to receive employer contributions or make pre-tax payroll contributions to an HSA if you have funds available to you in a general-purpose Health Care FSA.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account ("Dependent Care FSA") is designed to help you pay for eligible expenses directly related to the "well-being and protection" of a "qualifying individual" (defined below).

To be eligible, the services must make it possible for you and your spouse to work or to attend school on a full-time basis. Any type of dependent care that you could legally claim if you were filing for credit on your income taxes is eligible for funding under the Dependent Care FSA. You may contribute up to $5,000 to a Dependent Care FSA. You should note that your contributions in any Calendar Year will be limited to $5,000 as well.

For the purposes of this plan, a qualifying individual includes the following:

- your child, grandchild, brother or sister who is under age 13, who resides in your household for more than one-half of the year and who does not provide more than one-half of his or her own support for the year (if you are divorced or separated, certain qualifications and special custody/support rules may apply);
- a disabled spouse who resides in your household for more than one-half of the year; and
- a disabled relative or household member who is principally dependent on you for support and who resides in your household for more than one-half of the year.

Note: A disabled dependent must spend at least eight hours a day in your home. A disabled dependent who is confined to an institution for care would not qualify.

To be eligible to use this account, you must be actively working during the time your eligible dependent is receiving care; provided, however, that care provided during certain "short" or "temporary" absences for Illness or paid time off may be eligible if you are required to pay for such care on a weekly or longer basis. Also, if you work part-time, you do not have to allocate expenses between time worked and time not worked if you are required to pay for care on a weekly or longer basis.

Qualifications for Dependent Care Flexible Spending Account

You qualify to use this account if:

- you are a single parent;
- you have a working legal spouse;
- your spouse is a full-time student for at least five (5) months during the year you are working; or
- your spouse is disabled and unable to provide for his or her own care.

Eligible Expenses

Eligible dependent care expenses include:

- services provided to care for eligible dependents while you are at work, if the provider submits a tax ID or social security number;
- household services, if attributable to the care of your dependent;
- the services of a day care center (if the center provides care for more than six individuals, other than residents, it must comply with all applicable state and local laws);
- the services at a day camp, including a camp that specializes in a particular activity (such as a soccer or computer camp);
- care for a disabled dependent provided outside your home if the dependent is a child under age 13 or is in your home for at least eight hours a day;
- certain education expenses—for example, the cost of nursery school, including lunches—if your child is not yet in the first grade;
- expenses for care provided in your home, if the care is not provided by someone you or your spouse claims as a dependent on your federal income tax return, or your child who is under age 19 (even if you no longer claim that child as a dependent); and
- agency fees, application fees or deposits, if you are required to pay these expenses to obtain the related care.

To make sure your situation and the type of care being provided meets IRS requirements; refer to IRS Form 2441 and IRS Publication 503, "Child and Dependent Care Expenses" or visit *www.Flores247.com*. In addition, you should know that if you use a dependent care provider inside your home you may be considered the employer of that individual and may be responsible for withholding and paying employment taxes. For more information, refer to IRS Publication 926, "Employment Taxes for Household Employees." These forms and publications are available on the IRS website (*www.irs.gov*), and should be available at your local post office or public library.

Ineligible Expenses

In general, any expenses that cannot be claimed as dependent care expenses for income tax purposes are not reimbursable. Ineligible expenses include, but are not limited to the following:

- overnight camp;
- activity fees;
- non-employment related care, such as babysitting fees during non-working hours;
- school transportation;
- schooling in the first grade and beyond; and
- pre-first grade schooling that can be separated from the cost of care
- expenses incurred by a domestic partner or children of a domestic partner, unless such individuals otherwise qualify as IRS tax dependents

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Maximum Tax-Free Reimbursement

Generally, amounts reimbursed from your Dependent Care FSA are tax-free to you. However, federal law provides that the amount excluded from your gross income cannot exceed the lesser of:

- $5,000 ($2,500 if you are married and filing separate federal income tax returns);
- your annual income; or
- your legal spouse's annual income.

If your spouse is (1) a full-time student for at least five months during the year or (2) physically and/or mentally handicapped, there is a special rule to determine his or her annual income. To calculate the income, determine your spouse's actual taxable income (if any) earned each month that he or she is a full-time student or disabled. Then, for each month, compare this amount to either $250 (if you claim expenses for one dependent) or $500 (if you claim expenses for two or more dependents). The amount you use to determine your spouse's annual income is the greater of the actual earned income or these assumed monthly income amounts of either $250 or $500. By making an election under the Flexible Benefits Plan to contribute to a Dependent Care FSA, you are representing to the Company that your contributions to the Account are not expected to exceed these limits.

Claims. Claims for reimbursement, including substantiation of the expense, must be submitted timely by March 31 following the end of the Plan Year in which the expense was incurred in accordance with the claim instructions at *www.Flores247.com*.

7. Employee Assistance Program

If you are a Full-time or Part-time employee, you and your family are automatically covered under the employee assistance program ("EAP") at no cost to you. Interns are not eligible to participate in the EAP. The employee assistance program provides confidential telephone assessment, Counseling sessions and referral services to assist you and your family in times of need.

8. Business Travel Accident Coverage

If you die or are seriously injured while traveling on Company business, the business travel accident insurance coverage may pay benefits to you or your beneficiary. This coverage is provided by Devon to Full-time and Part-time employees at no cost to you and provides coverage of five times base salary up to $2 million dollars. Coverage for interns is at no cost and provides a benefit of two times base salary up to $500,000.

9. Tuition Reimbursement

You are eligible for tuition reimbursement benefits of up to $5,250 per year for qualifying educational expenses that relate to your employment at Devon. For additional information or to request pre-approval of a qualifying educational course, please contact HRConnect.

Privacy of Health Information

The receipt use and disclosure of protected health information by the medical, prescription, dental, vision, employee assistance program and health care flexible spending account portions of the Plans are governed by regulations issued under the Health Insurance Portability and Accountability Act (HIPAA). In accordance with these regulations, the Plan Administrator, certain employees of the Plans and the Plans' business associates may receive, use and disclose protected health information to carry out payment, treatment and health care operations under the Plans. These entities and individuals may use protected health information for such purposes without your consent or written authorization. In addition, your protected health information may be shared with the Plan Sponsor without your consent or written authorization for administrative purposes. In the normal course, if your protected health information is used or disclosed for any

other purpose, your written authorization for such use or disclosure will be required. See **Appendix G** for information regarding the privacy of your protected health information.

VII. CLAIMS PROCEDURE

A request for benefits is a "claim" subject to these procedures only if it is filed by you or your authorized representative in accordance with the Plans' claim filing guidelines. In general, claims must be filed in writing with the applicable provider identified in the "Plan Information – Claims Administrator" section of this SPD. Any claim that does not relate to a specific benefit under the Plans (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator at the address set forth in the "Additional Information" section below. A request for prior approval of a benefit or service where prior approval is not required under the Plans is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plans is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to allow the Claims Administrator to process the claim, you will be given an opportunity to provide the missing information.

If you want to bring a claim for benefits under a Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the Claims Administrator identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

Medical Benefits

The following claims procedures apply to medical benefits (including prescription drug), dental, vision and health care flexible spending account benefits provided under the Plans.

Claims Procedures

Post-Service Claims

Post-service claims are those claims that are filed for payment of benefits after medical care has been received. Claims must be submitted to the Claims Administrator no later than December 31 following the end of the Plan Year in which the service occurred. Claims must be in the form specified and include all documentation required by the Claims Administrator. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, if all needed information was provided with the claim. The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim and may request a one-time extension, not to exceed 15 days. Your claim will remain pending until all information is received.

Once notified of the need for additional information, you have 45 days to provide the required information. If all the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the required information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Benefit Plan or Flexible Benefits Plan on which the denial is based and provide the claim appeal procedures. You will also

be provided with a description of any other material or information necessary for you to re-submit the claim as well as explanation as to why the information is necessary.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim is a pre-service claim and is submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim.

If you file a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within five days after the pre-service claim is received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received and may request a one-time extension, not to exceed 15 days. Your claim will remain pending until all information is received.

Once notified of the extension, you have 45 days to provide the required information. If all the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the required information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Benefit Plan or Flexible Benefits Plan on which the denial is based, and provide the claim appeal procedures. You will also be provided with a description of any other material or information necessary for you to re-submit the claim as well as explanation as to why the information is necessary.

Urgent Claims that Require Immediate Action

Urgent care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations:

You will receive notice of the benefit determination in writing or electronically within 72-hours after the Claims Administrator receives all necessary information, considering the seriousness of your condition.

Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If you filed an urgent care claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- the Claims Administrator's receipt of the requested information; or
- the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Benefit Plan or Flexible Benefits Plan on which the denial is based, and provide the claim appeal procedures. You will

also be provided with a description of any other material or information necessary for you to re-submit the claim as well as explanation as to why the information is necessary.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period or number of treatments and your request to extend the treatment is an urgent care claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will decide on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described above.

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

With respect to the concurrent care claims, if your claim is denied, you will be notified of the denial at a time sufficiently in advance of the reduction or termination in treatment to allow you to appeal and obtain a determination on review of the denial before the treatment is reduced or terminated.

Finding Out the Status of a Claim

For information about the status of a claim, you can log on to the Claims Administrators website or call the Claims Administrator directly. When you call, have the date of service, the bill amount, the provider name and your identification number from your ID card ready.

You will receive an Explanation of Benefits ("EOB") for each claim filed, describing the expenses submitted, any exclusions or Deductibles and the benefits paid, if any.

Appeal Procedures

If you feel an error has been made in your records or in processing your claim, you should know that an appeals procedure is available to you.

The chart in the "Plan Information" section of this SPD lists the names, addresses and phone numbers of the insurer or Claims Administrator responsible for the plan option. If you have a question about a claim, you can contact the appropriate administrator directly.

Appealing a Claim

This section provides information to help you with the following:

- if you have a question or a concern about your benefits under one of the medical plan options; or
- you are notified that a claim has been denied because it has been determined that a service or benefit is excluded under one of the medical plan options and you wish to appeal such determination.

What to Do First

If your question or concern is about a benefit determination, you may informally contact the Claims Administrator before requesting a formal appeal. If the Claims Administrator representative cannot resolve the issue to your satisfaction over the phone, you may submit your question to the Claims Administrator in writing.

If you are not satisfied with a benefit determination as described in the "Claims Procedures" section of this SPD, you may appeal it as described below, with or without first informally contacting the Claims Administrator. If you first informally contact the Claims Administrator and later wish to request a formal appeal in writing, you should contact the Claims Administrator and request a formal appeal, at which time you will be provided with the appropriate address for submitting your appeal.

If you are appealing an urgent care claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" information in this section and contact the Claims Administrator immediately.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- the patient's name and the identification number from your ID card;
- the date(s) of service(s);
- the provider's name;
- the reason you believe the claim should be paid; and
- any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional, who was not involved in the prior determination, and has appropriate expertise in the field.

With your consent to share the pertinent claim information, the Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. Upon request, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits, including the right to know the identification of any medical or vocational experts whose advice was obtained, free of charge.

First Level of Appeal - Appeal to Claim Administrator
Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as described below.

- For appeals of pre-service claims (as defined in the "Claims Procedures" section of this SPD), the first level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim.

- For appeals of post-service claims (as defined in the "Claims Procedures" section of this SPD), the first level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

Please note that decisions are based only on whether benefits are available under the Benefit Plan or Flexible Benefits Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Second Level of Appeal - Appeal to Claim Administrator
Pre-Service and Post-Service Claim Appeals

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of first level appeal decision.

For appeals of pre-service claims (as defined in the "Claims Procedures" section of this SPD), the second level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim.

For appeals of post-service claims (as defined in the "Claims Procedures" section of this SPD), the first level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

The Claims Administrator has the exclusive right to interpret and administer the Devon medical plan options and these decisions are conclusive and binding.

Please note that decisions are based only on whether benefits are available under the Benefit Plan or Flexible Benefits Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, the ability to regain maximum function or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or

electronic determination within 72 hours following receipt of your request for review of the determination considering the seriousness of your condition.

For urgent claim appeals, Devon has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Benefit Plan or Flexible Benefits Plan. The Claims Administrator's decisions are conclusive and binding.

Other Benefits

Dependent Care Flexible Spending Account

Time Periods for Responding to Initial Claims

If you bring a claim for benefits under the Dependent Care Flexible Spending Account, the Claims Administrator will respond to you within 90 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Flexible Benefits Plan, the Claims Administrator will notify you within the initial 90-day period that the Claims Administrator needs up to an additional 90 days to review your claim.

Notice and Information Contained in Notice Denying Initial Claim

If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial. This notice will include the following:

- the specific reason or reasons for the denial;
- reference to specific provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect your claim and explanation why such information is necessary; and
- a description of the Flexible Benefit Plan's appeals procedures and the time limits applicable for such procedures.

Appealing a Denied Claim for Benefits

If your initial claim for benefits under the Dependent Care Flexible Spending Account is denied by the Claims Administrator, you may appeal the denial by filing a written request with the Claims Administrator within 60 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Claims Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.

Time Periods for Responding to Appealed Claims

If you appeal a denied claim for benefits under the Dependent Care Flexible Spending Accounts, the Claims Administrator will respond to your claim within 60 days after receipt of the appeal. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Flexible Benefits Plan, the Claims Administrator will notify you within the initial 60-day period that the Claims Administrator needs up to an additional 60 days to review your claim.

Notice and Information Contained in Notice Denying Appeal

If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial. This notice will include the following:

- the specific reason or reasons for the denial;
- reference to specific provisions on which the denial is based; and
- a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits.

The decision of the Claims Administrator shall be final and conclusive on all persons claiming benefits under the Flexible Benefits Plan, subject to applicable law. If you challenge the decision of the Claims Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in court. Facts and evidence that become known to you after having exhausted the Claims procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

External Review

An external review may be available for final adverse benefit determinations involving (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, or (2) rescission of coverage (i.e., a retroactive termination of coverage, whether the rescission has any effect on any particular benefit at the time). Claimants in urgent care situations and those receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process. External review is not available for final adverse determinations that relate to a failure to meet the eligibility requirements under the Plan. If your claim for benefits has been denied and you received a final adverse benefit determination in response to your subsequent appeal, the notification of final adverse benefit determination will provide instructions on how to request an external review. You may also contact the medical benefit Claims Administrator or HRConnect for more information on how to request an external review.

All Other Benefits

You should follow the claims procedures set forth in the “Claim Procedures” section of the insurance certificate of coverage available on HRConnect or other benefit summary provided to you by the insurer or provider. Contact the Claims Administrator for the benefit listed in “Funding and Claims Administrator Information” in Article IX.

Legal Actions

If you wish to bring a claim-related legal action against Devon, you must first go through the claims and appeals procedures described in this SPD or applicable insurance certificate. You may choose to bring legal action after the second level of appeal by the Claims Administrator. You may not bring legal action more than 12 months after you’ve gone through the appeals process.

VIII. CONTINUATION OF MEDICAL COVERAGE UNDER COBRA

Under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), you and/or your spouse and dependent children may be eligible to continue health coverage if your or their coverage ends because of certain "qualifying events." The right to continue coverage may apply to medical, dental and vision benefits, EAP and FSA coverage. You may have additional rights to continued benefits under state law. **Appendix F** contains a notice outlining the continuation of coverage available under COBRA.

Special Rules Apply to Health Care Flexible Spending Account. Note that regulations issued by the IRS provide that continuation of coverage rights under COBRA are applicable with respect to arrangements such as the health care flexible spending account, but special rules apply. First, COBRA continuation coverage will be offered only if your reimbursements for the year under the health care flexible spending account at the time coverage is lost do not exceed the total contributions to the Spending Account for the year. Second, if COBRA continuation coverage is offered under the health care flexible spending account it will only be offered for the balance of plan year in which coverage is lost and will not be offered for subsequent years.

Please be aware that any contributions you make under the health care flexible spending account pursuant to COBRA will be made on an after-tax basis at a rate of 102% of the amount available for reimbursement. Therefore, the chief advantage of participating in the account – that is, the tax savings attributable to payment of qualifying expenses with before-tax dollars – will not be available to you.

IX. GENERAL PLAN INFORMATION

Plan Information

The official plan names, plan identification numbers, and Plan Year (fiscal year used for plan records) for the Plans are as follows:

Plan Names: Devon Energy Corporation Employee Benefit Plan and Devon Energy Corporation Flexible Benefits Plan

Plan Numbers: 501 and 502

Plan Year: The twelve (12) month period commencing January 1 and ending December 31.

Type of Plan: The Benefit Plan is a welfare benefit plan providing the following types of benefits: (1) medical (including prescription drugs and telemedicine), (2) dental, (3) vision, (4) health reimbursement account, (5) life insurance, (6) accidental death and dismemberment insurance, (7) disability insurance, (8) business travel accident insurance, (9) employee assistance program and (10) tuition reimbursement benefits.

The Flexible Benefits Plan is a Section 125 cafeteria plan with pre-tax premium and flexible spending account components.

Type of Administration: The Plans provides both self-insured and insured welfare benefits.

Company/Plan Sponsor Information:
The name, address and telephone number of Devon/Plan Sponsor are as follows:

Devon Energy Corporation
333 W. Sheridan Avenue
Oklahoma City, OK 73102
(405) 552-7987

Employer Identification Number ("EIN"):
The employer identification number assigned to Devon by the IRS is as follows:

73-1567067

Plan Administrator Information:
The name and business address of the Plan Administrator are as follows:

The Devon Energy Corporation Benefits Committee
c/o Jeremy Colby
Devon Energy Corporation
333 W. Sheridan Avenue
Oklahoma City, OK 73102
(405) 552-7987

Agent for Service of Legal Process:

The agent for the service of legal process for the Plans is:

CT Corporation
1833 South Morgan Road
Oklahoma City, OK 73128

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

Funding and Claims Administrator Information:
This section provides information regarding the third-party providers with which the Plans has entered into contracts and describes the funding source of benefits under the Plans (guaranteed under contracts or from Devon's general assets). Also included is important claims filing contact information.

Benefit	Claims Administrator Contact Information
Medical *The Benefit Plan has contracted with the following provider to provide medical benefits and claims services for the medical benefit available under the Plan. Benefits are paid from Devon's general assets and are not guaranteed under the contract.*	Blue Cross/Blue Shield of Illinois P.O. Box 1220 Chicago, IL 60690-1220 (800) 311-0419 www.bcbsil.com
HRA *The Benefit Plan has contracted with the following provider to administer the health reimbursement account claims services for incentives for non-HSA eligible employees available under the Plan. Benefits are paid from Devon's general assets and are not guaranteed under the contract.*	Flores (800) 532-3327 *www.Flores247.com*
HSA *The HSA custodian contact information is provided for your convenience. The HSA is not governed by ERISA, not an employer-sponsored plan and not part of the Benefit Plan.*	Fidelity (800) 890-4015 *www.401k.com*
Dental *The Benefit Plan has contracted with the following provider to provide dental benefits and claim services under the Plan. Benefits are guaranteed under the contract.*	Delta Dental (800) 522-0188 *www.deltadentalok.org*
Vision *The Benefit Plan has contracted with the following provider to provide vision benefits and claim services under the Plan. Benefits are guaranteed under the contract.*	VSP (800) 877-7195 *www.vsp.com*
Medical - Prescription coverage *The Benefit Plan has contracted with the following provider to provide prescription benefits and claims services for the prescription benefit available under the Plan. Benefits are paid from Devon's general assets and are not guaranteed under the contract.*	CVS Caremark PO Box 6590 Lee's Summit, MO 64064-6590 (855) 361-8567 *https://www.caremark.com/wps/portal*
Medical – Telemedicine *The Benefit Plan has contracted with the following provider to provide telehealth services for the telemedicine benefit under the Plan. Benefits are paid from Devon's general assets and are not guaranteed under the contract.*	MDLIVE (888) 676-4204 www.mdlive.com/bcbsil

Benefit	Claims Administrator Contact Information
Short-term Disability *The Plan Administrator administers the short-term disability benefits. Benefits are paid from Devon's general assets and are not guaranteed under the contract.*	Prudential P.O. Box 13480 Philadelphia, PA 19101 (800) 842-1718

Benefit	Claims Administrator Contact Information
Long-term Disability *The Benefit Plan has contracted with the following provider to provide long term disability benefits and claim services under the Plan. Benefits are guaranteed under the contract.*	Prudential P.O. Box 13480 Philadelphia, PA 19101 (800) 842-1718
Life Insurance *The Benefit Plan has contracted with the following provider to provide basic and voluntary life insurance under the Plan. Benefits are guaranteed under the contract.*	Prudential P.O. Box 8517 Philadelphia, PA 19176 (800) 524-0542 Overnight Street Address: 2101 Welsh Road Dresher, PA 19025
AD&D Insurance *The Benefit Plan has contracted with the following provider to provide basic and voluntary accidental death and dismemberment insurance under the Plan. Benefits are guaranteed under the contract.*	Prudential P.O. Box 8517 Philadelphia, PA 19176 (800) 524-0542 Overnight Street Address: 2101 Welsh Road Dresher, PA 19025
Business Travel Accident Insurance *The Benefit Plan has contracted with the following provider to provide business travel accident insurance under the Plan. Benefits are guaranteed under the contract.*	Prudential P.O. Box 8517 Philadelphia, PA 19176 (800) 524-0542 Overnight Street Address: 2101 Welsh Road Dresher, PA 19025
Employee Assistance Program *The Benefit Plan has contracted with the following provider to provide employee assistance benefits under the Plan. Benefits are guaranteed under the contract.*	Lyra Health devon.lyrahealth.com **(877) 849-1352**
Flexible Spending Accounts *The Flexible Benefits Plan has contracted with the following provider to provide medical care and dependent care flexible spending account claims services under the Plan. Benefits are paid from Devon's general assets and are not guaranteed under the contract.*	Flores www.Flores247.com (800) 532-3327

Additional General Plan Information

Nondiscrimination

Contributions and benefits under the Plans will not discriminate in favor of "highly compensated employees" or "key employees" as those categories of employees are defined in the Internal Revenue Code. Devon may limit or deny your compensation reduction agreement to the extent necessary to avoid such discrimination in compliance with federal law.

Amendment or Termination of Plan

Devon reserves the right to suspend, amend, modify, or terminate the Plans in any manner at any time, including the right to modify or eliminate any cost-sharing between Devon and participants.

Changes are made by action of Devon's board of directors, or to the extent authorized by resolution of its board of directors or by the Devon Energy Corporation Benefits Committee.

The procedure for amendment or modification of the Plans, programs, or policies shall consist of the lawful adoption of a written amendment or modification to the Plans, programs, or policies by majority vote at a validly held meeting or by unanimous, written consent, followed by the filing of such duly adopted amendment or modification by the secretary with the official records of the company. Participants will be notified in due course concerning substantial changes.

Benefits for claims occurring after the effective date of plan modification or termination are payable in accordance with the revised plan documents.

All statements in this book, the official plan documents, and all representations by Devon or its personnel are subject to this right of amendment, modification, suspension, or termination. These rights apply without limitation, even after an individual's circumstances have changed by retirement or otherwise.

Plan benefits do not become vested. In the event either of the Plans is terminated, assets held in trust, if any, for the Plans will be used to provide benefits for employees of Devon or a successor, or they may be used in other ways not prohibited by the Internal Revenue Code or regulations.

No Contract of Employment

The Plans are not intended to be, and may not be construed as constituting, a contract or other arrangement between you and Devon that you will be employed for any specific period.

Loss of Benefits

Except as might otherwise be described in the separate descriptive booklets, your coverage generally ends on the day of employment termination or loss of eligibility. There are also circumstances which may result in ineligibility or in denial, loss, suspension, offset, reduction or recovery of medical benefits that a Participant otherwise expected the Devon Plan to provide. These circumstances include, but are not limited:

- subrogation, recovery, and third-party recovery rights of the Plans;
- coordination of benefits when a Participant is enrolled in more than one plan and the Devon Benefit Plan is not the primary plan;
- possible reductions when private Hospital rooms are used and for certain Multiple Surgical Procedures;

- reductions due to charges that exceed Usual and Customary Charges;
- reductions or denials due to services that are not generally accepted as appropriate, and/or which are not Medically Necessary, and/or which are considered as over utilization;
- treatment, services or supplies that are excluded from coverage by the Benefit Plan, whether Medically Necessary;
- non-compliance with the Benefit Plan's precertification requirements; or
- non-compliance with a claim filing deadline of a benefit under the Plans.

Third Party Liability / Subrogation

General Principle

When you or your dependent receive benefits under the Benefit Plan which are related to medical expenses that are also payable under workers' compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your dependent shall reimburse the Benefit Plan for the related benefits received out of any funds or monies you or your dependent recovers from any third party. This is the case regardless of whether the third-party recovery is designated for medical costs or expenses.

Specific Requirements and Benefit Plan Rights

Because the Benefit Plan is entitled to reimbursement, the Benefit Plan shall be fully subrogated to all rights, recovery or causes of actions or claims that you or your dependent may have against any third party. The Benefit Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the way the recovery is structured or worded, and even if you or your dependent has not been paid or fully reimbursed for all their damages or expenses.

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

The Benefit Plan may enforce its subrogation or reimbursement rights by requiring you or your dependent to assert a claim to any of the benefits to which you or your dependent may be entitled. The Benefit Plan will not pay attorney's fees or costs associated with the claim or lawsuit without express written authorization from Devon.

If the Benefit Plan should become aware that you or your dependent has received a third party payment, amount or recovery and not reported such amount, the Benefit Plan, in its sole discretion, may suspend all further benefits payments related to you or any of your dependents until the reimbursable portion is returned to the Benefit Plan, offset against amounts that would otherwise be paid to or on behalf of you or your dependents or terminate you or your dependent's coverage under the Benefit Plan.

Participant Duties and Actions

By participating in the Benefit Plan, you and your dependents consent and agree that a constructive trust, lien, or an equitable lien by agreement in favor of the Benefit Plan exists regarding any settlement or recovery from a third person or party. In accordance with that constructive trust, lien, or equitable lien by agreement, you and your dependents agree to cooperate with the Benefit Plan in reimbursing it for Benefit Plan costs and expenses.

Once you or your dependent has any reason to believe that you or they may be entitled to recovery from any third party, you or your dependent must notify the Benefit Plan. At that time, you and your dependent (and your or their attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Benefit Plan's subrogation rights and the Benefit Plan's right to be reimbursed for expenses arising from circumstances that entitle you or your dependent to any payment, amount or recovery from a third party.

If you or your dependent fails or refuses to execute the required subrogation/reimbursement agreement, the Benefit Plan may deny payment of any benefits to you and any of your dependents until the agreement is signed. Alternatively, if you or your dependent fails or refuses to execute the required subrogation/reimbursement agreement and the Benefit Plan nevertheless pays benefits to or on behalf of you or your dependent, you or your dependent's acceptance of such benefits shall constitute agreement to the Benefit Plan's right to subrogation or reimbursement and you or your dependent's agreement to a constructive trust, lien and/or equitable lien by agreement in favor of the Benefit Plan on any payment, amount or recovery that you recover from any third party..

You and your dependent consent and agree that you or they shall not assign your or their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Benefit Plan's consent. As such, the Benefit Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from Devon. Any funds received by or on behalf of you or your dependent will be treated as being held in constructive trust on behalf the Benefit Plan. You or your dependent may not receive any of the funds until you or your dependent has fully paid the Benefit Plan's claims for subrogation and reimbursement.

Coordination of Medical Benefits

The Benefit Plan has a coordination of benefits feature with respect to medical benefits. This prevents duplication of benefits if you or your dependent is covered by more than one medical plan. When a claim is made, the "primary" plan pays benefits first, without regard to the other plan. When the Benefit Plan is secondary, the Benefit Plan calculates what it would have paid if it were primary and reduces benefits by what the other plan has paid.

The Benefit Plan will not supplement the other plan but will coordinate with the other plan to bring your reimbursement to what the Benefit Plan would have paid. In no circumstances will the Benefit Plan pay more than it would have paid if it were your primary coverage. Generally, the plan covering a person as an employee is the "primary" plan while the plan covering the same person as dependent is the "secondary" plan.

Coordination of benefits rules apply whenever you or a dependent is covered by more than one insurance plan. Plan includes any other type of coverage for persons in a group—whether the plan is fully insured or self-insured. No-fault auto insurance that is required by law is also included,

even if it is not provided on a group basis. The level of benefits required by law will be considered when benefits are coordinated.

Coordination with Other Medical Plans (Other than Medicare)

Primary and secondary plans are determined as follows:

- The plan covering a person as an employee is the primary plan, and the plan covering the same person as a dependent is the secondary plan.
- For dependent children, the plan of the parent whose birthday occurs earlier in the Calendar Year is primary (regardless of the year of birth). If both parents have the same birthday, the plan that has covered a parent for the longer period is primary. If the other plan follows a gender rule (i.e., male's plan pays first) instead of the birthday rule to determine order of benefits, the other plan's provision will apply.

In the case of separated or divorced parents, primary and secondary plans are determined as follows:

- If a court decree awards joint custody but does not specify which parent is responsible for health care expenses, the rules above apply.
- If a court decree has given financial responsibility for medical care for eligible dependent children to one parent, the plan of this parent is primary.
- If there is not a court decree establishing financial responsibility for medical care for eligible dependent children,
    - the plan that covers the parent with custody pays first;
    - if the parent with custody has remarried, the plan of the custodial parent pays first, then the plan of the stepparent and last, the plan of the parent without custody.

If none of these rules apply, the plan that has covered the individual for the longest period is primary.

Coordination Under the Benefit Plan Medical Options

Coordination depends on whether you or your dependents obtain care on an in-network or out-of-network basis, and on which plan is primary.

For example, assume your spouse is covered under his or her employer's plan (which is therefore primary) and as your dependent under one of the Benefit Plan medical options. Let's also assume Deductibles under the two plans have been met. If your spouse received medical care that was not provided by an in-network provider, the Benefit Plan medical option will pay benefits using the Usual and Customary Charge as the basis for calculating coordination of benefits. Likewise, when an in-network provider is used, the Benefit Plan medical option will pay benefits using the negotiated rate as the basis for calculating coordination of benefits.

Coordination with Medicare

If you are an active employee or covered dependent and become eligible for Medicare, your Benefit Plan medical coverage will be your primary source of coverage (with Medicare secondary), unless you elect otherwise. If your eligibility for Medicare is due to

End Stage Renal Disease, the Benefit Plan will continue to cover you for up to 30 months, as required by law. In such case, the Benefit Plan will be your primary source of coverage (with Medicare secondary) during this period. If you also cover your spouse or domestic partner (and he or she is not covered as an employee under another employer's plan), your Benefit Plan medical coverage is primary for your spouse or domestic partner as well, regardless of whether your spouse or domestic partner is under or over age 65.

If you are receiving long-term disability benefits from Devon and are covered under the Plans until age 65 (LTD participants prior to Jan. 1, 2020), once you become Medicare-eligible, your group sponsored medical coverage will be secondary to Medicare.

Recoupment

The Plans have the right to recover any mistaken payment, any overpayment, any payment that is made to any individual who was not eligible for that payment or any payment that was required to have been made to the Plans under the "Third Party Liability" section above. The Plans, or its designee, may withhold or offset future benefit payments, sue to recover such amounts, or may use any other lawful remedy to recoup any such amounts.

No Assignment of Benefits

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plans, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the Covered Participant and shall not constitute an assignment of benefits under the Plans or a waiver of this provision. Additionally, while you or your dependent, under ERISA, may appoint an authorized representative to file a claim for benefits or appeal a denied claim for benefits on your or their behalf in accordance with the relevant provisions under ERISA, no such appointment may be made to an out-of-network provider and no such appointment to any provider (whether in-network or out-of-network) shall render any provider, or cause such provider to be, a beneficiary under the Plans.

Qualified Medical Child Support Order

If a qualified medical child support order ("QMCSO") issued in a domestic relation proceeding (e.g., a divorce or legal separation proceeding) requires you as a parent to cover a child who is not in your custody, you may do so. To be qualified, a medical child support order must include:

- name and last known address of the parent who is covered under the Benefit Plan;
- name and last known address of each child to be covered under the Benefit Plan;
- type of coverage to be provided to each child; and
- period the coverage is to be provided.

QMCSOs should be sent to the Plan Administrator. Upon receipt, the Plan Administrator will notify you and describe the Plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Benefit Plan. As a beneficiary covered under the Benefit Plan, your child will be entitled to information that the Benefit Plan provides to other beneficiaries under ERISA's reporting and disclosure rules. You may receive from the Plan Administrator, without charge, a copy of the Benefit Plan's QMCSO procedures.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to cover reconstructive surgery and prostheses following mastectomies. All medical plans and HMOs provide this coverage, subject to applicable Deductibles and coinsurance.

If you receive benefits for a Medically Necessary mastectomy, and if you elect breast reconstruction after the mastectomy, you will also be covered for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of all stages of mastectomy including lymphedema.

Newborns' and Mothers' Health Protection Act

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

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

Mental Health Parity

The medical benefits under the Benefit Plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with the Plan, as required by Code Section 9812 and ERISA Section 712, and the regulations thereunder.

- *Lifetime or Annual Dollar Limits*. The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

- *Financial Requirement or Treatment Limitations*. The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.
- *Criteria for medical necessity determinations*. The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential Participant, beneficiary, or in-network provider upon request.

The manner in which these restrictions apply to the Plan will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

Patient Protection and Affordable Care Act

No Lifetime or Annual Limits. The Benefit Plan does not impose a lifetime or annual limit on the dollar value of Essential Health Benefits provided. Essential Health Benefits are health-related items and services that fall into ten categories, as defined in PPACA §1302 and further determined by the Secretary of Health and Human Services.

For purposes of determining whether a benefit or service is an Essential Health Benefit for purposes of permissible annual or lifetime limits and cost sharing limits (see below) under PPACA, the Plan has chosen the State of Utah as its benchmark state.

No Rescission of Coverage. The Benefit Plan will not cancel or discontinue medical benefits with a retroactive effect with respect to you or your covered dependents except in the event of fraud, intentional misrepresentation, nonpayment of premiums, etc.

No Pre-Existing Condition Exclusion. The Benefit Plan will not impose a pre-existing condition exclusion on medical benefits.

No Cost Sharing on Recommended Preventive Care. The medical benefits under the Benefit Plan will not require participant cost-sharing on recommended Preventive Care provided by in-network providers. Preventive Care services covered in-network at 100% will be reviewed annually and updated prospectively to comply with recommendations of:

- the United States Preventive Care Task Force;
- the Advisory Committee on Immunization Practices that have been adopted by the Director of the Centers for Disease Control and Prevention; and
- the Comprehensive Guidelines supported by the Health Resources and Services Administration.

Coverage of Clinical Trials. Medical benefits under the Benefit Plan shall not deny participation in an approved clinical trial for which a covered person is a "qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A covered person participating in such an approved clinical trial will not be discriminated against because of his or her participation in the approved clinical trial. For purposes of this provision, the terms "qualified individual," "life threatening disease or condition," approved clinical trial" and "routine patient costs" shall have the same meaning as found in Section 2709 of the Public Health Services Act.

Cost Sharing Limits. Medical benefits under the Benefit Plan shall comply with the overall cost-sharing limit (i.e., out-of-pocket maximum) mandated by PPACA. For purposes of this provision, cost-sharing includes deductibles, co-insurance, co-pays or similar charges, and any other required expenditure that is a qualified medical expense with respect to Essential Health Benefits covered under the Plan. Cost-sharing shall not include premiums, balance billing amounts for non-network providers or spending for services that are not covered under the Plan. Notwithstanding the foregoing, Devon reserves the right to maintain bifurcated out-of-pocket maximums as permitted by law.

Patient Protections. To the extent applicable, medical benefits under the Benefit Plan shall comply with the patient protections regarding choice of health care professionals and Medical Emergency care services under Public Health Services Act § 2719A.

X. STATEMENT OF ERISA RIGHTS

As a participant in the Plans, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants will be entitled to:

Receive Information About Your Plans and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plans, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plans' annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse, or dependent children if there is a loss of coverage under the Plans because of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plans on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plans, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plans and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Benefit Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek

assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plans, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-EBSA (3272). You can view available publications on the website at *www.dol.gov/ebsa*.

APPENDIX A – MATERIALS INCORPORATED BY REFERENCE

Medical
PPO Benefit Summary available online at www.bcbsil.com

CVS Caremark Benefit Summary available online at https://www.caremark.com/wps/portal

Flores HRA Benefit Summary and forms available at www.Flores247.com

Delta Dental
Delta Dental Benefit Summary Effective 1/1/2024

Vision
VSP Vision Benefit Summary Effective 1/1/2024

Life and Accident Insurance
Prudential Term Life and AD&D Certificate of Coverage dated January 1, 2022

Full-time Employees working temporarily part-time dated January 1, 2022

Business Travel Accident Insurance
Prudential Certificate of Accident Insurance Policy Number BG-44197-OK dated January 1, 2021

Disability Insurance
Prudential Pilots Long-Term Disability Coverage Contract Number G44197-OK dated March 1, 2018
Prudential All Employees Other Than Executives and Pilots Long-Term Disability Coverage Contract Number G44197-OK dated March 1, 2018
Prudential Executive Long-Term Disability Coverage Contract Number G44197-OK dated March 1, 2018

Flexible Spending Accounts
Flores Flexible Spending Account Instructions and Forms on www.Flores247.com

Employee Assistance Program
Benefit Summary available online at devon.lyrahealth.com

APPENDIX B – MEDICAL BENEFIT DEFINITIONS

The following definitions apply to medical, prescription, telemedicine, dental and vision coverage under the Benefit Plan.

"Accidental Injury" means accidental bodily injury caused by unexpected external means, resulting, directly and independently of all other causes, in necessary care rendered by a Physician.

"Actively at Work" means the active expenditure of time and energy in the service of the Employer, except that an employee shall be deemed actively at work on each day of a regular paid time off or on a regular non-working day, provided he was actively at work on the last preceding regular working day.

"Add-on Procedure" means a surgical procedure performed during one period of anesthesia that requires additional Physician resources, should be identified separately from the main procedure, and is worthy of separate consideration at the same level of consideration as the procedure to which it is being added.

"**Allowable Charge**" means an average contract rate for network providers. If Allowable Charge does not equate to the billed charges, you will be responsible for the difference, along with any applicable Coinsurance and Deductible amounts. THIS DIFFERENCE MAY BE CONSIDERABLE. To find out an estimate of the Plan's allowable charge for a service, you may call the customer service number shown on the back of your Identification Card.

"Ambulatory Surgical Facility" means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis, and which is duly licensed by the appropriate state and local authority to provide such services.
An "Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.
A "Non-Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility

"Ancillary Services" means services rendered in connection with inpatient or outpatient care in a Hospital or in connection with a Medical Emergency including the following: ambulance, anesthesiology, assistant surgeon, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a Medical Emergency.

"Bariatric Surgery" means Surgery on the stomach and/or intestines to help a person with extreme obesity lose weight**"**

"Benefit Percentage" means the portion of eligible expenses payable by the Benefit Plan in accordance with the coverage provisions as stated in the Benefit Plan.

"Benefit Plan" whenever used herein without qualification, means the Devon Energy Corporation Employee Benefit Plan as described in the Plan Document, and as it may be amended from time to time.

"Benefits Committee" means the Devon Energy Corporation Benefits Committee.

"Bilateral Procedures" means identical surgical procedures performed on corresponding sides of the body, either through the same or separate incisions.

"Birthing Center" means a free-standing facility that:

(1) is licensed to provide a setting for prenatal care, delivery and immediate postpartum care;
(2) has an organized staff of Physicians;
(3) has permanent facilities that are equipped and operated primarily for childbirth;
(4) has a contract with at least one nearby Hospital for immediate acceptance of patients who require Hospital care;
(5) does not provide accommodations for patients to stay overnight; and
(6) provides continuous services of Physicians, registered nurses or certified nurse midwife practitioners when a patient is in the facility.

"Calendar Year" means January 1 through December 31 of the same year. For new employees and dependents, a Calendar Year begins on the individual's Effective Date and runs through December 31 of the same year.

"Claims Administrator" means the Claims Administrator as set forth in "General Plan Administration" section of this SPD.

"COBRA" means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

"Common Fund" means a share in the cost of a claimant's attorney fees and/or legal expenses. Using the Common Fund can reduce the Benefit Plan's reimbursement because of the portion that will go towards attorney's fees.

"Complications of Pregnancy" means conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; or nonelective cesarean section, ectopic pregnancy which is terminated, or spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible. Complications of pregnancy does not mean false labor, occasional spotting, Physician-prescribed rest during pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, or similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

"Cosmetic Procedures" means procedures performed solely to improve appearance.

"Covered Participant" means any employee or dependent covered under the Benefit Plan.

"Custodial Care" means care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can (according to generally accepted medical standards) be performed by individuals who have no medical training. Examples of Custodial Care include help in walking and getting out of bed; assistance in bathing, dressing, and feeding; or supervision over medication which could normally be self-administered.

"Deductible" means the amount of covered medical expenses which must be paid by a Covered Participant each Calendar Year before benefits are payable under the Benefit Plan. A separate Deductible applies to a covered employee and each of the employee's dependents, subject to the Family Deductible Limit. As applied to dental benefits under the Benefit Plan, this term means the amount of covered dental expenses which must be paid by a Covered Participant each Calendar Year before benefits are payable under the Benefit Plan. A separate Deductible applies to a covered employee and each of the employee's dependents, subject to the Family Deductible Limit.

"Dentist" means a currently licensed dentist practicing within the scope of the license or any other Physician furnishing dental services which the Physician is licensed to perform.

"Devon" means Devon Energy Corporation and all affiliated companies in the United States.

"Durable Medical Equipment" means equipment prescribed by the attending Physician which: is Medically Necessary; is not primarily or customarily used for non-medical purposes; is designed for prolonged use; and serves a specific therapeutic purpose in the treatment of an injury or Illness.

"Employee" means a person who is directly employed by Devon and who is performing his customary duties at the Employer's facility or other location designated by the Employer. Not all Employees are eligible for benefits. See Section III – Eligibility for more information.

"Employer" means Devon Energy Corporation and all affiliated companies in the United States.

"**End Stage Renal Disease**" means permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"**Essential Health Benefits**" means health-related items and services that fall into the following categories, as defined in PPACA §1302 and further determined by the Secretary of Health and Human Services:

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

"Experimental or Investigational" means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as Standard Medical Treatment for the condition being treated or, if any of such items required federal or other governmental agency approval, such approval was not granted at the time services were provided. Approval by a federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, medical treatment includes medical, surgical, mental health treatment, Substance Use Disorder Treatment, or dental treatment.

Standard Medical Treatment means the services or supplies that are in general use in the medical community in the United States, and:
• have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;

• are appropriate for the Hospital or Facility Other Provider in which they were performed; and

• the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of the Claim Administrator shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-fixed programs in making its determination.

Although a Physician or Professional Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort. The Claim Administrator still may determine such services or supplies to be Experimental/Investigational with this definition. Treatment provided as part of a clinic trial or research study is Experimental/Investigational. Approval by a government or regulatory agency will be taken into consideration in assessing Experimental/Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Family Deductible Limit" applies collectively to all Covered Participants in the same family. When the family Deductible limit is satisfied, no further Deductibles need to be satisfied in the Calendar Year.

"Generic Drug" means a prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. The Benefit Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"**HRA**" means a health reimbursement account. An HRA is a notional account credited with contributions from Devon to help participants pay out-of-pocket qualified medical expenses.

"**HSA**" means a health savings account. An HSA is an individual account that may be established by an HSA-eligible individual enrolled in a high-deductible health plan to pay out-of-pocket qualified medical expenses.

"**Home Health Care**" means a coordinated plan of skilled nursing care and other therapeutic services provided by a Home Health Care Agency.

"Home Health Care Agency" means an agency or organization that:

(1) is licensed and primarily engaged in providing skilled nursing care and other therapeutic services;

(2) has policies established by a professional group associated with the agency or organization that includes at least one Physician and one registered nurse ("R.N.") who provide full-time supervision of such services; and

(3) maintains complete medical records on each individual and has a full-time administrator.

"Hospice Care" means a coordinated plan of home and inpatient care which treats the terminally ill patient and family as a unit. The plan provides care to meet the special needs of the family unit during the final stages of a terminal Illness and during bereavement. Care is provided by a team made up of trained medical personnel, homemakers, and counselors. The team acts under an independent hospice administration and it helps the family unit cope with physical, psychological, spiritual, social and economic stresses.

"Hospice Care Program" means a centrally administered program designed to provide for the physical, psychological, and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility, or special hospice care unit.

"Hospital" means an institution that:

(1) is licensed to provide and is engaged primarily in providing on an inpatient basis, for compensation from its patients, diagnostic and therapeutic facilities for the surgical, medical diagnosis, treatment and care of ill and injured persons;

(2) operates 24 hours a day every day under continuous supervision of a staff of doctors (MD, DO);

(3) continuously provides on the premises of the facility 24 hours a day skilled nursing services by licensed nurses under the direction of a full-time R.N.;

(4) provides, or has a written agreement with another Hospital in the area for the provision of, generally accepted diagnostic or therapeutic services that may be required during a confinement; and

(5) is not, other than incidentally, a place for rest, a place for the aged, a nursing home, a place for alcoholics, a residential treatment center, or a convalescent Hospital.

"Hospital Expenses" means charges by a Hospital for room and board and/or for care in an Intensive Care Unit, provided that its charges for such care are furnished at the direction of a Physician. Hospital expenses for private room accommodations which are more than the average charge for semi-private accommodations in the facility shall not be considered under the Benefit Plan for any purpose (except as specified in the "Schedule of Medical Benefits").

"Illness" means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term "Illness" when used in connection with a newborn child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

"Immediate Family" means an individual who is related to a Covered Participant, whether the relationship is by blood or exists in law, including a spouse, domestic partner, parent, child, brother or sister.

"Intensive Care Unit" means an accommodation in a Hospital which is reserved for critically and seriously ill patients requiring constant audiovisual observation as prescribed by the attending Physician, and which provides room and board, nursing care by registered nurses whose duties are confined to care of patients in the Intensive Care Unit, and special equipment or supplies immediately available on a standby basis segregated from the rest of the Hospital's facilities.

"Internal Revenue Code" means the Internal Revenue Code of 1986, as amended.

"Late Entrant" means an individual who enrolls other than during the initial enrollment period or a special enrollment period as provided under the "Eligibility" section of this SPD.

"Lifetime" means while a person is covered under the Benefit Plan. Lifetime does not mean during the lifetime of the Covered Participant.

"Made-Whole Doctrine" means a claimant is not 100% recovered from injury and will continue to have indefinite pain or diminished capacity. Therefore, he is not "made whole" as he was prior to the incident. Under Make Whole Doctrines the court can excuse the entire repayment obligation.

"**Maintenance Drug**" means prescriptions commonly used to treat conditions that are considered chronic or long-term as determined by CVS Caremark. For purposes of the PPO plan and HSA eligibility, some Maintenance Drugs are also determined to be preventive Maintenance Drugs by CVS Caremark. Preventive Maintenance Drugs are not subject to the Deductible under the PPO plan but are subject to applicable copays and coinsurance.

"Maximum Benefit" as applied to dental benefits under the Benefit Plan, means the total amount of dental benefits payable under the Benefit Plan on behalf of a Covered Participant during any Calendar Year (unless specified otherwise).

"Medical Emergency" means treatment for an injury, illness or condition manifesting itself by acute symptoms of enough severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:

- serious jeopardy to the covered person's health;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

Such conditions include but are not limited to suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, emergency medical care rendered in accident cases and other acute conditions. For purposes of benefits payable under the Benefit Plan, the Claims Administrator will determine the existence of a Medical Emergency.

"Medical Services Advisory Program or MSA" means the program established by the Claim Administrator to perform a review of inpatient Hospital covered services prior to such services being rendered.

"Medically Necessary" means the expense incurred upon the recommendation and approval of a Physician for the medical services and supplies generally furnished for cases of comparable nature and severity in the geographical area concerned. Any agreement as to fees or charges

made between the individual and the Physician shall not bind the Benefit Plan in determining its liability with respect to necessary expenses. These incurred expenses must be:

(1) consistent with the symptoms of diagnosis and treatment of the condition, Illness, or injury;
(2) appropriate with regard to standards of good medical practice;
(3) not primarily for the convenience of the patient, the Physician or other provider; and
(4) the most appropriate level of services which can safely be provided to the patient.

When applied to an inpatient, it means that the patient's medical symptoms or conditions require that the services or supplies cannot be safely provided to the patient as an outpatient.

The fact that a Physician might prescribe, order, recommend, or approve a service or supply does not make it Medically Necessary or make the charge an allowable expense under the Benefit Plan, even though it is not specifically listed as an exclusion.

"Medicare" means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

"Behavioral Unit" means the unit established by the Claims Administrator to perform preadmission review and length of stay review for Inpatient Hospital services for treatment of Mental Illness or Substance Abuse.

"Mental Illness" means any disease or condition that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

"Multiple Surgical Procedures" means when more than one surgical procedure is performed during the same period of anesthesia.

"Myofascial Pain Dysfunction ("MPD")" means a disorder involving muscles surrounding and adjacent to the temporomandibular joint ("TMJ") area which is characterized by preauricular, temporal, occipital and/or jaw pain; spasm and/or tenderness of the masticatory muscles; and/or limited jaw movement.

"Negotiated Fees" means amounts that PPO providers or participating pharmacies have contracted to accept as payment in full for eligible expenses of the Benefit Plan.

"**Non-Emergent Care**" means care or treatment received in an emergency room that is not a Medical Emergency.

"Non-Preferred Drug" A Non-Preferred Drug is a brand name drug that has not been selected and is not on the Preferred Drug list.

"Orthotic Device" means an apparatus used to support, align, prevent or correct deformities, or to improve the function of movable parts of the body.

"Out-of-Area" means any area in which a PPO Hospital or provider is not available.

"Overutilization" means:

(1) the practice of applying more than what is necessary to evaluate and treat the problem at hand; or

(2) a redundancy in treatment options; or

(3) that which most practitioners in the discipline would consider to be more than enough measures.

"**PPACA**" means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act, and related guidance.

"Permanently and Totally Disabled" means an individual must be unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

"Pharmacy" means a licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

"PHI" means protected health information under HIPAA.

"Physician" means a duly licensed doctor of medicine ("M.D.") a doctor of osteopathy ("D.O."), a licensed podiatrist ("D.P.M."), a doctor of optometry ("O.D."), a doctor of chiropractic ("D.C.") a psychologist, a Physician's assistant ("P.A.") and any other licensed practitioner who is required to be recognized for health insurance by law or regulation and is acting within the scope of their license.

"Plan Administrator" means Devon.

"Plan Sponsor" means Devon.

"**Plan Year**" means the Calendar Year.

"Preferred Drug" A Preferred Drug is a brand name drug that has been selected as a Preferred Drug and is on the Preferred Drug list to help control the cost of the prescription drug benefit.

"Preferred Provider Organization" or "PPO" means a group of Physicians, Hospitals or other healthcare providers within a specified geographical area who have contracted to provide health care services at reduced rates.

"Primary Procedure" as applied to Multiple Surgical Procedures, means the procedure with the highest assigned relative value unit according to the relative value studies ("RVS") manual. If relative value units between procedures are equal, the procedure with the highest billed charge will be considered as the Primary Procedure.

"Psychiatric Day Treatment Facility" as used herein, means an institution that:

(1) is a mental health facility which provides treatment for individuals suffering from acute mental, nervous or emotional disorders, in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program, and is clinically supervised by a Doctor of Medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology; and

(2) is accredited by the Program for Psychiatric Facilities or its successor, or the Joint Commission on Accreditation of Hospitals; and

(3) treats its patients for not more than eight (8) hours in any 24-hour period.

"QMCSO" means a Qualified Medical Child Support Order in accordance with the Omnibus Budget Reconciliation Act of 1993, as amended.

"Rehabilitation Facility" means a facility that provides services of non-acute rehabilitation. All services are provided under the direction of a physiatrist, a medical doctor with a specialty in rehabilitation and physical medicine. The facility is staffed around the clock by registered nurses and it does not provide services of a custodial nature. The facility must be Medicare certified, licensed by the State Department of Health as a "special Hospital" and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is also accredited by the Commission on Accreditation of Rehabilitation Facilities.

"Residential Treatment Facility" means a facility operating legally as a residential treatment facility for mental and nervous disorders or Substance Abuse conditions and licensed as such by the state in which the facility operates.

"Same Operative Area" as applied to Multiple Surgical Procedures, means when a procedure is performed through the same incision or orifice during the same period of anesthesia.

"Secondary Procedure" as applied to Multiple Surgical Procedures, means the procedure that does not have the highest assigned relative value unit according to the relative value studies (RVS) manual. If relative value units between procedures are equal, the procedure that does not have the highest billed charge will be considered as the Secondary Procedure.

"Separate Operative Area" as applied to Multiple Surgical Procedures, means when a procedure is performed through a separate incision or orifice during the same period of anesthesia.

"Separate (incidental) Procedure" means a surgical procedure that, when performed at the same time as another procedure, does not require any additional Physician resources and therefore, should not be identified separately from the main procedure.

"Skilled Nursing Facility" (this term also applies to a facility which refers to itself as an extended care facility or convalescent facility) means a facility that:

(1) is licensed to provide professional nursing services on an inpatient basis to patients convalescing from injury or Illness to help restore patients to self-care in essential daily living activities;

(2) provides continuous nursing services by licensed nurses for 24 hours of every day, under the direction of a full-time registered nurse (R.N.);

(3) provides services for compensation and under the full-time supervision of a Physician;

(4) maintains a complete medical record on each patient;

(5) has an effective utilization review plan; and

(6) is not, other than incidentally, a clinic, a place for rest, a place devoted to care of the aged, a place for treatment of Mental Illness or mental retardation, or a place for Custodial Care.

"SPD" means this summary plan description for the Devon Energy Corporation Employee Benefit Plan and Flexible Benefits Plan.

"Specialty Facility" means a long-term acute care facility that specializes in rehabilitation ventilator-dependent patients or patients who need long term acute care and are too sick for a nursing facility, but do not require acute care.

"Substance Abuse" means the condition caused by physical and/or emotional dependence on drugs, narcotics, alcohol or other addictive substances resulting in a chronic disorder which affects physical health and/or personal or social functioning. This does not include dependence on tobacco or ordinary caffeine-containing beverages.

"Temporomandibular Joint Dysfunction ("TMJ")" means jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex muscles, nerves and other tissues related to the temporomandibular joint.

"Totally Disabled" as applied to an employee means (unless specifically provided otherwise) the complete inability of an employee to substantially perform the important daily duties of the employee's own occupation, for which the employee is reasonably suited by education, training or experience. As applied to a dependent, the term means the dependent is prevented solely because of a non-occupational injury or non-occupational disease from engaging in all the normal activities of a person of like age and sex and in good health.

"Treatment Plan" means a program of dental care and treatment planned in written outline by a dentist upon examination of a Covered Participant.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Usual and Customary Charges" means those charges made for medical services and/or supplies essential to the care of a Covered Participant which will be considered reasonable and customary if they are the amount normally charged by the service provider for similar services and supplies and do not exceed 200% of Medicare negotiated rates. In determining whether charges are usual and customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances.

Charges of a participating network provider will not be subject to Usual and Customary Charge limitations, but to Negotiated Fees instead.

APPENDIX C - COVERED MEDICAL EXPENSES, EXCLUSIONS FROM COVERAGE AND COST MANAGEMENT PROGRAM

COVERED MEDICAL EXPENSES

The following provisions apply to medical coverage under the Benefit Plan.

The Benefit Plan provides coverage for a wide range of medical services and supplies. The charges for these services and supplies are considered eligible expenses to the extent (unless they are otherwise specified as covered) that they are: Medically Necessary; prescribed, rendered or furnished by a Physician; Usual and Customary Charges for non-participating providers; Negotiated Fees for participating network providers; and provided for care and treatment of a covered Illness or injury.

Covered medical expenses include, but are not limited to, charges for the following.

(1) **ALLERGY TESTING, ALLERGY INJECTIONS AND ALLERGY SERUMS:** Allergy testing, allergy injections, and allergy serums dispensed and/or administered at a Physician's office, and the syringes necessary to administer them.

(2) **AMBULANCE SERVICES:** Air ambulance (if Medically Necessary) or ground ambulance for transportation to or from the nearest appropriate Hospital by a licensed ambulance service.

(3) **AMBULATORY SURGICAL FACILITY:** Treatment, services and supplies furnished by an Ambulatory Surgical Facility.

(4) **ANESTHETICS:** Anesthetics and their professional administration; services of an anesthesiologist.

(5) **BARIATRIC SURGERY**
Your benefits for bariatric surgery are paid differently than your benefits for other conditions.

Whenever bariatric surgery treatment is recommended by your Physician, you must contact the Claim Administrator by telephone before your bariatric surgery treatment has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved bariatric surgery Programs. Benefits will be provided for bariatric surgery performed at any other Hospital but will be provided at a lower payment level.

Benefits for services rendered by a Blue Distinction Center will be provided at 80% of the Eligible Charge or Maximum Allowance, after you have met your program deductible.

Benefits for services rendered by a Claim Administrator approved Participating Provider bariatric surgery program facility will be provided at 70% of the Eligible Charge or Maximum Allowance, after you have met your program deductible.

Benefits for services rendered by a Non-Participating Provider bariatric surgery program facility will be provided at 60% of the Eligible Charge or Maximum Allowance, after you have met your program deductible.

(6) **BIRTHING CENTER:** Care, treatment and services furnished by a Birthing Center ***(please rely on the advice of your Physician when considering a Birthing Center)***.

(7) **BLOOD AND BLOOD DERIVATIVES:** Blood transfusion services, including the cost of whole blood or blood plasma not donated or replaced.

(8) **CHEMOTHERAPY/RADIATION THERAPY:** Chemotherapy, radiation therapy, and treatment with radioactive substances; materials and services of a technician.

(9) **CHIROPRACTIC SERVICES:** Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body performed by a Physician (as defined by the Benefit Plan) to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

(10) **COLONOSCOPIES**: Routine Colonoscopies are covered at 100% for all participants as a Preventive Care. All other colonoscopies of a diagnostic nature are subject to the Plan's copay, coinsurance and Deductible provisions.

(11) **CONTACT LENSES OR EYEGLASSES:** Initial purchase of contact lenses or eyeglasses (but not both) if required following cataract surgery.

(12) **CONTRACEPTIVE DEVICES:** Charges incurred for contraceptive devices (e.g., Norplant, IUDs and diaphragms) including the insertion and removal of injectable or implantable devices and related professional services if Medically Necessary or for contraceptive purposes.

(13) **CONTRACEPTIVE INJECTIONS:** Contraceptive injections administered at a Physician's office if Medically Necessary or for contraceptive purposes. For a description of coverage of contraceptive injections when administered by a pharmacist, refer to prescription drug benefits in **Appendix D.**

(14) **COSMETIC PROCEDURES/RECONSTRUCTIVE SURGERY:** Cosmetic procedures/ reconstructive surgery only if:

- for the repair of an Accidental Injury;
- for reconstruction incidental to or following surgery resulting from an injury or Illness;
- for correction of a congenital defect that results in a functional defect of a Covered Dependent child; or
- for reconstruction of the breast on which a Medically Necessary mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and treatment of physical complications for all stages of the mastectomy, including lymphedemas.

(15) **COUNSELING**: Services of a Licensed Marriage Therapist and licensed counselors for marriage and family Counseling.

(16) **DIAGNOSTIC X-RAY AND LABORATORY SERVICES:** Diagnostic X-ray and laboratory examinations; services of a radiologist or pathologist.

(17) **DURABLE MEDICAL EQUIPMENT:** Rental, or initial purchase, of Durable Medical (or surgical) Equipment and accessories needed to operate the equipment (purchase is covered **only** if it is shown that long term use is planned, and the equipment cannot be rented, or it is likely to cost less to purchase it than to rent it). Repair or replacement will be covered **only** when required due to growth or development of a dependent child, medical necessity because of a change in the Covered Participant's physical condition, or deterioration from normal wear and tear if recommended by the attending Physician. However, replacement is covered **only** if it is likely to cost less to buy a replacement than

repair the existing equipment or to rent like equipment. Charges for more than one item of equipment for the same or similar purpose are **not** covered. Covered items include, but are not limited to, crutches and braces, a durable brace specially made for and fitted to the Covered Participant, and rental of wheelchairs and Hospital beds.

(18) **GENDER REASSIGNMENT:** benefits for covered services for gender reassignment surgery, including related services and supplies, will be provided the same as any other condition.

(19) **HEARING EXAMS AND HEARING AIDS:** Routine hearing exams for determining the level of hearing and the initial purchase of hearing aids.

(20) **HOME HEALTH CARE AND SKILLED NURSING:** Charges by a Home Health Care Agency on its own behalf for covered services and supplies furnished in the patient's home in accordance with a Home Health Care plan made by the attending Physician. Part-time or intermittent nursing care by a registered nurse ("R.N.") or a licensed practical nurse ("L.P.N.") or licensed vocational nurse ("L.V.N.") and home health aide services provided in conjunction with nursing services are covered under the Benefit Plan if the attending Physician certifies that treatment of the condition would require confinement as a Hospital inpatient in the absence of home health care. Home health care expenses shall not include charges for: services or supplies not included in the Home Health Care plan; services of a person who ordinarily resides in the patient's home or is a member of the patient's family, or dependents of the patient; transportation services; Custodial Care. Home Health Care and Skilled Nursing are subject to case management.

(21) **HOSPICE CARE:** Services and supplies furnished in a licensed inpatient hospice facility or in the patient's home by a licensed hospice care program when the attending Physician certifies that life expectancy is six (6) months or less. Hospice care expenses shall also include charges for bereavement Counseling of the Covered Participant's Immediate Family prior to, and within 3 months after, the Covered Participant's death and charges for respite care provided to give temporary relief to the family or other caregivers in emergencies and/or from the daily demands of caring for a terminally ill person. Hospice Care is subject to case management.

(22) **HOSPITAL CARE (INPATIENT):** The following services and supplies while an inpatient at a Hospital:

- daily room charge in a Hospital, but not to exceed the daily rate equal to the average Hospital semi-private room charge (charges when a Hospital private room accommodation has been used will be reimbursed at the average semi-private room rate in the facility; if a Hospital has private rooms only, the maximum eligible charge will be 80% of the lowest private room charge);
- charges for confinement in an Intensive Care Unit;
- meals, special diets, nursing care;
- maternity and routine nursing care while mother is Hospital confined (under Federal law, group health plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The 48-hour period [or 96-hour period if applicable] begins at the time a delivery occurs in the Hospital [or in the case of multiple births, at the time of the last delivery] or, if the delivery occurs outside the Hospital, at the time a mother and/or newborn are admitted. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the

mother or her newborn earlier than 48 hours [or 96 hours if applicable] following the delivery);

- operating, delivery, recovery and other treatment rooms;
- prescribed drugs and medications;
- dressings and casts;
- use of Hospital equipment;
- Hospital laboratory and radiology services; and
- treatment by a Physician or surgeon.

(23) **HOSPITAL CARE (OUTPATIENT):** Treatment, services and supplies furnished by a Hospital on an outpatient basis to a Covered Participant not admitted as a registered bed patient.

(24) **INFERTILITY COVERAGE:** All medical services and pharmaceutical prescriptions related to the diagnosis and treatment of infertility are covered up to a lifetime maximum of $20,000.

(25) **IMPACTED WISDOM TEETH**: Surgical removal of bony, impacted wisdom teeth.

(26) **INJECTABLE AND INTRAVENOUS PRESCRIPTION MEDICATIONS (OTHER THAN INSULIN):** Refer to the description of covered prescription benefits in **Appendix D**.

(27) **INSULIN AND DIABETIC SUPPLIES:** Refer to description of covered prescription benefits in **Appendix D** for coverage of injectable insulin, insulin syringes, chemstrips and blood lancets. Insulin pumps and blood glucose monitors are covered through the medical plan if not used as convenience items.

(28) **MAMMOGRAMS**: Routine Mammograms are covered for all female participants as Preventive Care. If a participant has a personal history of breast cancer and more than one mammogram per Calendar Year is required, additional routine diagnostic mammograms are covered according to regular Benefit Plan benefits. Digital mammograms are subject to the same guidelines as normal mammograms.

(29) **MEDICAL AND SURGICAL SUPPLIES:** Casts, splints, other devices used in the reduction of fractures and dislocations, trusses, surgical dressings.

(30) **MENTAL AND NERVOUS DISORDERS:** Services provided for treatment of Mental Illness and services provided by a Physician (as defined by the Benefit Plan), including group therapy and collateral visits with members of the patient's Immediate Family.

(31) **MULTIPLE SURGICAL PROCEDURES:** The Claims Administrator will determine which Multiple Surgical Procedures will be considered as Primary, Secondary, Bilateral, Add-on, or Separate (Incidental) Procedures for the purpose of determining benefits under the Benefit Plan. Multiple Surgical Procedure allowances are specified below:

Multiple Surgical Procedure Allowances:

- Primary Procedure, Bilateral Primary Procedure, or Add-on to Primary procedure: Usual and Customary Charge or Negotiated Fee;
- Secondary Procedure in same operative area: limited to 50% of Usual and Customary Charge or Negotiated Fee;
- Bilateral Secondary Procedure in same operative area: limited to 50% of Usual and Customary Charge or Negotiated Fee;
- Add-on to Secondary Procedure in same operative area: limited to 50% of Usual and Customary Charge or Negotiated Fee;

- Separate (Incidental) Procedure in same operative area as any of the above: not covered;
- Separate operative area: Usual and Customary Charge or Negotiated Fee.

(32) **NEWBORN CARE:** Routine care of a Hospital-confined newborn child, if coverage for the newborn child is requested, if necessary, according to the eligibility requirements of the Benefit Plan. The Benefit Plan will cover up to 5 days of Hospitalization or until the mother's discharge, whichever occurs first, on the same basis as an Illness of such newborn child, including routine nursery care, Physician charges, necessary laboratory tests, and circumcision. ***Such charges will be considered as part of the mother's charges.***

(33) **NURSING SERVICES:** Services of a registered nurse ("R.N."), licensed vocational nurse ("L.V.N."), or licensed practical nurse ("L.P.N."), other than a person related by blood or marriage. The Benefit Plan provides benefits for skilled nursing care furnished by a registered nurse or a licensed practical or vocational nurse if the services of a registered nurse are not available. In-Hospital private duty nursing services are **not** covered. Charges for skilled nursing services provided in the home are covered under the Home Health Care provision.

(34) **OCCUPATIONAL THERAPY:** Charges for services rendered by a registered or licensed occupational therapist, but **only** for those services requiring the technical medical proficiency and skills of a recognized occupational therapist and rendered in accordance with a Physician's specific instructions as to type and duration to restore or improve lost or impaired function. Services for outpatient occupational therapy are covered **only** when the Covered Participant can actively participate in such therapy, and there is documented continuous physical improvement.

(35) **ORGAN TRANSPLANTS:** Eligible Expenses incurred because of a human to human organ or tissue transplant are covered subject to the following conditions.

- Benefits are available for human organ, tissue and bone marrow transplantation, subject to determination made on an individual case by case basis to establish medical necessity.
- Benefits will be provided **only** when the Hospital and Physician customarily charge a transplant recipient for such care and services.
- Benefits will **not** be provided under the Benefit Plan for the donor when **only** the transplant recipient is a Covered Participant, unless the donor has **no** other health coverage, or the donor has other health coverage under which **no** benefits are available.
- When only the donor is a Covered Participant, the donor will receive benefits for care and services necessary to the extent such benefits are **not** provided under any coverage available to the recipient (benefits will not be provided to any recipient who is not a Covered Participant).
- When the recipient and donor are both Covered Participants, benefits will be provided for both in accordance with their respective eligible expenses. A second opinion must be obtained prior to undergoing any transplant procedure. The opinion obtained must concur with the attending Physician's findings regarding the medical necessity of such procedure.

(36) **ORTHOTIC DEVICES:** Orthotic Devices used to support, align, prevent or correct deformities, or to improve the function of movable parts of the body, except for supportive devices for the feet (such as arch supports) and orthopedic shoes which are **not** covered. Repair or replacement of covered Orthotic Devices will **only** be covered when required

due to growth or development of a dependent child, medical necessity because of a change in the Covered Participant's physical condition, or deterioration from normal wear and tear if recommended by the attending Physician.

(37) **OXYGEN:** Oxygen or other gases and rental of equipment for its administration including intermittent positive pressure breathing (IPPB) equipment.

(38) **PHYSICAL THERAPY:** Services of a licensed physical therapist (but **only** for those services requiring the technical medical proficiency and skills of a recognized physical therapist and rendered in accordance with a Physician's specific instructions as to type and duration) and services by a Physician (as defined by the Benefit Plan).

(39) **PHYSICIAN CARE:** Professional services of a Physician for surgical and medical care, including but not limited to, surgery, anesthesia, inpatient medical visits, consultations, office visits, and office treatment.

(40) **PREADMISSION/PREOPERATIVE TESTING:** Tests or exams relating to surgery for a Covered Participant who is scheduled for surgery. If Medically Necessary preoperative testing relating to surgery is performed at a Physician's office, diagnostic laboratory, Ambulatory Surgical Facility or on a Hospital outpatient basis within 7 days prior to the scheduled surgery, the Benefit Plan will pay for eligible expenses for the testing provided:

- the charge for the surgery is an eligible expense;
- the tests would have been covered had the patient been confined as a Hospital patient;
- the tests are not repeated when the patient is confined for the surgery;
- the test results are a part of the patient's medical records;
- the surgery is performed in a Hospital; and
- the service is identified as preadmission or preoperative testing.

(41) **PREGNANCY CARE:** Care and treatment for pregnancy and Complications of Pregnancy shall be covered on the same basis as for any other Illness.

(42) **PREVENTIVE CARE:** Preventive care health services are recommended by government task forces and defined to include the following:

- Evidence-based items or services with an A or B rating recommended by the United States Preventative Services Task Force.
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- Evidence-informed preventive care and screening provided for in the comprehensive guidelines support by the Health Resource and Services Administration (HRSA) for infants, children, and adolescents.
- Other evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA for women.

Preventive Care covered by the Plans may change from year to year as recommendations are updated. Preventive prescription drugs are medications designated by federal government guidelines under the Affordable Care Act as preventive. They are not subject to the Deductible (if applicable), copays or coinsurance.

(43) **PROSTHETIC DEVICES:** Prosthetic devices such as artificial limbs or eyes. After a mastectomy, an external breast prosthesis is covered. Prosthetic device repair or replacement will **only** be covered when required due to growth or development of a dependent child, medical necessity because of a change in the Covered Participant's physical condition, or deterioration from normal wear and tear if recommended by the

attending Physician. Bras made solely for use with an external breast prosthesis are covered, limited to one every 12 months.

(44) **PSYCHIATRIC DAY TREATMENT FACILITIES:** Eligible expenses incurred for treatment in a psychiatric day treatment facility for a Mental Illness or Substance Abuse condition if the attending Physician certifies that such treatment is in lieu of hospitalization, will be subject to the same benefits and limitations as applicable to treatment provided on an inpatient basis for Mental Illness or Substance Abuse condition. Any benefits so provided shall be considered as inpatient care and treatment in a Hospital.

(45) **REHABILITATION FACILITIES:** Services and supplies (including room and board) furnished by a Rehabilitation Facility. The Covered Participant must be under the continuous care of a Physician and the attending Physician must certify that the individual requires nursing care 24 hours a day. Nursing care must be rendered by a registered nurse or a licensed vocational or practical nurse. The confinement cannot be primarily for domiciliary, custodial, personal type care, care due to senility, alcoholism, drug abuse, blindness, deafness, mental deficiency, tuberculosis, or Mental Illness. This benefit shall not include charges for vocational therapy or Custodial Care.

(46) **RESIDENTIAL TREATMENT FACILITIES:** Eligible expenses incurred for treatment in a residential treatment facility for Mental Illness or Substance Abuse conditions if the attending Physician certifies that such treatment is in lieu of hospitalization, will be subject to the same benefits and limitations as applicable to treatment provided on an inpatient basis for Mental Illness or Substance Abuse conditions.

(47) **SKILLED NURSING FACILITIES:** Services and supplies (including room and board) furnished by a Skilled Nursing Facility.

(48) **SKIN TAGS**: Removal of skin tags is covered.

(49) **SPEECH THERAPY:** Charges for services of a licensed speech therapist (or, in states not requiring a license, one who holds a Certificate of Clinical Competence from the American Speech and Hearing Association) when rendered in accordance with a Physician's specific instructions as to type and duration but **only** when Medically Necessary.

(50) **STERILIZATION PROCEDURES:** Voluntary sterilization procedures shall be covered on the same basis as for any other Illness.

(51) **SUBSTANCE ABUSE:** Services provided for treatment of Substance Abuse conditions.

(52) **TEMPOROMANDIBULAR JOINT DYSFUNCTION:** Benefits are available for the surgical and non-surgical treatment of temporomandibular joint syndrome and Myofascial Pain Dysfunction.

(53) **TREATMENT IN MOUTH OR ORAL CAVITY:** Coverage is limited to:

- surgical treatment of fractures and dislocations of the jaw or for treatment of Accidental Injury to sound, natural teeth, including replacement of such teeth, within **six** months after the date of an accident (except when delay of treatment is Medically Necessary);
- surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
- removal of non-odontogenic lesions, tumors or cysts;
- incision and drainage of non-odontogenic cellulitis;
- surgical treatment of accessory sinuses, salivary glands, ducts and tongue;
- treatment to correct a non-odontogenic congenital defect that results in a functional defect of a covered dependent child.

EXCLUSIONS FROM COVERAGE

No coverage is provided under the Benefit Plan for expenses incurred for treatment, services and supplies:

(1) for which the patient or employee has no legal obligation to pay;

(2) for which no charge would have been made if the patient or employee had no health coverage;

(3) rendered by a member of the patient's Immediate Family or by a person who ordinarily resides with the patient;

(4) which are not Medically Necessary for the diagnosis and treatment of an Illness or injury, unless stated otherwise as covered in the Benefit Plan;

(5) which exceed the Usual and Customary Charges for non-participating providers, or the Negotiated Fees for participating network providers;

(6) which are not recommended or approved by the attending Physician;

(7) for intentionally self-inflicted injury (unless such injury results from a medical or Mental Illness condition);

(8) which are furnished in a government owned or operated facility or any other Hospital where care is provided at government expense, unless it is non-service related;

(9) which result directly or indirectly from war, whether declared or undeclared, except when an individual remains covered under the Benefit Plan (with coverage that is secondary to the individual's government coverage) during the first six (6) months of active duty military;

(10) for Accidental Injury or Illness arising out of or during any employment for wage or profit or which is covered by workers' compensation or occupational disease policy, or any expenses payable under compromise settlement agreements arising from a workers' compensation claim;

(11) for injury resulting from or sustained because of committing or attempting to commit an illegal occupation, an illegal act, an assault or a felony, unless such injury results from a medical condition (physical or Mental Illness condition);

(12) resulting from or sustained because of participation in a riot or insurrection;

(13) which are not generally accepted in the United States as being necessary and appropriate for the treatment of the patient's Illness or injury;

(14) which are still considered experimental or investigational and not "generally accepted" by the medical profession;

(15) for cosmetic procedures/reconstructive surgery, except as specified under "Covered Medical Expenses" above;

(16) for treatment of sexual dysfunctions;

(17) for reversal or attempted reversal of sterilization;

(18) for charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, in-vitro fertilization, or other such elective procedures more than the lifetime maximum benefit as specified in the Benefit Plan;

(19) for adoption;

(20) for a surrogate mother and all related newborn child expenses;

(21) for elective abortions, unless the life of the mother is endangered, or the pregnancy is the result of a criminal act;

(22) for smoking cessation services, devices, or medications, except for programs as specified under “Preventive Benefits” listed in the “Detailed Schedule of Medical Benefits” in this SPD;

(23) for nutritional supplements, including prescription vitamins (except for pre-natal vitamins requiring a prescription to be covered under the Plan’s prescription drug benefit);

(24) for exercise equipment or exercise programs such as for weight reduction (except for a Medically Necessary cardiac rehabilitation program following myocardial infarction and/or cardiac surgery);

(25) for routine foot care, except for persons diagnosed with diabetes.

- services and supplies for fallen arches or flat feet
- services for subluxations of the foot

(26) for initial purchase of Durable Medical (or surgical) Equipment and accessories needed to operate the equipment unless it is shown that long term use is planned, and the equipment cannot be rented, or it is likely to cost less to purchase it than to rent it;

(27) for repair or replacement of Durable Medical (or surgical) Equipment and accessories needed to operate the equipment unless required due to growth or development of a dependent child, medical necessity because of a change in the Covered Participant’s physical condition, or deterioration from normal wear and tear if recommended by the attending Physician (in addition, replacement is not covered unless it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment);

(28) for more than one item of Durable Medical (or surgical) Equipment if it is for the same or similar purpose;

(29) for repair or replacement of prosthetic devices, except when required due to growth or development of a dependent child, medical necessity because of a change in the Covered Participant’s physical condition, or deterioration from normal wear and tear if recommended by the attending Physician;

(30) for eye exercises and visual training (orthoptics);

(31) for routine examinations to determining level of visual acuity, eyeglasses or contact lenses, except as specified under the “Detailed Schedule of Medical Benefits” in this SPD and the initial pair of contact lenses or eyeglasses required following cataract surgery;

(32) for radial keratotomy surgery, orthokeratology, and any eye surgeries in lieu of corrective lenses;

(33) for routine or preventive care, except as specified in the “Detailed Schedule of Medical Benefits” in this SPD;

(34) for routine or preventive immunizations or vaccinations, except immunizations as specified in the “Detailed Schedule of Medical Benefits” in this SPD and gamma globulin injections;

(35) for orthognathic conditions (including associated diagnostic procedures) and for orthognathic surgery due to an orthognathic condition or any other condition, except when Medically Necessary;

(36) for preparing medical reports or itemized bills;

(37) for travel or accommodations, whether or not recommended by a Physician;

(38) for hypnosis, acupuncture, holistic medicine and any goal-oriented therapy;

(39) associated with non-emergency Hospital admissions on either a Friday or a Saturday unless a surgical procedure is performed within 24 hours of admission;

(40) for tuition or special education, or for educational testing or training;

(41) for learning deficiencies and behavioral problems (including associated diagnostic testing), except for attention deficit disorder ("ADD") and attention deficit hyperactivity disorder ("ADHD");

(42) for surgery utilized as treatment of neurosis, psychoneurosis, psychopathy, psychosis and other mental, nervous and emotional Illness;

(43) for admission to a Hospital primarily to control or change the patient's environment and/or during which the patient receives psychiatric care that could have been safely and adequately provided on an outpatient basis or in a lesser facility than a Hospital;

(44) for care in a health resort, rest home, nursing home, residential treatment center, or any institution primarily providing Custodial Care;

(45) for Custodial Care for a Covered Participant who is mentally or physically disabled and is not under specific medical, surgical or psychiatric treatment which is likely to reduce the disability or enable the patient to live outside an institution providing care;

(46) for Hospital care and services or supplies when the Covered Participant's condition does not require constant direction and supervision by a Physician, constant availability of licensed nursing personnel and immediate availability of diagnostic therapeutic facilities and equipment found only in the Hospital setting or if the primary cause of such a confinement was for rest or Custodial Care;

(47) for in-Hospital private duty nursing services;

(48) for personal hygiene, comfort, or convenience items, including, but not limited to, air conditioners, humidifiers, air purification units, electric heating units, orthopedic mattresses, blood pressure instruments, scales, and first aid supplies;

(49) incurred outside the United States if the Covered Participant traveled to such a location without the prior written approval of the Plan Administrator for the sole purpose of obtaining medical services, drugs, or supplies;

(50) for industrial safety glasses or goggles (whether or not a prescription is required) including examinations, lenses or frames;

(51) for any lenses, which do not require a prescription;

(52) which are considered as Overutilization, as determined by the Claims Administrator;

(53) for any claims filed later than the end of the year following year of service; or

(54) for any applicable non-compliance penalties, ineligible expenses, prescription drug copays or coinsurance.

NOTE: All of the exclusions in this section include complications resulting from any excluded coverage, including, but not limited to, any reversal procedure unless stated otherwise.

COST MANAGEMENT PROGRAM

The Claim Administrator has established the Medical Services Advisory Program (MSA) to perform a review of inpatient Hospital covered services **prior to** such services being rendered.

The MSA Program is staffed primarily by registered nurses and other personnel with clinical backgrounds. The Physicians in our medical department are an essential part of the MSA Program.

Failure to contact the MSA or to comply with the determinations of the MSA will result in a reduction in benefits. The MSA's toll-free telephone number is on your Blue Cross and Blue Shield

identification card. Please read the provisions below very carefully. The MSA Program provisions described below are subject to the claims and appeals procedures of the Benefit Plan described in the "Claims Procedure" section of this SPD. Preadmission review claims are considered to be "Pre-Service Claims" under this section.

The provisions of the MSA Program section do not apply to the treatment of Mental Illness and Substance Abuse rehabilitation treatment. The provisions for the treatment of Mental Illness and Substance Abuse rehabilitation treatment are specified in the Claim Administrator's Behavioral Health Unit section of this Appendix.

A. PREADMISSION REVIEW – NONEMERGENCY / NON-MATERNITY INPATIENT

(1) Inpatient Hospital Preadmission Review

Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Benefit Plan.

Whenever a non-emergency or non-maternity inpatient Hospital admission is recommended by your Physician, you must, to receive maximum benefits described in this SPD, call the MSA. This call must be made at least one business day prior to the Hospital admission.

If the proposed Hospital admission or health care services are not Medically Necessary, it will be referred to the Claim Administrator's Physician for review. If the Claim Administrator's Physician concurs that the proposed admission or health care services are not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The MSA will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

(2) Emergency Admission Review

Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Benefit Plan.

In the event of an emergency admission, you or someone who calls on your behalf must, to receive maximum benefits described in this SPD, notify the MSA no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

(3) Maternity Admission Review

Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Benefit Plan.

In the event of a maternity admission, you or someone who calls on your behalf must, to receive maximum benefits described in this SPD, notify the MSA no later than two

business days after the admission has occurred to have the inpatient Hospital admission reviewed. If the call is made any later than the specified period, you will not be eligible for maximum benefits.

(4) **Skilled Nursing Facility Preadmission Review**

Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

(5) **Private Duty Nursing Service Review**

Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever Private Duty Nursing Service is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to receiving services.

(6) **Coordinated Home Care Program Preadmission Review**

Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

(7) **Outpatient Services Prior Authorization Review**

Outpatient Service Prior Authorization Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan.

Whenever the following Outpatient procedure(s)/services(s), are recommended by your Physician, in order to receive maximum benefits under this Health Care Plan, you must call the Claim Administrator's medical pre-notification number. This call must be made at least two business days prior to receiving these services:

- Coordinated Home Care Program services
- Home hemodialysis
- Home Hospice
- Home Infusion Therapy
- All home health services
- Outpatient Infusion Drugs
- Private Duty Nursing
- Transplant evaluations

Cardiac (Heart related):

- Diagnostic Heart Catheterization
- Cardiac Advanced Imaging Services: MRI, Magnetic Resonance Angiogram (MRA), PET, PET-CT, CT, Computed Tomography Angiography (CTA), Nuclear Medicine

• Lipid Apheresis

Ears, Nose and Throat (ENT):
• Bone Conduction Hearing Aids
• Cochlear Implant
• Nasal and Sinus Surgery

Gastroenterology (Stomach):
• Gastric Electrical Stimulation (GES)

Neurological:
• Deep Brain Stimulation
• Sacral Nerve Neuromodulation/Stimulation
• Vagus Nerve Stimulation (VNS)

Orthopedic (Musculoskeletal):
• Artificial Intervertebral Disc
• Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions
• Femoroacetabular impingement (FAI) Syndrome
• Lumbar Spinal Fusion
• Meniscal Allografts and other Meniscal Implants
• Orthopedic Applications of Stem-Cell Therapy

Pain Management:
• Occipital Nerve Stimulation
• Surgical Deactivation of Headache Trigger Sites
• Percutaneous and Implanted Nerve Stimulation and Neuromodulation
• Spinal Cord Stimulation

Radiology:
• Advanced Imaging Services: MRI, Magnetic Resonance Angiogram (MRA), PET, PET-CT, CT, Computed Tomography Angiography (CTA), Nuclear Medicine (including Cardiology)

Sleep Medicine:
• Diagnostic Attended Sleep Studies

Surgical Procedures:
• Orthognathic Surgery; Face reconstruction
• Mastopexy; Breast lift
• Reduction Mammoplasty; Breast Reduction

Wound Care:
• Hyperbaric Oxygen (HBO2) Therapy

Specialty Pharmacy:
• Medical Benefit Specialty Drugs (Specialty drugs administered by your Provider)

Non-Emergency Fixed-Wing Ambulance Transportation:
• Non-Emergency Fixed-Wing Ambulance Transportation

Whenever the following Outpatient services(s), received by a Non-Participating Provider, are recommended by your Physician, in order to receive maximum benefits under this Health Care Plan, you must call the Claim Administrator's medical pre-notification number. This call must be made at least two business days prior to receiving these services:

- Dialysis
- Elective Surgery

If an Inpatient Emergency Hospital Admission occurs after an Outpatient service, in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Claim Administrator.

The Claim Administrator will send a letter to you, your Physician and the Hospital or facility with a determination of your Prior Authorization review no later than fifteen (15) calendar days after the Claim Administrator receives the request for Prior Authorization review. However, in some instances depending on the timing of the request for review, these letters will not be received prior to your scheduled date of service or procedure.

For specific details about the Prior Authorization requirements for any of the above referenced Outpatient services, please call the customer service toll-free telephone number on the back of your Identification Card. The Claim Administrator reserves the right to no longer require Prior Authorization during your benefit period for any or all of the listed services. Updates to the list of services requiring Prior Authorization may be confirmed by calling the customer service number.

B. CASE MANAGEMENT

After your case has been evaluated, you may be assigned a case manager. In some cases, if your condition would require care in a Hospital or other health care facility, the case manager may recommend an alternative treatment plan.

Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The case manager will continue to monitor your case for the duration of your condition. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Benefit Plan. Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Benefit Plan.

C. LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Benefit Plan.

Upon completion of the preadmission or emergency admission review, the MSA will send you a letter confirming that you or your representative called the MSA. A letter assigning a length of service or length of stay will be sent to your Physician and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued inpatient care or other health care service is Medically Necessary as determined by the MSA. If the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to the Claim Administrator's Physician for review.

D. MEDICALLY NECESSARY DETERMINATION

The decision that inpatient care or other health care services or supplies are not Medically Necessary will be determined by the MSA. Should the Claim Administrator's Physician concur that the inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other provider, and will specify the dates that are not in benefit. For further details regarding Medically Necessary care and other exclusions from coverage under the Benefit Plan see **Appendix C**.

The MSA does not determine your course of treatment or whether you receive health care services. The decision regarding the course of treatment and receipt of health care services is a matter entirely between you and your Physician. The MSA's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under the Benefit Plan.

If the Claim Administrator determines that all or any portion of an inpatient Hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that your Benefit Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the MSA and the Claim Administrator's Physician decide they were not Medically Necessary.

E. MSA PROCEDURE

When you contact the MSA, you should be prepared to provide the following information:

(1) the name of the attending and/or admitting Physician;
(2) the name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
(3) the scheduled admission and/or service date; and
(4) a preliminary diagnosis or reason for the admission and/or service.

When you contact the MSA, the MSA:

(1) will review the medical information provided and may follow up with the provider; or
(2) may determine that the services to be rendered are not Medically Necessary.

F. APPEAL PROCEDURE- MSA

If you or your Physician disagree with the determination of the MSA prior to or while receiving services, you may appeal that decision by contacting the MSA or the Claim Administrator's medical director. In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from the MSA, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Blue Cross and Blue Shield of Illinois
P. O. Box A3957
Chicago, Illinois 60601

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator if you do so within 30 days of the date you asked for a review. Also, during this 30-day period, you may review any pertinent documents held by the Claim Administrator if you request an appointment in writing.

Within a reasonable period appropriate to the medical circumstances, but not later than 30 days after receiving your request for review, the Claim Administrator will send you its decision on the Claim.

G. FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the MSA will not interfere with your relationship with any provider. However, the Claim Administer has established the MSA program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits described in this SPD.

If you fail to notify the MSA and seek preadmission review as required, then upon receipt of the claim it is determined by the Claims Administrator that the services were not Medically Necessary or were Experimental, Investigational and/or Unproven, it may be the Covered Person's responsibility to pay the full cost of the services received. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this SPD nor can it be applied to your out-of-pocket expense limit, if applicable, as described in this SPD.

H. MEDICARE ELIGIBLE MEMBERS

The provisions of this Medical Services Advisory Program do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Benefit Plan.

I. CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

The Claim Administrator's Behavioral Health Unit has been established to perform preadmission review and length of stay review for your inpatient Hospital services for the treatment of Mental

Illness and Substance Use. The Behavioral Health Unit is staffed primarily by Physicians, Psychologists, Clinical Social Workers, and registered nurses.

The Behavioral Health Unit provisions described below are subject to the claims and appeals procedures described in Article VII of this SPD. Preadmission review claims are considered to be "Pre-Service Claims" under this section.

Failure to contact the Behavioral Health Unit or to comply with the determinations of the Behavioral Health Unit will result in a reduction of benefits. The Behavioral Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

J. PREADMISSION REVIEW – MENTAL ILLNESS AND SUBSTANCE ABUSE INPATIENT

(1) Inpatient Hospital Preadmission Review

Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Benefit Plan.

Whenever a nonemergency inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder is recommended by your Physician, you must, to receive maximum benefits described in this SPD, call the Behavioral Health Unit. This call must be made at least one day prior to the Hospital admission.

If the proposed Hospital admission does not meet the criteria for Medically Necessary care, it will be referred to a Physician in the Behavioral Health Unit. If the Behavioral Health Unit Physician concurs that the proposed admission does not meet the criteria for Medically Necessary care, some days or the entire hospitalization will be denied. Your Physician and the Hospital will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The Behavioral Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

(2) Residential Treatment Center

Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.

Whenever an admission to a Residential Treatment Center for the treatment of Mental Illness or Substance Use Disorder is recommended by your Physician, you must, in order to receive maximum benefits under this Health Care Plan, call the Behavioral Health Unit. This call must be made at least one day prior to scheduling of the admission. Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section. This call must be made at least one day prior to the Inpatient Hospital admission.

(3) **Emergency Mental Illness Admission Review**

Emergency Mental Illness admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Benefit.

In the event of an emergency Mental Illness admission, you or someone who calls on your behalf must, to receive maximum benefits under this SPD, notify the Behavioral Health Unit no later than 48 hours or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time, you will not be eligible for maximum benefits.

(4) **Partial Hospitalization Treatment Program Review**

Partial hospitalization treatment program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Benefit.

Whenever an admission to a partial hospitalization treatment program is recommended by your Physician, you must, to receive maximum benefits described in this SPD, call the Behavioral Health Unit. This call must be made at least one day prior to the admission.

(5) **Length of Stay Review**

Length of stay review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Benefit Plan.

Upon completion of the preadmission or emergency admission review, the Behavioral Health Unit will send you a letter confirming that you or your representative called the Behavioral Health Unit. A letter assigning a length of service or length of stay will be sent to your Physician and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued inpatient care or other health care service is Medically Necessary as determined by the Behavioral Health Unit. If the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Behavioral Health Unit Physician for review.

(6) **OUTPATIENT SERVICE PRIOR AUTHORIZATION REVIEW**

In order to receive maximum benefits under this Health Care Plan for Outpatient services for the treatment of Mental Illness or Substance Use Disorder, you must, except as otherwise provided, obtain Prior Authorization for the following Outpatient service(s) by calling the Behavioral Health Unit:

- Psychological testing
- Neuropsychological testing
- Electroconvulsive therapy

• Intensive Outpatient Programs

• Repetitive Transcranial Magnetic Stimulation

• Applied Behavior Analysis (ABA) Therapies

Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section. This call must be made at least one day prior to the scheduling of the planned Outpatient services(s). The Behavioral Health Unit will obtain information regarding the Outpatient service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after an Outpatient service, in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Behavioral Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

K. MEDICALLY NECESSARY DETERMINATION

The decision that inpatient care, outpatient service, or other health care services or supplies are not Medically Necessary will be determined by the Behavioral Health Unit. Should the Behavioral Health Unit Physician concur that the inpatient care, outpatient service, or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other provider, and will specify the dates that are not in benefit. For further details regarding Medically Necessary care and other exclusions described in this SPD, see the section entitled “Exclusions from Coverage” in **Appendix C**.

The Behavioral Health Unit does not determine your course of treatment or whether you receive health care services. The decision regarding the course of treatment and receipt of health care services is a matter entirely between you and your Physician. The Behavioral Health Unit’s determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under the Benefit Plan.

If the Behavioral Health Unit determines that all or any portion of an inpatient Hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that your Benefit Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Behavioral Health Unit Physician decides they were not Medically Necessary.

L. BEHAVIORAL HEALTH UNIT PROCEDURE

When you contact the Behavioral Health Unit, you should be prepared to provide the following information:

(1) the name of the attending and/or admitting provider;
(2) the name of the Hospital or facility where the admission and/or service has been scheduled;
(3) the scheduled admission and/or service date; and
(4) a preliminary diagnosis or reason for the admission and/or service.

When you contact the Behavioral Health Unit, the Behavioral Health Unit:

(1) will review the medical information provided and follow-up with the provider;
(2) may determine that the services to be rendered are not Medically Necessary.

M. APPEAL PROCEDURE – DETERMINATIONS OF THE BEHAVIORAL HEALTH UNIT

If you or your Physician disagree with the determinations of the Behavioral Health Unit prior to or while receiving services, you or the provider may appeal that determination by contacting the Behavioral Health Unit and requesting an expedited appeal. The Behavioral Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your provider will be notified of the Behavioral Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your provider still disagrees with the Behavioral Health Unit Physician, you may request an appeal in writing.

APPENDIX D – COVERED PRESCRIPTION DRUG EXPENSES AND EXCLUSIONS FROM COVERAGE

COVERED PRESCRIPTION EXPENSES

The following provisions apply to prescription drug benefit under the Benefit Plan.

The following are **covered** under the Benefit Plan's prescription drug coverage:

(1) non-injectable federal legend drugs;
(2) State-restricted drugs;
(3) compounded medications with prior authorization;
(4) insulin;
(5) insulin needles and syringes;
(6) over the counter diabetic supplies;
(7) oral, transferals, intrauterine or injectable contraceptives;
(9) Nicobid (all strengths); When running test claims for Nicobid but it rejects because OTCs (Over the Counter) are not covered
(10) Retin-A with Prior Authorization
(11) legend smoking deterrents;
and
(13) self-injectables specified through the prescription drug vendor (contact CVS Caremark at (855) 361-8567 to determine whether a self-injectable drug is covered).

EXCLUSIONS FROM COVERAGE

The following are **excluded** from prescription drug coverage under the Benefit Plan:

(1) non-federal legend drugs;
(2) injectable medications except as specified through the prescription drug vendor (contact CVS Caremark at (855) 361-8567 to determine whether a self-injectable drug is covered).
(3) ostomy supplies;
(4) immunizing agents, biologicals, blood, or blood plasma;
(5) drugs intended to promote or stimulate hair growth only (e.g., Rogaine, Propecia) or for cosmetic purposes only (e.g., Renova, Vaniga TriLuma Botox cosmetic, Solage, Avage);
(6) drugs labeled "Caution-limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual;
(7) medication for which the cost is recoverable under any workers' compensation or occupational disease law or any State or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the member;
(8) medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, Skilled Nursing Facility, convalescent Hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals; and
(9) any prescription refilled more than the number of refills specified by the Physician, or any refill dispensed after one year from the Physician's original order.

NOTE: FDA approval of a drug does not guarantee inclusion as a covered item under the prescription drug benefits available under the Benefit Plan. Newly approved drugs may be subject to review by Devon before being covered or may be excluded altogether. In

addition, the level of coverage for some drugs may vary depending on the medication's therapeutic classification. As a result, some medications (including, but not limited to, newly approved drugs) may be subject to quantity limits or may require prior authorization before being dispensed.

APPENDIX E – COVERED DENTAL EXPENSES AND EXCLUSIONS FROM COVERAGE

COVERED DENTAL EXPENSES

The following provisions apply to the dental benefit under the Benefit Plan.

The following are covered by the Benefit Plan's dental coverage:

(1) **PREVENTIVE AND DIAGNOSTIC SERVICES:**

- (a) routine oral evaluation limited to two evaluations per Calendar Year;
- (b) prophylaxis (removal of plaque, calculus, and stains) and scaling in presence of generalized moderate or severe gingival inflammation – full mouth, limited to any combination of two per Calendar Year;
- (c) topical application of fluoride for persons up to age 18, limited to one application per Calendar Year;
- (d) topical application of a sealant on each permanent posterior tooth for persons up to age 15, limited to permanent posterior teeth free of caries and restorations on the occlusal surfaces. Limited to one application per tooth during any period of 36 consecutive months;
- (e) office visit, limited to twice per Calendar Year;
- (f) space maintainers for missing primary posterior teeth for persons up to age 16, and not for orthodontic purposes;
- (g) oral hygiene instruction, limited to one per Calendar Year; and
- (h) dental radiographic images (X-rays), including:
  - (1) full mouth series or panoramic view, limited to once during any period of 36 consecutive months;
  - (2) bitewing(s), limited to one series per Calendar Year;
  - (3) periapical (s); and
  - (4) other radiographic images as needed for diagnosis.

(2) **BASIC AND RESTORATIVE SERVICES:**

- (a) extractions;
- (b) palliative (emergency) treatment of dental plan – minor procedures;
- (c) occlusal analysis, occlusal adjustment, and an inhibiting appliance to correct a harmful habit (such as bruxism or thumb sucking);
- (d) endodontics including root canal therapy;
- (e) amalgam or composite fillings;
- (f) antibiotic drugs injected by the attending dentist;
- (g) general anesthesia/IV sedation in conjunction with surgical procedures;
- (h) surgical removal of impacted wisdom teeth
- (i) alveolar and gingival reconstruction, periodontal scaling and root planing, gingivectomy, osseous surgery, or other treatment of periodontal abscess and periodontitis;

(j) repair or recementing of crowns, inlays, onlays, veneers, removable dentures or fixed partial dentures, or relining of dentures;

(k) complete and partial denture adjustments and repairs – adjustments or repair to a denture within **six** months of its installation is **not** a covered dental service; and

(l) prefabricated stainless-steel crown on a primary tooth, only for persons through age 11.

(3) **MAJOR SERVICES:**

(a) inlays, onlays, and gold foil restorations (fillings);

(b) stainless steel, acrylic, porcelain, and gold crowns; and gold dowel pins;

(c) initial installation of partial or full removable dentures or fixed partial (including the accompanying inlays and crowns to form abutments) to replace one or more natural teeth extracted; and

(d) replacement of existing partial or full removable dentures or fixed partial dentures, or the addition of teeth to an existing partial removable denture or to fixed partial dentures to replace extracted natural teeth, but only if:

(1) the existing denture or fixed partial denture was installed at least five years prior to its replacement and cannot be made serviceable; or

(2) the existing denture is an immediate temporary denture, and replacement by a permanent denture is required and takes place within 12 months from the date of installation of the immediate temporary denture.

(4) **ORTHODONTIC TREATMENT:**

The Benefit Plan will provide benefits for orthodontic treatment, subject to any limitations specified in the "Detailed Schedule of Dental Benefits." Benefits include:

(a) comprehensive full-banded treatment; including initial (and subsequent, if any) installation of orthodontic appliances and adjustment of orthodontic appliances; and

(b) all other traditional orthodontic treatment required by accepted orthodontic practice, including dental X-rays.

EXCLUSIONS FROM COVERAGE

The following are **excluded** from dental coverage under the Benefit Plan:

(1) treatment by other than a dentist, except that scaling or cleaning of teeth may be performed by a licensed dental hygienist if treatment is rendered under a dentist's supervision and direction; treatment by other than a properly licensed dentist (unless allowed by state law), except radiographic images (x-rays) ordered by a dentist, cleaning and scaling of teeth, and topical application of fluoride may be performed by a properly licensed hygienist if treatment is rendered under the supervision and guidance of the dentist, in accordance with generally accepted dental standards;

(2) dental care rendered or supplied by a dentist employed by a government, or at the expense of a government or agency thereof;

(3) Illness or injury which is covered by a workers' compensation law or similar legislation;

(4) expenses payable under the Medical Benefit provisions of the Benefit Plan;

(5) related appliances beyond the cost of a standard complete or partial denture, whichever is applicable;

(6) replacement or modification of crowns, gold restoration, implants or appliance constructed in association therewith if the Benefit Plan covered the original placement within the previous five **(5)** years;

(7) prosthetic devices (including fixed partial dentures and crowns) and the fitting thereof which were ordered before the person was covered under the Benefit Plan or which were ordered while the Covered Participant was covered under the Benefit Plan, but installed or delivered more than 30 days after termination of his coverage under the Benefit Plan;

(8) replacement of a lost or stolen prosthetic device;

(9) treatment for congenital (hereditary) or developmental malformations, cosmetic surgery or dentistry for cosmetic reasons; cleft palate; maxillary or mandibular (upper and lower jaw) degeneration; enamel hypoplasia (lack of development); fluorosis;

(10) plaque control or oral hygiene (except as specified under "Preventive and Diagnostic Services" above;

(11) charges for missed or canceled appointments or completion of claim forms;

(12) charges for services which were not recommended or prescribed by a Physician or Dentist;

(13) charges for dental treatment which is experimental in nature, or which is not yet approved by the Council of Dental Therapeutics of the American Dental Association;

(14) charges for the use of gold if treatment could have been provided at a lower cost by using a reasonable substitute consistent within generally accepted dental practice;

(15) dental services required as the result of any war (declared or undeclared), except when an individual remains covered under the Benefit Plan (with coverage that is secondary to the individual's government coverage) during the first six (6) months of active-duty military; and

(16) dental services required because of engaging in a riot or insurrection or any intentionally self-inflicted injury unless the injury is the result of a medical condition (physical or Mental Illness condition

(17) charges for house calls or hospital calls;

(18) charges for any professional services performed by a relative of the patient, for which no charge is made that the patient is legally obligated to pay, or for which no charge would be made in the absence of dental coverage;

(19) prescriptions, pre-medications, and relative analgesia; and

(20) benefits for dental services when a claim is received for payment later than December 31 following the end of Calendar Year in which services are rendered.

APPENDIX F – GENERAL COBRA NOTICE

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of medical, dental, vision, employee assistance and health care flexible spending account coverage under the Plans. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

You and your spouse and dependents may have additional rights to continued benefits under state law. For additional information, contact HRConnect. Federal law does not require COBRA for your domestic partner; however, the Plan does offer COBRA-like coverage for your domestic partner and their covered dependent children.

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

In some cases, you may also have additional rights to continued benefits under state law. For additional information review the booklets, descriptive material and certificates of coverage provided by Devon and third-party providers.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plans is lost because of the qualifying event. Under the Plans, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- you become divorced or legally separated from your spouse.

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

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

When is COBRA Coverage Available?

The Plans will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days of the qualifying event.

You must provide notice to:

HR Connect
(855) 810-3555
HRConnect@dvn.com

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plans is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of the Social Security Administration disability determination and prior to the end of the original 18-month period, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide a copy of the Social Security Administration disability determination to:

Flores & Associates
P.O. BOX 31397
Charlotte, NC 28231-1397
(800) 532-3327

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plans. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plans as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plans had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Special Rule for Medical Care Flexible Spending Account

In the case of the Medical Care Flexible Spending Account, special rules apply. First, COBRA continuation coverage will be offered only if your reimbursements for the year under the Medical Care Flexible Spending Account at the time coverage is lost do not exceed the total contributions to the Spending Account for the year. Second, if COBRA continuation coverage is offered under the Medical Care Flexible Spending Account it will only be offered for the balance of the plan year in which coverage is lost and will not be offered for subsequent years.

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

Electing COBRA Continuation Coverage

To elect continuation coverage, you must complete an election form prescribed by the Plan Administrator and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

Paying for COBRA Continuation Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

If You Have Questions

Questions concerning your Plans, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep Your Plans Informed of Address Changes

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

Plan Contact Information

Information about the Plans and COBRA continuation coverage can be obtained from:

Flores & Associates
P.O. BOX 31397
Charlotte, NC 28231-1397
(800) 532-3327

Continuation Coverage During Military Service

Employees and dependents who lose health coverage due to the employee's military leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 (also referred to as "USERRA") may elect to continue coverage for up to 24 months. Any individual who elects to continue such coverage will be required to make the same premium payments as a COBRA participant.

Conversion to an Individual Policy

At the end of the 18, 29, or 36-month COBRA continuation coverage period, you may be eligible to convert your coverage to an individual policy. If you are eligible, you will be required to make the necessary arrangements directly with the insurance carriers. The necessary information should be contained in the materials provided by the insurance carriers. If not, you should check with HRConnect. Conversion coverage may not be the same as the coverage you have under the Plans. Instead, it will be one of the insurance carrier's standard conversion policies. There is no conversion option applicable to the Medical Care Flexible Spending Account.

APPENDIX G – HIPAA PRIVACY & PROTECTED HEALTH INFORMATION

The following provisions permit the Plans to disclose your protected health information ("PHI"), as defined in HIPAA, to the Plan Sponsor to the extent that such PHI is necessary for the Plan Sponsor to carry out its administrative functions related to the Plans.

Disclosure to The Plan Sponsor: The Plan (or health insurance issuer with the Plan's permission) may disclose your PHI to the Plan Sponsor that is necessary for the Plan Sponsor to carry out the following administrative functions related to the Plans.

The Plan Sponsor needs access to PHI to:

- determine whether you and/or your dependent are eligible for benefits under the Plans;
- determine the amount of benefits, if any, you and/or your dependent are entitled to from the Plans;
- determine or find facts that are relevant to any claim for benefits from the Plans;
- determine whether a participant's benefits should be terminated or suspended;
- perform duties relating to the establishment, maintenance, and administration of the Plans;
- communicate with participants regarding the status of their claims;
- recover any overpayment or mistaken payments made to claimants; and
- handle participant issues about subrogation and third-party claims.

The Plan Sponsor may use and disclose your PHI provided to it from the Plans (or health insurance issuer) only for the administrative purposes described above.

Limitations and Requirements Related to the Use and Disclosure of PHI: The Plan Sponsor agrees to the following limitations and requirements related to its use and disclosure of your PHI received from the Plans:

(a) **Use and Further Disclosure.** The Plan Sponsor will not use or further disclose your PHI other than as permitted or required by this document or as required by law.

(I) **Minimum Necessary Standard.** When using or disclosing your PHI or when requesting your PHI from the Plans, the Plan Sponsor will make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

(b) **Agents and Subcontractors.** The Plan Sponsor will require any agents, including subcontractors, to whom it provides your PHI received from the Plans to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.

(c) **Employment-Related Actions and Decisions.** Except as permitted by HIPAA and other applicable law, the Plan Sponsor will not use your PHI to take employment-related actions or make employment-related decisions about you, or in connection with any other employee benefit plan of the Plan Sponsor.

(d) **Reporting of Improper Use or Disclosure.** The Plan Sponsor shall promptly report to the Plans any improper use or disclosure of your PHI of which it becomes aware.

(e) **Adequate Protection.** The Plan Sponsor will provide adequate protection of your PHI and separation between the Plans and the Plan Sponsor by:

(1) ensuring that only the privacy employees as defined in the Devon Energy HIPAA Privacy Policy will have access to your PHI provided by the Plans;

(2) restricting access to and use of your PHI to only the employees identified above and only for the administrative functions performed by the Plan Sponsor on behalf of the Plans that are described above;

(3) requiring any agents of the Plans who receive your PHI to abide by the Plans' privacy rules; and

(4) using the following procedure to resolve issues of noncompliance by the employees identified above.

a. The Plans will be immediately notified, and the Plans and Plan Sponsor will work together to remedy the situation and mitigate any harmful effect resulting from the use or disclosure of PHI.

b. After an investigation into the alleged incident, those employees who are found to be in violation of these policies or the HIPAA Privacy Regulations will be sanctioned as is deemed appropriate.

c. The Plans and Plan Sponsor will work together to create new safeguards and procedures to prevent a future incident of noncompliance.

(f) **Return or Destruction of PHI.** If feasible, the Plan Sponsor will return or destroy all PHI received from the Plans that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(g) **Participant Rights.** The Plan Sponsor will provide you with the following rights:

(1) the right to access to your PHI;

(2) the right to amend your PHI upon request (or the Plan Sponsor will explain to you in writing why the requested amendment was denied) and incorporate any such amendment into your PHI; and

(3) the right to an accounting of all disclosures of your PHI.

(h) **Cooperation with HHS.** The Plan Sponsor will make its books, records, and internal practices relating to the use and disclosure of PHI received from the Plans available to the Department of Health and Human Services for verification of the Plans' compliance with HIPAA.

Certification: The Plans will disclose PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that the Plan documents have been amended in accordance with HIPAA, and that the Plan Sponsor will protect the PHI as described above.

Security Standards Requirement: Plan Sponsor will take the following steps to reasonably and appropriately safeguard the electronic protected health information that it receives, transmits, creates or maintains from, or on behalf of, the Plans in its capacity as the sponsor of the Plans:

- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plans;
- implement reasonable and appropriate security measures for ensuring that there is adequate separation required by 45 CFR §164.504(f)(2)(iii), between the Plan Sponsor and the Plans that it sponsors;
- ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and
- report to the Plans any security incident of which it becomes aware; including any attempted or successful unauthorized access, use, disclosure or destruction of information or interference with system operations, that involve electronic protected health information provided to Plan Sponsor by, or on behalf of, the Plans that it sponsors.

APPENDIX H – MEDICAID AND CHIP NOTICE

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your dependents are eligible for Medicaid or CHIP and you're eligible for health coverage sponsored by Devon, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your dependents aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

Already enrolled in Medicaid or CHIP. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

Not enrolled in Medicaid or CHIP. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for the Devon-sponsored health plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Devon-sponsored health plan, you will be allowed to enroll in the Devon-sponsored health plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

FOR MORE INFORMATION

For more information, call HRConnect at (855) 810-3555. You can also contact the Department of Labor at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

STATE CONTACT INFORMATION

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2022. You should contact your State for further information on eligibility:

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Programhttp://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center:1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery. com/hipp/index.html Phone: 1-877-357-3268
GEORGIA-Medicaid	**MAINE-Medicaid**
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840

IOWA-Medicaid and CHIP (Hawki)	MINNESOTA-Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA-Medicaid	**SOUTH CAROLINA-Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.govPhone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493

NEW YORK-Medicaid	UTAH-Medicaid and CHIP
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any more States have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

APPENDIX I – GENERAL MEDICARE PART D NOTICE

This notice is intended for active employees. If you are not an active employee, Medicare may be primary for you regardless of your participation in this plan. Please consult Medicare.gov or the Devon Retirement Service Center if you have questions.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Devon and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Devon has determined that the prescription drug coverage offered by the Devon Energy Corporation Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing prescription coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Devon coverage will be affected.

What Happens When

If you…	*Then…*
Want to continue your Devon sponsored medical and prescription drug coverage and be eligible to contribute to an HSA…	▪ You should not enroll in Medicare Part D (or any other Medicare plan) coverage if you are not currently enrolled in Medicare.

Drop or lose your Devon sponsored medical coverage and go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage…	▪ Your monthly premium for Medicare Part D will go up at least 1% per month for every month after that you did not have Medicare Part D coverage ▪ You will have to pay this higher premium if you have Medicare Part D coverage ▪ You may have to wait until the next November to enroll in Medicare Part D coverage

If you do decide to join a Medicare drug plan and drop your current Devon coverage, you may enroll back into Devon Energy Corporations Employee Benefit Plan during a subsequent annual open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Devon and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) if you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Devon changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 3, 2023
Name of Entity/Sender:	Devon Energy Corporation
Contact--Position/Office:	Retirement Service Center
Address:	333 West Sheridan Ave. Oklahoma City, OK 73102-8260
Phone Number:	888-338-6676

As with any plan, the Company reserves the right to amend, change, or cancel the benefits at any time, subject to the appropriate terms of the plans and applicable laws.