Effective: January 1, 2023

Summary of Benefits
(7670-00-411042)

for

Windstream Medical Plan,
a component of the
Windstream Services, LLC Welfare Benefit Plan

BENEFITS ADMINISTERED BY

UMR℠

A UnitedHealthcare Company

Table of Contents

WINDSTREAM

MEDICAL PLAN

SUMMARY OF BENEFITS

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan as well as information on a Covered Person's rights and obligations under the WINDSTREAM MEDICAL PLAN, a component of the WINDSTREAM SERVICES, LLC WELFARE BENEFIT PLAN (the "Plan"). References to the "Plan" in this Summary of Benefits mean the Windstream Medical Plan component benefits described in this document or the entire Windstream Services, LLC Welfare Benefit Plan, as applicable depending on the context.

This Summary of Benefits is a component of the *Windstream Services, LLC Welfare Benefit Plan Summary Plan Description*, a separate document which together with this Summary of Benefits is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA) and to serve as the summary plan description ("SPD") required by ERISA.

Windstream Services, LLC and a number of related companies participate in this Plan. References to "Windstream" in this summary may refer to either Windstream Services, LLC only or to Windstream Services, LLC and the other participating Employers, as applicable based on the context.

As a valued Employee of Windstream, we are pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

WINDSTREAM SERVICES, LLC is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. Except where otherwise noted, the Third Party Administrators for the benefits described in this document are UMR, Inc. (hereinafter "UMR") for medical claims, and Express Scripts for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The Plan Sponsor assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Glossary of Terms, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Glossary will help to better understand the provisions of this Plan.

Individuals covered under this Plan will be receiving an identification card to present to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

This document becomes effective on January 1, 2023.

The Company reserves the right to amend, modify, terminate, and partially terminate the medical Plan at any time.

PLAN INFORMATION

Effective: 01-01-2022

Plan Name	WINDSTREAM SERVICES, LLC WELFARE BENEFIT PLAN
Plan Sponsor	WINDSTREAM SERVICES II, LLC 4001 N. RODNEY PARHAM RD LITTLE ROCK AR 72212 1-866-553-9409
Name, Address And Phone Number Of Plan Administrator	WINDSTREAM BENEFITS COMMITTEE 4001 N. RODNEY PARHAM RD LITTLE ROCK AR 72212 501-748-7000
Named Fiduciary	WINDSTREAM BENEFITS COMMITTEE
Employer Identification Number Assigned By The IRS	85-2049794
Plan Number Assigned By The Plan	501
Type Of Benefit Plan Provided	The Plan is a welfare benefits plan. The benefits described in this document are self-funded group health Plan benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical.
Name And Address Of Agent For Service Of Legal Process	WINDSTREAM SERVICES, LLC 4001 N. RODNEY PARHAM RD LITTLE ROCK AR 72212 Services of legal process may also be made upon the Plan Administrator.
Funding Of The Plan	Employer and Employee Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by the Plan Sponsor. Benefits are paid from the Employer's general assets.
Collective Bargaining Provisions	The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of the agreements may be obtained upon written request to the Plan Administrator, and such agreements are available for examination.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
ERISA Plan Year	January 1 through December 31

ERISA And Other Federal Compliance

It is intended that this Plan meet all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, including the SPD, of which this Summary of Benefits is a component, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrators shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 084, 094 – $4,000 Plan

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior-Authorization may be required before benefits will be considered for payment. Failure to obtain Prior-Authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and Prior-Authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year: • Per Person • Per Family ***Note: If Family Coverage Is Elected, The Full Family Deductible Amount Must Be Met Before The Plan Will Begin Paying At The Plan Participation Level.***	 $4,000 $8,000	 $8,000 $16,000
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	 70%	 50%
Annual Out-Of-Pocket Maximum: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.*** • Per Person • Per Family ***Note: If Family Coverage Is Elected, The Full Family Out-Of-Pocket Maximum Amount Must Be Met Before The Plan Will Begin Paying Covered Expenses In Full.***	 $6,550 $13,100	 $13,100 $26,200
Acupuncture Treatment: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	 12 Visits 70%	 50%
Ambulance Transportation: • Paid By Plan After In-Network Deductible ***Note: Medical Necessity Will Be Reviewed For Non-Emergent Ambulance Services.***	 70%	 70%
Augmentation Communication Device – Not Covered.		

	IN-NETWORK	OUT-OF-NETWORK
Breast Pumps:		
Personal Breast Pumps:		
• Paid By Plan After Deductible	100% (Deductible Waived)	100%
Hospital Grade Rental:		
• Paid By Plan After Deductible	100%	100%
Note: Coverage To Be Provided Up To Six Months On A Monthly Basis. All Accessories And Supplies Are Considered Part Of The Monthly Rental Allowance. See Covered Medical Benefits For Additional Information.		
Chiropractic Services:		
• Maximum Visits Per Calendar Year	30 Visits	
• Co-pay Per Visit	$80	Not Applicable
• Paid By Plan After Deductible	70%	50%
Note: Medical Necessity Will Be Reviewed After 25 Visits.		
Contraceptive Methods And Counseling Approved By The FDA:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Note: Contraceptives Covered Under The Prescription Drug Plan Administered By Express Scripts Are Excluded.		
Diabetic Supplies – Covered Under Medical And Rx Benefit:		
• Paid By Plan After Deductible	70%	50%
Durable Medical Equipment:		
• Paid By Plan After Deductible	70%	50%
Emergency Services / Treatment:		
Urgent Care:		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Walk-In Retail Health Clinics:		
• Co-pay Per Visit	$40	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Emergency Room / Emergency Physicians:		
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours)	$300	$300
• Paid By Plan After In-Network Deductible	70%	70%

	IN-NETWORK	OUT-OF-NETWORK
Expanded Preventive List For Specific Chronic Conditions – Refer To The Covered Medical Benefits Section For Details:		
Antiresorptive Therapy For The Diagnosis Of Osteoporosis And/Or Osteopenia:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Beta-Blockers For The Diagnosis Of Congestive Heart Failure:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Blood Pressure Monitor For The Diagnosis Of Hypertension:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Retinopathy Screening, Glucometer, Hemoglobin A1C Testing, And Insulin For The Diagnosis of Diabetes:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Peak Flow Meter And Inhaled Corticosteroids For The Diagnosis Of Asthma:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
International Normalized Ratio (INR) Testing For The Diagnosis Of Liver Disease And/Or Bleeding Disorders:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Low-Density Lipoprotein (LDL) Testing For The Diagnosis Of Heart Disease:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Beta-Blockers For The Diagnosis Of Coronary Artery Disease:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility:		
• Maximum Days Per Calendar Year	120 Days	
• Paid By Plan After Deductible	70%	50%
Group Counseling:		
• Paid By Plan After Deductible	70%	50%

	IN-NETWORK	OUT-OF-NETWORK
Hearing Services:		
Exams, Tests:		
• Paid By Plan After Deductible	70%	50%
Hearing Aids And Fittings:		
• Maximum Benefit Per Calendar Year	$1,000 Per Ear	
• Paid By Plan After Deductible	70%	50%
Note: Cochlear Implant Included In Maximum.		
Implantable Hearing Devices And Auditory Brain Stem Implant:		
• Maximum Benefit Per Lifetime	1 Brain Stem Implant And 1 Cochlear Implant	
• Paid By Plan After Deductible	70%	50%
Note: Auditory Brain Stem Implants Require A Diagnosis of Neurofibromatosis Type II (NF2) Who Has Undergone Or Is Undergoing Removal Of Bilateral Acoustic Tumors.		
Home Health Care Benefits:		
• Maximum Visits Per Calendar Year	120 Visits	
• Paid By Plan After Deductible	70%	50%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits:		
Hospice Services:		
• Paid By Plan After Deductible	70%	50%
Bereavement Counseling:		
• Paid By Plan After Deductible	70%	50%
Respite Care:		
• Paid By Plan After Deductible	70%	50%
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	70%	50%
Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:		
• Paid By Plan After Deductible	70%	50%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	70%	50%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Lab And X-Ray Charges:		
• Paid By Plan After Deductible	70%	50%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	70%	50%
Outpatient Imaging Charges:		
• Paid By Plan After Deductible	70%	50%
Maternity:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Non-Routine Prenatal Services, Delivery And Postnatal Care:		
• Paid By Plan After Deductible	70%	50%
Mental Health, Substance Use Disorder And Chemical Dependency Benefits:		
Inpatient Services / Physician Charges:		
• Paid By Plan After Deductible	70%	50%
Residential Treatment:		
• Maximum Days Per Calendar Year	120 Days	
• Paid By Plan After Deductible	70%	50%
Outpatient Or Partial Hospitalization Services And Physician Charges:		
• Paid By Plan After Deductible	70%	50%
Office Visit:		
• Co-pay Per Visit	$40	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Morbid Obesity Treatment:		
• Maximum Benefit One Procedure Per Lifetime	1 Procedure	
• Paid By Plan After Deductible	70%	50%
Physician Office Services:		
Primary Care Physician Office Services:		
• Co-pay Per Visit	$40	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Specialist Physician Office Services:		
• Co-pay Per Visit	$80	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%

	IN-NETWORK	OUT-OF-NETWORK
Diabetic Supplies, Needles, Syringes Administered In An Office Visit Setting:		
• Paid By Plan After Deductible	70%	50%
Allergy Injections:		
• Paid By Plan After Deductible	70%	50%
Allergy Testing:		
• Paid By Plan After Deductible	70%	50%
Allergy Serum:		
• Paid By Plan After Deductible	70%	50%
Diagnostic X-Ray And Laboratory Tests:		
• Paid By Plan After Deductible	70%	50%
Office Advanced Imaging:		
• Paid By Plan After Deductible	70%	50%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
Preventive / Routine Physical Exams At Appropriate Ages:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Immunizations:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine Diagnostic Tests, Lab And X-Rays At Appropriate Ages:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine Mammograms And Breast Exams:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine Pelvic Exams And Pap Test:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine Fecal Blood Culture:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine PSA Test And Prostate Exams:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	50%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine Eye Exams And Glaucoma Testing:		
To Age 5		
• Maximum Visits Per Calendar Year	1 Visits	
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet And Nutrition:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
In Addition, The Following Preventive / Routine For Women Services Are Covered: ➢ **Gestational Diabetes Screening** ➢ **Papillomavirus DNA Testing** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling And Screening for Human Immune-deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies and Counseling *(See Covered Medical Benefits For Additional Information)*** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)***		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
***These Services May Also Apply To Men.**		
Private Duty Nursing:		
• Maximum Visits Per Calendar Year	60 Visits	
• Paid By Plan After Deductible	70%	50%
Sterilizations:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%

	IN-NETWORK	OUT-OF-NETWORK
Teladoc Services: **General Medicine:** • Co-pay Per Occurrence • Paid By Plan After Deductible **Dermatology:** • Co-pay Per Occurrence • Paid By Plan After Deductible **Behavioral Health:** • Co-pay Per Occurrence • Paid By Plan After Deductible	 $40 100% (Deductible Waived) $40 100% (Deductible Waived) $40 100% (Deductible Waived)	
Temporomandibular Joint Disorder Benefits: • Paid By Plan After Deductible	70%	50%
Therapy Services: • Co-pay Per Visit • Paid By Plan After Deductible	$80 100% (Deductible Waived)	Not Applicable 50%
Travel And Lodging For Restrictive Services – Refer To The Covered Medical Benefits Section For Details: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	 $5,000 70%	
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	 $500 70%	 50%
All Other Covered Expenses: • Paid By Plan After Deductible	70%	50%

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) 084, 094		
Transplant Services At A Designated Transplant Facility: **Transplant Services:** • Paid By Plan After Deductible **Travel And Housing:** • Maximum Benefit Per Transplant • Paid By Plan After Deductible Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation and For Up To One Year From Date Of Transplant.	 100% $10,000 100% (Deductible Waived)	
Transplant Services: Non-Designated Transplant Facility **Transplant Services:** • Paid By Plan After Deductible **Travel And Housing:** • Maximum Benefit Per Transplant • Paid By Plan After Deductible	 70% $10,000 70%	 50% 50%

CORONAVIRUS PANDEMIC, TEMPORARY BENEFITS

Effective: 01-01-2022

During the coronavirus (COVID-19) pandemic, the Plan will provide temporary benefits as specified below. These benefit enhancements apply solely and exclusively during the temporary period specified herein and will not be available at the conclusion of the public health emergency. All other terms, conditions, exclusions or limitations in this Summary of Benefits continue to apply and must be satisfied in order for any benefits to be paid.

Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act

Effective March 18, 2020, in accordance with the FFCRA and CARES Act, the Plan shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during the federally-declared public health emergency period. Benefits are available for services rendered by an In-Network or Out-of-Network Provider.

(1) FDA-approved diagnostic testing products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 and the administration of such diagnostic tests.

FDA-approved over-the counter COVID-19 testing products will be covered at 100% through you prescription drug plan.

(2) Items and services furnished to an individual during health care Provider office visits (including in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of a diagnostic test, or an evaluation to determine if a diagnostic test is necessary.

(3) COVID-19 vaccine coverage that has received a recommendation from either the U.S. Preventive Services Task Force (USPSTF) or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) and makes them a qualifying coronarvirus preventive service with respect to the individual involved, and their administration.

COVID-19 vaccines may still be available under Preventive / Routine Care Benefits after the expiration of the COVID-19 Public Health Emergency.

In the event that any new federal laws or regulations are enacted, the Plan will comply with the applicable law or regulation.

PROGYNY

NOTE: UMR (the claims administrator) does not administer the benefits within this provision. Please contact the Benefit Manager or Your Employer with any questions related to this coverage.

Progyny is the premier fertility benefit designed to provide all-inclusive comprehensive coverage for cutting-edge fertility treatments to assist any member wishing to have a child. Progyny's program includes a credentialed provider network, and a personalized concierge-style member support team (Patient Care Advocates) who offer education, support, and coordinated care.

Progyny's program does not require a medical diagnosis of infertility in order to access fertility treatment services, which ensures that members of the LGBTQ+ community and single parents by choice receive equitable access to coverage.

Through Progyny's benefit, members have access to a full suite of fertility treatment options, which may include (but may not be limited to):

> *Artificial Insemination (IUI), Cryopreservation of oocytes and sperm, FDA Bloodwork and Testing, Fresh/VF Cycle, Frozen Embryo Transfer (FET), Frozen Oocyte Transfer (includes fertilization of previously frozen oocytes and transfer), /VF Freeze-All, Patient Care Advocate (PCA) Concierge Support, pre-authorized fertility medications (via Progyny Rx), PGT-A (PGS, or Pre-implantation Genetic Screening) to assess embryo viability, PGT-M (PGD, or Pre-implantation Genetic Diagnosis), Pregnancy Gap Coverage (Pregnancy monitoring coverage until the in-network fertility clinic releases the member into the care of the member's OBGYN medical provider), Tissue Transportation (transportation of member's previously frozen reproductive tissue to in-network facilities), and the purchase of donor tissue (eggs and sperm).*

Progyny's benefit has the following standard exclusions:

Home ovulation prediction kits, dependent child/children benefits, services and supplies furnished by an out-of-network provider, and treatments that are outside the standard of care and considered experimental by the American Society of Reproductive Medicine.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

CO-PAYS

A Co-pay is the amount that the Covered Person pays each time certain services are received. The Co-pay is typically a flat dollar amount and is paid at the time of service or when billed by the provider. Co-pays do not apply toward satisfaction of Deductibles. Co-pays apply toward satisfaction of in-network and out-of-network out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

A Deductible is an amount of money paid once per Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person Incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the applicable benefit level's total individual and family Deductible.

PLAN PARTICIPATION

The Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s). The Plan Participation rate is shown on the Schedule of Benefits.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is the most the Covered Person pays each year for Covered Expenses. There are separate in-network and out-of-network out-of-pocket maximums for this Plan. Annual out-of-pocket maximums are shown on the Schedule of Benefits. Amounts the Covered Person Incurs for Covered Expenses will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). If the Covered Person's out-of-pocket expenses in a Plan Year exceed the annual out-of-pocket maximum, the Plan pays 100% of the Covered Expenses through the end of the Plan Year.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Any amounts over the Recognized Amount, Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

The eligible out-of-pocket expenses that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any "fee forgiveness", "not out-of-pocket" or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by the Plan Administrator. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from You or Your Dependents in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

WAITING PERIOD

If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an Active Employee becomes eligible for coverage under the terms of this Plan.

The Waiting Period for an otherwise eligible Active Employee is:

You are eligible for coverage on the first day of the month following completion of 8 calendar weeks of regular employment in a covered position.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this Plan. Employees must enroll online at www.windstreambenefits.com within 30 days from the date your information is entered into the benefits enrollment system.

ELIGIBILITY REQUIREMENTS

Active Employees

An **eligible Active Employee** is:

- A person who is classified by the Employer on both payroll and personnel records as a regular fulltime Employee who is regularly scheduled to work 30 or more hours per week; or
- An Employee who worked at least 30 hours per week during a measurement period as defined in the applicable Affordable Care Act regulations, as determined by the Plan Administrator in its sole discretion. (An Employee will be informed by the Plan Administrator if they are eligible for benefits under this provision.)

For purposes of this Plan, none of the following classifications of workers are considered to be eligible Active Employees except as determined by the Plan Administrator in its sole discretion:

- Leased Employees.
- An independent contractor.
- A consultant who is paid on other than a regular wage or salary by the Employer.
- A member of the Employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the Employer's leave policy, provided that contributions continue to be paid on a timely basis. The contributions will be based on the Active Employee subsidized rate.

The Employer's or Plan Administrator's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the Employer or Plan Administrator agrees to such reclassification, shall change a person's eligibility for benefits.

Retired Employees

An eligible Retired Employee is a Retired Employee who is under age 65, except as described herein.

Age 65 Exception: Certain Retired Employees who are eligible for subsidized coverage have been permitted to continue participation in this Plan after turning 65. Effective as of 11:59 p.m. on December 31, 2021, the Plan Sponsor is limiting the group of Retired Employees who will be eligible to participate after turning age 65. Beginning January 1, 2022, only Retired Employees classified by the Plan Sponsor as GTE Agreement Retirees who are eligible to participate in the Plan at a reduced premium rate due to Employer-provided subsidies will be eligible to continue participation after reaching age 65.

See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage.

Retired Employees may enroll in coverage within 30 days of the date of his or her termination/retirement from the Employer. If a Retired Employee does not enroll in coverage within 30 days of the date of his or her termination/retirement from the Employer, he or she is no longer eligible to enroll in the Plan as a Retired Employee at any time in the future, and coverage for his or her Dependents will be declined as well.

Dependents

An **eligible Dependent** includes:

- Your spouse (the lawful husband or wife) who is not legally separated or divorced from You but does not include common law marriages. Spouses of Retired Employees who are subject to the age 65 limitation also are only eligible for coverage until age 65.

- Your Children up to age 26 without regard to school status, marital status, financial dependency, residency, or eligibility for their own employer's Plan.

- Your Children age 26 or over who are incapable of self-support because of a disability and were covered under the Plan prior to reaching the limiting age of 26 may be able to continue coverage subject to annual recertification. For additional information, please contact Your Benefits Center.

- Children include the following persons:

  - A biological Child;
  - Any of the following persons in a parent-Child relationship with You, the Employee:
    - Your step Children;
    - Your adopted Children;
    - Your legal ward; or
    - Children lawfully Placed for Adoption with You, and
  - A grandchild only if Your Child (who is the parent and is an eligible family member) is enrolled in the Plan and Your grandchild lives with You and is dependent on **You** for support (Your grandchild or the parent of the grandchild must be listed on Your federal tax return as a Dependent);

Additional Rules:

Your spouse or Child will not be eligible for coverage if they have Employee coverage under this Plan.

If both the Employee and spouse are covered as Employees, their eligible Children may be covered by only one parent.

- A Dependent does not include the following:

  - A foster Child unless a Legal Ward of the Employee;
  - Any other relative or individual unless explicitly covered by this Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee shall not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have a notice obligation to notify the Plan should the Dependent's eligibility status change throughout the Plan year. Please notify Businessolver at 1-888-850-1712 regarding status changes.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of:

- If You apply within the enrollment period, Your coverage will become effective the first day of the month following the date You complete Your Waiting Period. If Your Waiting Period ends on the first day of the month, Your coverage will not begin until the first day of the following month; or

- If You apply after the completion of Your Enrollment Period, You will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective January 1 following application during the annual open enrollment period. (Persons who apply under the Special Enrollment Provision are not considered Late Enrollees).

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or

- The date You acquire Your Dependent if application is made within 30 days of acquiring the Dependent (calculated as event date + 30 calendar days); or

- January 1 following application during the annual open enrollment period. The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 30 days (calculated as event date + 30 calendar days) after Your hire date, or more than 30 days following the date (calculated as event date + 30 calendar days) You acquire the Dependent; or

- The later of the date specified in a Qualified Medical Child Support Order or the first of the month following the receipt of a QMCSO.

Your contributions will be updated as described in the Cost of Coverage section later in this document. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, covered Employees will be able to make a change in coverage for themselves and their eligible Dependents. It is important to choose coverage carefully during the annual enrollment period because the benefit election You make will be in effect for the entire calendar year unless You or Your Dependent experience a special enrollment period as defined by the Plan.

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

The Plan Administrator or Employer will give eligible Employees written or electronic notice prior to the start of an annual open enrollment period. If You and/or Your Dependent become covered under this Plan as a result of electing coverage during the annual open enrollment period, the following shall apply:

- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and

- The Effective Date of coverage shall be January 1 following the annual open enrollment period.

If You are a Retired Employee, please note that once You cancel coverage (voluntarily or due to non-payment of premiums) for Yourself or Your Dependent(s), You and/or/Your Dependents may not re-enroll in the WINDSTREAM MEDICAL PLAN in any future Annual Open Enrollment or at any other time.

MEDICAL SURCHARGE FOR WORKING SPOUSES

The Plan has a spousal surcharge of $100 per month, deducted on a pay period basis (if You are a bargaining Employee, refer to Your collective bargaining agreement for applicability). The surcharge is applied to Employees with a spouse who has medical coverage or a contribution toward medical coverage available through his/her employer but chooses to enroll in medical coverage under Windstream's Plan**.**

When You enroll in the Plan and have a spouse, review the following to understand if the Spousal Surcharge will apply to your premium:

- Named spouse is not employed or is self-employed and does not have access to an employer sponsored medical plan. Spousal surcharge will not apply if the spouse enrolls in the WINDSTREAM MEDICAL PLAN.

- Named spouse is actively employed by Windstream. The spousal surcharge will not apply if the spouse enrolls in the WINDSTREAM MEDICAL PLAN.

- Named spouse is employed and his/her employer offers medical coverage or a contribution toward purchasing medical coverage. The spousal surcharge will apply if the spouse enrolls in the WINDSTREAM MEDICAL PLAN.

- Named spouse is employed but his/her employer does not offer medical coverage or a contribution toward purchasing medical coverage. Spousal surcharge is not required. Please list the employer's name, address and contact information.

  The surcharge will only be applied for the following tier levels of coverage if You attest that Your spouse's employer offers medical coverage or a contribution toward purchasing medical coverage:

- Employee + Spouse, or

- Employee + Family

Some employers who offer medical coverage may have closed their annual election period or have a plan year different than the Jan. 1 – Dec. 31 calendar year. Other employers do not have annual enrollment periods. Spouses in these situations can enroll in the WINDSTREAM MEDICAL PLAN during Windstream's annual enrollment or during a special enrollment period as allowed under this Plan but will need to pay the surcharge.

A few employers provide access to an employer sponsored medical plan but contribute nothing or very little toward the cost of coverage. Spouses in this situation can enroll in the WINDSTREAM MEDICAL PLAN but will need to pay the surcharge.

Many spouses work part-time and their employers offer very minimal medical coverage, for example, certain retail establishments. Spouses in these situations can enroll in the WINDSTREAM MEDICAL PLAN but will need to pay the surcharge.

There are also employers who provide spouses with a certain amount of money toward purchasing their own medical coverage. Spouses in these situations can enroll in the WINDSTREAM MEDICAL PLAN but will need to pay the surcharge.

Some spouses may not be employed but may have access to Medicare benefits. Since Medicare is not an employer sponsored medical plan, the surcharge will not apply.

CHANGE IN SURCHARGE

If Your spouse's employment status or medical plan or contribution availability changes during the year, You must submit an updated Affidavit for Spousal Surcharge online within 30 days of the employment change (calculated as event date + 30 calendar days). Changes to the surcharge will be applied as soon as administratively possible on a go-forward basis only, but not before the Effective Date of the change submitted. Refunds and retroactive adjustment are not provided, so prompt submission is important.

COST OF COVERAGE

Premium Costs – Active Employees: You and Windstream share the premium cost of medical coverage for You and Your enrolled family members. Your cost for coverage depends on the medical Plan option and coverage level You choose. You pay Your share of the cost of coverage as pre-tax contributions through automatic payroll deductions

Premium Costs – Retired Employees: If You are a Retired Employee, You will make monthly premium payments via one of the methods provided by the Plan Administrator. In some cases, Windstream subsidizes the premium costs for Retired Employees and their Dependents. However, in most cases, the Retired Employee and/or the Retired Employee's Dependents must pay the full unsubsidized premium cost in order to participate in the Plan.

Additional Cost-Sharing: Employees and Dependents also are responsible for sharing in the cost of coverage through Deductibles and Co-pays, out-of-pocket expenses, and Plan Participation amounts as described in the Schedule of Benefits.

The WINDSTREAM MEDICAL PLAN is self-funded. This means that the dollars contributed by Employees and Windstream are used to pay doctors, Hospitals, and other facilities for services received by enrollees. The best ways to slow the rising cost of health care is for our Employees and their families to improve or maintain their health along with making consumer-minded decisions regarding where to receive care.

There is no guarantee that the cost of coverage will not increase in the future. Periodically, this amount may change to adjust for the overall cost of coverage. The level of any Employee contribution required under the Plan is set by the Plan Sponsor. The Plan Sponsor reserves the right to change the level of Employee contributions.

When You enroll for coverage as a new hire, Your premium contributions will begin as soon as administratively possible on or following Your Effective Date of coverage.

When You enroll for coverage during the Annual Enrollment period, Your new Plan Year premium contributions will begin on the first pay date on or following January 1.

When You make changes to Your coverage due to a qualifying life or work event, Your premium contribution and coverage changes will not update until Your event has been entered. Your paycheck deductions (or monthly premium payments) will change on a go-forward basis as soon as administratively possible. Refunds and retroactive premium adjustments are not provided, so promptly submitting Your qualified life or work event is important. Although premium contributions are not adjusted retroactively, Your coverage changes will be effective per the Effective Date of coverage rules in the Plan.

SPECIAL ENROLLMENT PROVISIONS

Under the Health Insurance Portability and Accountability Act (HIPAA) and
Windstream's Section 125 Cafeteria Plan

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage, a change in family status, or for certain other events as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees. In some cases, You may be able to or required to terminate coverage. You must request Your enrollment change within 30 days (calculated as event date + 30 calendar days) by entering it online at www.windstreambenefits.com.

If an Employee or an Employee's Dependent loses coverage under Medicaid or a State Children's Health Insurance Program (CHIP) as a result of loss of eligibility, or if an Eligible Employee or an Eligible Employee's Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, then the Employee must request their change within 60 days of such termination or determination of eligibility to enroll (calculated as date of determination + 60 days) by entering it online at www.windstreambenefits.com.

During Your online session, You will be prompted to complete an Affidavit for Benefit Change which will require You to return Dependent documentation before Your changes are approved. To understand when and how Your premium contributions will be updated, see the Cost of Coverage section under Eligibility and Enrollment.

In any event, Your and Your Dependent's coverage will never begin before Your Waiting Period is satisfied. In any event, Your change must correspond and be consistent with Your event. For example, if Your Child loses eligibility status under the Plan, You will need to terminate coverage for that Child rather than elect coverage.

LOSS OF HEALTH COVERAGE

Current Employees and their Dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage if the following conditions are met:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and

- The coverage under the other group health plan or health insurance policy was:

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage is offered; or
  - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan within 30 calendar days of the date the other coverage ends (calculated as date coverage ends + 30 calendar days). Loss of coverage includes loss of an Indian Tribal government or tribal organization, a state health benefits risk pool, or foreign government group health plan.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

Cancellation of an individual health plan (for instance, coverage through an individual exchange marketplace), unless it meets the Loss of Coverage criteria above, does not constitute a Special Enrollment Provision under this Plan.

NEW ELIGIBILITY OR LOSS OF ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If an Employee or an Employee's Dependent loses coverage under Medicaid or a State Children's Health Insurance Program (CHIP) as a result of loss of eligibility, or if an Eligible Employee or an Eligible Employee's Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, then the Employee must request their corresponding change within 60 days of such termination or determination of eligibility to enroll (calculated as date of determination + 60 days).

CHANGE IN FAMILY STATUS

Employees and their Dependents have a special opportunity to enroll or terminate coverage under this Plan if there is a change in family status:

- Change in marital status, including marriage; death of spouse; divorce, legal separation, or annulment, or
- Change in the number of Your Dependents through birth, death, adoption, Placement for Adoption, or Legal Guardianship, or
- An event that causes a Dependent to satisfy or cease to satisfy eligibility requirements under the Plan.

You must request Your enrollment changes within 30 calendar days (event date + 30 calendar days of Your status change).

CHANGE TO CORRESPOND TO A CHANGE MADE UNDER DEPENDENT'S EMPLOYER'S PLAN

If Your spouse's, former spouse's, or other Dependent's employer allows an election change based on a status change due to (1) marriage, divorce, death, birth, adoption, Legal Guardianship, or (2) loss of eligibility status under the other employer's plan, including termination of employment or change in place of residence making them ineligible for the other employer's plan, You may make an election change under this Plan. The change must be on account of and correspond with the change made under Your spouse's, former spouse's, or other Dependent's plan. You must request the change within 30 days (event date + 30 calendar days).

You may also be eligible to enroll or terminate You and Your eligible Dependents in one of the Windstream-sponsored health care programs within 30 days of Your Dependent's annual enrollment period if the plan year for Your Dependent does NOT coincide with this Plan's year (January 1 through December 31). Your election change must correspond with a change and must actually be made under Your Dependent's employer's plan.

For example, if Your spouse elects to cover Your family under Your spouse's medical care plan during the open enrollment period for that plan, You may drop coverage for Your family under this Plan. An election change will only be effective if You request Your change within 30 days after the end of Your spouse's open enrollment period (last day of enrollment window + 30 calendar days). Once approved, Your election will be effective consistent with Your spouse's election (e.g. Your spouse's annual enrollment occurs in June for a July 1 effective date; therefore Your election would be effective July 1).

SIGNIFICANT CHANGES IN COST OR COVERAGE

If You are enrolled in the Plan and there is a significant increase in the cost (as determined by the Plan Administrator) during the period of coverage, You may elect coverage under another Plan option available in Your geographic location that provides similar coverage. If no other Plan option is available, You may terminate Your coverage prospectively.

If You are enrolled in the Plan and there is a significant reduction in the Plan coverage (as determined by the Plan Administrator) during the period of coverage or if the Plan ends during the period of coverage, You may elect coverage under another Plan option available in Your geographic location that provides similar coverage.

If there is a plan option added or significantly improved or eliminated during the period of coverage, You may elect the newly added option (or elect another option if an option has been eliminated).

AFTER A CHANGE IN EMPLOYMENT STATUS

If You or Your Dependent experiences a change in employment status that results in gaining or losing eligibility for coverage under this Plan or Your Dependent's employer's plan, You may be eligible to enroll or terminate You and Your eligible Dependents in this Plan within 30 days of Your or Your Dependent's change in employment status (event date + 30 calendar days). Your election change must be on account of and correspond with the change in status. Examples of changes in employment status include:

- Beginning or ending employment;
- A strike or lockout;
- Starting or returning from an unpaid leave of absence;
- Changing from part-time to full-time employment or vice versa; and
- A change in work location.

SPECIAL PROVISIONS RELATING TO THE FAMILY AND MEDICAL LEAVE ACT (FMLA) OR QUALIFIED CHILD SUPPORT ORDERS (QMCSO)

See the Other Federal Provisions section of this Plan for more information regarding Your rights under FMLA or if You are ordered by a court to provide coverage through a QMCSO.

ENTITLEMENT TO MEDICARE

If You, or Your Dependent that is enrolled in the Plan becomes entitled to coverage under Medicare, You may make an election to drop coverage or reduce coverage for You, or such Dependent. If You, or Your Dependent who has been entitled to coverage under Medicare loses eligibility for coverage, You may add or increase the coverage for You, or such Dependent.

You must request Your change within 30 days of the effective date or termination date of Medicare or Medicare coverage (effective or termination date + 30 calendar days).

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

Note: The Plan has the right to ask for certain documents to verify the event and determine eligibility.

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the date of the marriage; or
- In the case of dissolution of marriage on the day of the event; or
- In the case of divorce, legal separation, or annulment on the day of the event; or
- In the case of a spouse's commencement or termination of employment with a gain/loss of coverage, on the date of the loss/gain of coverage; or
- In the case of a Child's commencement or termination of employment with a gain/loss of coverage, on the date of the loss/gain of coverage; or
- In the case of any other change in employment status, on the date of the employment status change; or
- In the case of an Employee, spouse or family member becoming eligible for Medicare, on the date of the Medicare effective date. This event allows You to cancel or reduce coverage only for the individual who is eligible for Medicare; or
- In the case of a change of coverage to correspond with spouse or family member's change under another employer's plan due to marriage, divorce, death, birth/adoption/Legal Guardianship, end of eligibility status under the other employer's plan, change in place of residence making them ineligible for the other employer's plan, or because the other employer's plan year is different than this Plan (the spouse or family member's plan year does not run January 1 to December 31), on the date corresponding to the effective date of change; or
- In the case of loss of coverage under a medical care program of an Indian Tribal government or tribal organization, a state health benefits risk pool, or foreign government group health plan on the event date; or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of acquiring a legal ward or Guardianship, on the date of acquiring such a legal ward or Guardianship; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received.

TERMINATION

For information about continuing coverage, refer to the COBRA section of this SPD.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The day before Your event date in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status or special enrollment; or
- The last day of the Plan year if You voluntarily cancel coverage by not enrolling while remaining eligible during the Annual Open Enrollment Period; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the Plan Administrator except if You are temporarily absent from work due to active military duty. Refer to USERRA under the USERRA section; or
- The last day of the month in which Your employment ends (except as described below with respect to Retired Employees); or
- The last day of the month in which You retire, unless you are designated an eligible Retired Employee, in which case you will be given the option to elect to continue coverage pursuant to the terms that apply to Retired Employees; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends, except as described below with respect to Dependents of Retired Employees; or
- The effective date of your Dependent's death on which Your deceased dependent will be removed from Your medical and Prescription Drug coverage (if applicable); or
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or
- The last day of the month in which your Dependent Spouse reaches age 65 if you are covered as a Retired Employee and you and your Dependent spouse are subject to the age 65 limitation; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section, or

- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criteria listed in the Eligibility and Enrollment section; or

- The day before Your event date in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status or special enrollment; or

- The last day of the Plan year if You voluntarily cancel coverage by not enrolling while remaining eligible during the Annual Open Enrollment Period; or

- The day prior to the effective date in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

Notwithstanding the above, if an Employee is covered as a Retired Employee:

- In some cases, depending on a Retired Employee's "R-Code", if the Retired Employee dies, the Retired Employee's covered Dependent may be permitted to continue coverage as a primary covered individual or Dependent, as appropriate, as long as such Dependent remains otherwise eligible; and

- If the Retired Employee's coverage ends because such Retired Employee reaches the age limit for coverage and the Retired Employee's covered Spouse has not yet reached age 65, the Retired Employee's covered Spouse and other Dependents may remain covered until the Spouse reaches the age limit, provided they remain otherwise eligible.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be an ongoing employee for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, Your coverage will be reinstated.

If:
- Your coverage ends due to termination of employment, unpaid leave of absence, reduction of hours, or layoff; and
- You are not credited with any hours of service in accordance with the crediting rules of the Affordable Care Act during a consecutive 13-week period following your termination of employment or the commencement of unpaid leave of absence, reduction of hours, or layoff, and
- You subsequently resume work in a benefits-eligible position, then

You will be treated as a new hire and will be required to meet all of the requirements of a new Employee.

Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

Bargaining Employees, refer to the provisions outlined in Your collective bargaining agreement.

COBRA CONTINUATION OF COVERAGE

Important. Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents 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. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all of the requirements of federal law. The Plan Administrator or the COBRA Administrator will provide additional information to You or Your Dependents as required.

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 the coverage thru 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.

The COBRA Administrator for this Plan is:
Windstream (c/o BUSINESSOLVER.COM, INC)
Address: PO Box 850512, Minneapolis, MN 55485-0512
Phone: 888-850-1712
Website: mywindstreambenefits.com

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

An Employee will become a Qualified Beneficiary if coverage under the Plan is lost because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled “The Right to Extend Coverage” for more information.)

The spouse of an Employee will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

Spouse Qualifying Event	Length of Continuation
• The Employee dies	up to 36 months
• The Employee’s hours of employment are reduced	up to 18 months
• The Employee employment ends for any reason other than his or her gross misconduct	up to 18 months
• The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• You become divorced or legally separated from Your spouse	up to 36 months

The Dependent Children of an Employee become Qualified Beneficiaries if coverage is lost under the Plan because any of the following Qualifying Events happen:

Dependent Children Qualifying Event	Length of Continuation
• The Employee dies	up to 36 months
• The Employee’s employment ends for any reason other than his or her gross misconduct	up to 18 months
• The Employee’s hours of employment are reduced	up to 18 months
• The Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child stops being eligible for coverage under the Plan as a Dependent	up to 36 months

If you are a Retired Employee, or the spouse or a Dependent Child of a Retired Employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because the Employer declares bankruptcy under Chapter 11.

Note: A spouse or Dependent Child newly acquired (newborn or adopted) during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage.

COBRA NOTICE PROCEDURES

Effective: 01-01-2022

THE NOTICE(S) A COVERED PERSON MUST PROVIDE

To be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the Plan Administrator or the COBRA Administrator.

All COBRA notices or other COBRA related information required to be provided to the Plan Administrator must be sent in writing to:

Windstream (c/o BUSINESSOLVER.COM, INC)
Address: PO Box 850512, Minneapolis, MN 55485-0512
Phone: 888-850-1712
Website: mywindstreambenefits.com

All notices or other information required to be provided to the COBRA Administrator must be sent in writing to:
WEX
PO BOX 2280
OMAHA NE 68103
Phone Number: (866) 451-3399

For purposes of the deadlines described in this COBRA Continuation of Coverage summary, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your Employer will give notice to the Plan Administrator when coverage terminates due to these Qualifying Events: Employee's termination of employment or reduction in hours; death of the Employee; or Qualified Beneficiary becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the Plan Administrator within 30 calendar days when these events occur.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of a Qualifying Events that is the divorce or legal separation of the Employee and a spouse or a Dependent Child ceasing to be eligible for coverage under the Plan. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The covered Employee or Qualified Beneficiary must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving the summary plan description, this Summary of Benefits or the General COBRA Notice.

A Qualified Beneficiary's written notice of an initial Qualifying event must include all of the following information:

- The name of the Employee who is or was covered under the Plan;
- The name(s) and address(es) of each Qualified Beneficiary who lost (or will lose) coverage under the Plan due to the qualifying event;
- The Qualifying Event giving rise to COBRA coverage;
- The date of the Qualifying Event; and
- The signature, name and contact information of the individual sending the notice.

Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that must be completed to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Qualified Beneficiary is provided with an election notice.

A Qualified Beneficiary must follow the COBRA Administrator's instructions to notify the COBRA Administrator of their election to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, the Qualified Beneficiary will lose his or her right to COBRA continuation coverage.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated back to the date coverage was lost, provided that the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will be effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the Employer and Employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If the Plan Administrator offers annual open enrollment opportunities for similarly situated non-COBRA covered participating Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope or, if online election is available, the date Your election is submitted electronically. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

After You make Your initial premium payment, You will be required to pay for Continuation Coverage for each subsequent month of coverage. These periodic payments are due on the first day of each month and there is a 30-day grace period after each due date to submit payment for that month. If You fail to make a monthly payment before the end of the grace period for that month, You will lose all rights to COBRA coverage under the Plan.

Additional information regarding due dates will be provided when the Qualified Beneficiary becomes eligible for and elects COBRA Continuation Coverage.

Note: Payment will not be considered made if a check is returned for non-sufficient funds, issued on a closed account or if payment is stopped by the payor.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is required within 30 calendar days after:

- The date any Qualified Beneficiary marries. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.

- The date a Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.

- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- The date any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.

- Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of the Plan:

- For Employees and Dependents. 18 months from the date coverage is lost due to the Qualifying Event, if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the date coverage is lost due to the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare enrollment date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only. 36 months from the date coverage is lost following the Qualifying Event if due to one of the following events:

  - Employee's death.
  - Employee's divorce or legal separation.
  - Former Employee becomes enrolled in Medicare.
  - A Dependent Child no longer being a Dependent as defined in the Plan.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA, in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualifying Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must notify the COBRA Administrator of the Social Security Administration's disability determination before the end of the 18-month period and within 60 days of the later of:

- The date of the SSA disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving the summary plan description, this Summary of Benefits, or the General COBRA Notice.

The notice must be provided in writing and must include the following information:
- The name and address of each Qualified Beneficiaries who is receiving COBRA due to the initial Qualifying Event;
- The name and address of the disabled Qualified Beneficiary;
- The date that the Qualified Beneficiary became disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the Qualified Beneficiary is no longer disabled; and
- The signature, name and contract information of the individual sending the notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events: (Dependents Only) If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (part A, part B or both) or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in case of a newborn or newly adopted Child being added as a result of a HIPAA Special Enrollment right. A Dependent acquired during COBRA continuation (other than newborns and newly adopted Children) is not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will only lead to the extension when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving the summary plan description, this Summary of Benefits or the General COBRA Notice.

The notice must be provided in writing and must include the following information:
- The name and address of each Qualified Beneficiaries who is receiving COBRA due to the initial Qualifying Event;
- The second Qualifying Event;
- The date of the second Qualifying Event; and
- The signature, name and contract information of the individual sending the notice.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage (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.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- Windstream ceases to maintain a group health plan for any Employees. (Note that if Windstream terminates the group health plan that the Qualified Beneficiary is under, but still maintains another group health plan for other similarly-situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same).

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means any of the following events, if such event would cause a Loss of Coverage under the terms of the Plan:

- The death of the covered Employee.

- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).

- A reduction in work hours of the covered Employee.

- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).

- The covered former Employee becomes enrolled in Medicare.

- A Dependent Child no longer being a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan 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 Patient Protection and Affordable Care Act, 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.

The Plan Administrator is:
WINDSTREAM BENEFITS COMMITTEE
4001 N. RODNEY PARHAM RD
LITTLE ROCK AR 72212

The COBRA Administrator is:
Windstream (c/o BUSINESSOLVER.COM, INC)
Address: PO Box 850512, Minneapolis, MN 55485-0512
Phone: 888-850-1712
Website: mywindstreambenefits.com

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. Employees on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following the military leave of absence cannot be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the Uniformed Service leave begins, or
- a period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the Employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

PROTECTION FROM BALANCE BILLING

This section is to be interpreted in accordance with the No Surprises Act, as amended. Covered health care services that are subject to the No Surprises Act requirements will be reimbursed according to this section. Retiree-only plans are not subject to the Protection from Balance Billing requirements.

Emergency health care services provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

Covered health care services provided at certain network facilities by Out-of-Network Physicians, when not Emergency health care services, will be reimbursed as set forth under Allowed Amounts below. For these covered health care services, the term “certain network facility” is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

Air Ambulance Transportation provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

ALLOWED AMOUNTS

For covered health care services that are Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are non-Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians who have not satisfied the notice and consent criteria, or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are Emergency health care services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD. Note: You may receive balance bills for post-stabilization services after an Emergency if Your attending Emergency Physician or treating provider determines that You can travel to an In-Network facility using non-medical or non-Emergency transportation but You choose to stay at the Out-of-Network facility, if the notice and consent requirements have been satisfied and the provider or facility acts in compliance with applicable state laws.

For covered health care services that are air Ambulance Transportation services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

Allowed amounts are determined in accordance with the claims administrator’s reimbursement policy guidelines or as required by law, as described in this SPD.

Effective: 01-01-2022

OUT-OF-NETWORK BENEFITS

When covered health care services are received from an Out-of-Network provider as described below, allowed amounts are determined as follows:

- For non-Emergency covered health care services received at certain network facilities from Out-of-Network Physicians when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary of Health and Human Services, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, You are not responsible, and an Out-of-Network Physician may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

Out-of-Network Providers satisfy the notice and consent requirement as follows:
- By obtaining Your written consent not later than 72 hours prior to the appointment date; or
- If the notice and consent is given on the date the appointment is made, if you make an appointment within 72 hours of the services being delivered.

- For Emergency health care services provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For air Ambulance Transportation provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

After the Plan has issued payment for covered health care services, the Plan may be required to pay the provider an additional amount or discount to resolve and settle the provider’s balance bill.

PROVIDER NETWORK

The word **"Network"** means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  United Healthcare Choice Plus

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.

Reimbursement for Covered Expenses received from Non-Network Physicians or health care facilities are The specific reimbursement formula used will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

Reimbursement for covered services received from providers, including Physicians or health care facilities, who are not part of Your network are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility; or
- The amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, or
- Using current publicly available data reflecting the costs for health care providers providing the same or similar services, adjusted for geographical differences plus a margin factor.

- **The Program for Transplant Services at a Designated Transplant Facility is:**

  OptumHealth

EXCEPTIONS TO THE PROVIDER NETWORK RATES

In addition to services required to be covered as specified under the Protection from Balance Billing section of this SPD, some benefits may be processed at In-Network benefit levels when provided by Out-of-Network providers. When Out-of-Network charges are covered in accordance with In-Network benefits, the charges may be subject to Plan limitations. The following exceptions may apply:

- Non-air Ambulance Transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Covered Services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network facility, as defined by the No Surprises Act.
- Ancillary Services, as defined by the No Surprises Act, provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist will be payable at the In-Network level of benefits when services are provided at an In-Network facility even if the provider is an Out-of-Network provider.
- If there is not an In-Network provider, or no In-Network provider is willing or able to provide the necessary service(s) to the Covered Person within a 50 mile radius of the Covered Person's residence, then the Out-of-Network charges will be processed as In-Network charges so long as the Covered Person provides appropriate documentation.
- If services are provided and there is no In-Network provider accessible, the services will be payable at the In-Network level of benefits.
- Even if the In-Network level is paid, the provider can still bill You the balance to the extent permitted by law.

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in his or her household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

UMR is required to confirm the list of Network Providers in its Provider Directory every 90 days. If You can show that You received inaccurate information from UMR that a Provider was listed in the Provider Directory on a particular claim, then You will only be liable for Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your Network cost-shares will be calculated based upon the Maximum Allowed Amount. In addition to Your Network cost-shares, the Out-of-Network Provider can also charge You for the difference between the Maximum Allowed Amount and their billed charges.

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the PPO benefit level by the prior claims administrator but which are not considered at the PPO benefit level by the current claims administrator may be paid at the applicable PPO benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous PPO but who is not a member of the Plan's current PPO in the Employee or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the PPO medical plan benefit level may continue for 90 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Covered Person is Inpatient in a Hospital on the effective date.
- Post acute Injury or Surgery within the past three months.

- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral Health – any previous treatment.

You or Your Dependent must call UMR within 30 days prior to the effective date or within 45 days after the effective date to see if You or Your Dependent are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective surgical procedures will not be covered by transitional level benefits.

CONTINUITY OF CARE

You or Your Dependents have the option of requesting extended care from Your current health care provider or facility if the provider or facility is no longer working with Your health Plan and is no longer considered In-Network.

The In-Network benefit level may continue for up to 90 days or until You no longer meet the criteria below, whichever is earlier, despite the fact that these expenses are no longer considered In-Network due to provider or facility termination from the Network. In order to be eligible, You or Your Dependents must have been, and must continue to be, under a treatment plan by a provider or facility who was a member of the participating Network. You must also be one of the following:

- An individual undergoing a course of treatment for a serious and complex condition that is either:
  - An acute Illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm.
  - A chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.
- An individual undergoing Inpatient or institutional care.
- An individual scheduled for non-elective surgical care, including necessary postoperative care.
- An individual who is pregnant and being treated.
- An individual who is terminally ill and receiving treatment for such Illness by a provider or facility.

To obtain a Continuity of Care form that You and Your provider will need to complete for the request to be considered, call the number on the back of Your ID card or access the benefit portal.

COVERED MEDICAL BENEFITS

Effective: 01-01-2022

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

1. **3D Mammograms,** for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care Benefits.

2. **Abortions (Elective),** including medical (abortifacient drugs) and therapeutic.

3. **Acupuncture Treatment.**

4. **Allergy Treatment** including: injections, testing and serum.

5. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped and used only to transport the sick and injured to the nearest medically appropriate Hospital.

6. **Anesthetics and their Administration.**

7. **Autism Spectrum Disorders (ASD)** treatment, when Medical Necessity is met.

   (ASD includes Autistic disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett syndrome and Pervasive Developmental Disorders).

   ASD Treatment may include any of the following services: Diagnosis and Assessment; Psychological, Psychiatric, and Pharmaceutical (medication management) care; Speech Therapy, Occupational Therapy, and Physical Therapy; or Applied Behavioral Analysis (ABA) Therapy.

   Treatment is prescribed and provided by a licensed healthcare professional practicing within the scope of their license (if ABA therapy, preferably a Board Certified Behavior Analyst, BCBA).

   If ABA Therapy meets Medical Necessity, frequency and duration will be subject to current UMR guidelines, for example ABA treatment up to 25 hours per week for 3-6 months. Treatment plans specific to ABA Therapy with goals-progress and updates are required at least every 6 months for review of ongoing therapy to evaluate continued Medical Necessity.

   Treatment is subject to all other plan provisions as applicable (such as Prescription benefit coverage, Behavioral/Mental Health coverage and/or coverage of Therapy services).

   Does not include services or treatment identified elsewhere in the plan as noncovered or excluded (such as Investigational/Experimental or Unproven, Custodial, Nutrition-Diet supplements, Educational or services that should be provided through the school district).

8. **Breast Pump (Personal Purchase):** New criteria requires the breast pump be purchased within 30 days of the Covered Person's estimated delivery date or after the Covered Person has given birth. Women whose estimated delivery dates are over 30 days out will be asked to call again closer to their due date or after they have given birth. The Covered Person does not need a prescription or Prior-Authorization to obtain a breast pump. One breast pump is allowed per pregnancy. See below for additional information on purchasing a breast pump:

    - The Covered Person may contact a Durable Medical Equipment (DME) supplier who will contact the Covered Person's doctor to verify the Covered Person's eligibility, validate the delivery date and obtain a Physician order before dispensing a breast pump.
    - A Covered Person may receive a breast pump at no cost-share by visiting the pharmacy at Target, presenting their health plan ID card and requesting a breast pump.

        - Like other DME breast pump suppliers, Target Pharmacy will contact the Covered Person's doctor to verify the Covered Person's eligibility, validate the delivery date and obtain a Physician order before dispensing a breast pump.
        - Covered Persons **may not** call Target Pharmacy and have the pump or other breast-feeding supplies shipped to them or order the breast pump online.
        - Covered Persons **may not** purchase breast pumps or other breast-feeding supplies at retail or online, and send the receipt for reimbursement.
        - Covered Persons will only receive breast pumps without cost-share at Target through the Pharmacy once eligibility is confirmed. Members **may not** choose a breast pump off the shelf and pay for it in the check-out line and expect reimbursement.

9. **Breast Pump (Rentals):** Hospital Grade Breast Pumps (heavy duty designed for multiple users), the personal use attachment kit and supplies, are covered by the Plan for the Covered Person who is a lactating mother when the Covered Person obtains the hospital grade breast pump within the first two months (60 days) following delivery. Hospital Grade Breast Pumps cannot be purchased and should be rented until they are no longer needed. Rental costs for the Hospital Grade Breast Pumps will only be covered up to the purchase price of the pump. To rent a breast pump, the Covered Person will simply need to contact a network Physician or durable medical equipment (DME) supplier. The Covered Person's infant must meet one or more of the following criteria:

    - Hospitalized newborn infant
    - Congenital malformations or genetic abnormalities impacting feeding (e.g. cleft lip and palate, Down's Syndrome)

    Note: Additional questions can be answered by the Plan Administrator.

10. **Breast Reductions** if Medically Necessary.

11. **Breastfeeding Support, Supplies and Counseling** in conjunction with each birth. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment are covered with no cost share to the member (See Breast Pumps for additional information on renting or purchasing breastfeeding supplies and equipment).

12. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (See Glossary of Terms) as well as a result of an Illness or Injury.

13. **Cardiac Rehabilitation** programs are covered if referred by a Physician, for patients who have:

    - had a heart attack in the last 12 months; or
    - had coronary bypass surgery; or
    - a stable angina pectoris.

    Services covered include:

    - Phase I, while the Covered Person is an Inpatient.
    - Phase II, while the Covered Person is in a Physician supervised Outpatient monitored low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

14. **Cataract or Aphakia Surgery** as well as protective lenses following such procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.

15. **Circumcision** and related expenses when care and treatment meet the definition of Medically Necessary. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

16. **Chiropractic Treatment** by a Qualified chiropractor. Services for diagnosis by physical examination and plain film radiography, and when Medically Necessary for treatments for musculoskeletal conditions. Refer to Maintenance Therapy under the General Exclusions section of this SPD.

17. **Cleft Palate and Cleft Lip:** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

18. **Congenital Heart Disease:** If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at an OptumHealth facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.

19. **Contraceptives and Counseling:** All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling. This Plan provides benefits for Prescription contraceptives, regardless of purpose. Prescription contraceptives that require a Physician to administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this SPD. Contraceptives covered under the Windstream Prescription Drug Program through Express Scripts are excluded from coverage under the medical Plan.

20. **Cornea Transplants** are payable at the percentage listed under All Other Covered Expenses on the Schedule of Benefits.

21. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.

22. **Dental Implant (Including Preparation Work)** if Medically Necessary.

23. **Dental Services** include:

- The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), excluding implants. Orthodontic services are limited to the stabilization and re-alignment of the Accident-involved teeth to their pre-Accident position. Reimbursement for this service will be based on a per tooth allowance. Treatment must be completed 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period. If the Covered Person is under age 15, reimbursement for dental care services provided after such 12 month period will be provided if:
  - Such reimbursement is requested within such 12 month period;
  - The request for reimbursement is accompanied by a plan of treatment;
  - In the opinion of the Plan, under standard dental practices the treatment could not have been provided within such 12 months period; and
  - Coverage for the injured Covered Person is in force when the treatment is rendered.
- Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if Medically Necessary.
- Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

24. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs.

25. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. This also includes use of equipment or supplies, unless covered through the Prescription Benefits section. Charges are paid the same as any other Illness.

26. **Durable Medical Equipment** subject to all of the following:

- The equipment must meet the definition of Durable Medical Equipment as defined in the Glossary of Terms. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds and oxygen equipment.
- The equipment must be prescribed by a Physician.
- The equipment is subject to review under the UMR CARE Provision of this SPD, if applicable.
- The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
- The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.
- If the equipment is purchased, benefits may be payable for subsequent repairs including batteries or replacement only if required:
  - due to the growth or development of a Dependent Child;
  - when necessary because of a change in the Covered Person's physical condition; or
  - because of deterioration caused from normal wear and tear.

  The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.
- This Plan covers taxes, shipping and handling charges for Durable Medical Equipment.
- Diabetic supplies, needles and syringes are covered if billed by a Durable Medical vendor.

27. **Emergency Room Hospital and Physician Services** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

28. **Emergency Services Provided in a Foreign Country,** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital or Physician services in a provider's office, as shown in the Schedule of Benefits.

29. **Extended Care Facility Services** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. Covered Person must obtain Prior-Authorization for services in advance. (Refer to the UMR CARE section of this SPD). The following benefits are covered:

    - Room and board.
    - Miscellaneous services, supplies and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

30. **Eye Refractions** if related to a covered medical condition.

31. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
    - Treatment of corns, calluses and toenails, when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
    - Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.

32. **Gender Dysphoria:**

    Benefits for the treatment of Gender Dysphoria, limited to the following services:

    - Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described in the Mental Health Benefits section of this SPD.
    - Cross-sex hormone therapy:
        - Cross-sex hormone therapy administered by a medical provider (for example, during an office visit) as described in the Mental Health Benefits section of this SPD.
        - Cross-sex hormone therapy dispensed from a pharmacy as described in the Prescription Drug Benefits section of this SPD.
    - Puberty-suppressing medication injected or implanted by a medical provider in a clinical setting.
    - Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
    - Surgical field and facial electrolysis to eliminate hair in the specified area.
    - Treatment of speech, language, voice, communication and/or auditory processing disorder.
    - Surgery for the treatment of Gender Dysphoria, including the surgeries listed below:
      Male to Female:
        - Clitoroplasty (creation of clitoris)
        - Labiaplasty (creation of labia)
        - Orchiectomy (removal of testicles)
        - Penectomy (removal of penis)
        - Urethroplasty (reconstruction of female urethra)
        - Vaginoplasty (creation of vagina)
        - Breast Augmentation.
        - Body shaping procedures including facial feminization surgery.

      Female to Male:
        - Bilateral mastectomy or breast reduction
        - Hysterectomy (removal of uterus)
        - Metoidioplasty (creation of penis, using clitoris)
        - Penile prosthesis
        - Phalloplasty (creation of penis)
        - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
        - Scrotoplasty (creation of scrotum)
        - Testicular prosthesis
        - Urethroplasty (reconstruction of male urethra)

- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)
- Body shaping procedures

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one Qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - The Covered Person has experienced persistent, well-documented Gender Dysphoria.
  - The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
  - The Covered Person must be 18 years of age or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two Qualified behavioral health providers experienced in treating Gender Dysphoria who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - The Covered Person has experienced persistent, well-documented Gender Dysphoria.
  - The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
  - The Covered Person must be 18 years of age or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - The Covered Person must complete at least 12 months of successful, continuous, full-time, real-life experience in the desired gender.
  - The Covered Person must complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

- The treatment plan must be based on identifiable external sources, including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Coverage does not include procedures that are cosmetic as stated in the General Exclusions section of this SPD. Cosmetic procedures include, but are not limited to, the following:

- Abdominoplasty.
- Blepharoplasty.
- Body contouring, such as lipoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Injection of fillers or neurotoxins.
- Lip augmentation.
- Lip reduction.

- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction, reduction thyroid chondroplasty, or trachea shave (removal or reduction of the Adam's apple).
- Voice lessons and voice therapy.
- Voice modification surgery.

33. **Genetic Counseling** based on Medical Necessity.

34. **Genetic Testing** when Medically Necessary (see below).

    Genetic Testing MUST meet the following requirements:

    The test is not considered Experimental or Investigational. The test is performed by a CLIA-certified laboratory. The test result will directly impact/influence the disease treatment of the covered member. In some cases, testing is accompanied by pretest and posttest counseling.

    The products of an amniocentesis are covered, to determine the presence of a disease or congenital anomaly in the fetus, or genetic testing of a Covered Person's tissue to determine if the person has a specific disease (not to determine if the person is a carrier of a genetic abnormality, subject to established coverage policy).

    And must meet at least one of the following:

    - The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
    - Conventional diagnostic procedures are inconclusive.
    - The patient has risk factors and a particular family history that indicate a genetic cause.
    - The patient meets defined criteria that place them at high genetic risk for the condition.

    Generally, genetic testing is not covered for:

    - Population screening without a personal or family history, with the exception of preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies
    - Informational purposes alone (i.e., testing of minors for adult-onset conditions, and self-referrals or home testing)
    - Test is considered Experimental or Investigational.

35. **Group Therapy.**

36. **Hearing Services** include:

    - Exams, tests, services and supplies to diagnose and treat a medical condition.
    - Implantable hearing devices and auditory brain stem implant for an individual 12 years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone or is undergoing removal of bilateral acoustic tumors.

37. **Home Health Care Services:** (Refer to Home Health Care section of this SPD).

38. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:

    - **Assessment** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
    - **Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include the services of a Physician; Qualified physical or occupational therapist; nutrition counseling services provided by or under the supervision of a Qualified dietician.
    - **Bereavement Counseling** benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and bundled with other hospice charges. Counseling services must be given by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable. The services must be furnished within six months of death.
    - **Respite Care:** to provide temporary relief for 24 hours to the family or other caregivers in the case of an emergency or to provide temporary relief from the daily demands of caring for a terminally ill person.

    The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

39. **Hospital Services (Includes Inpatient Services, Surgical Centers and Inpatient Birthing Centers).** The following benefits are covered:

    - Semi-private and private room and board services:
        - For network charges, this rate is based on the network agreement. Semi-private rate reductions may apply.
        - For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to the Protection from Balance Billing allowed amount, Usual and Customary charges, or Negotiated Rate, whichever is applicable.
    - Intensive care unit room and board.
    - Miscellaneous and Ancillary Services.
    - Blood, blood plasma and plasma expanders, when not available without charge.

    Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

40. **Hospital Services (Outpatient).**

    Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

41. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

42. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits.

43. **Learning Disability:** Special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability except for services that should be legally provided by a school.

44. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

45. **Maternity Benefits** for Covered Persons include:

    - Hospital or Birthing Center room and board.
    - Vaginal delivery or Cesarean section.
    - Non-routine prenatal care
    - Postnatal care.
    - Medically Necessary diagnostic testing.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Outpatient Birthing Centers.
    - Home births.
    - Midwives associated with a Physician.

46. **Maxillofacial Surgeries** if Medically Necessary.

47. **Medical Foods and Low Protein Modified:** Coverage is provided for medical foods and low protein modified food products for treatment of a Covered Person diagnosed with phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism if:

    - The medical foods and low protein modified food products are administered under the order of a licensed Physician; and
    - The medical foods and low protein food modified products are prescribed in accordance with coverage policy for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism; and
    - Any services or supplies provided for dietary and nutritional services when such services or supplies are the sole source of nutrition for the Covered Person.

48. **Mental Health Treatment** (Refer to Mental Health section of this SPD).

49. **Modifiers or Reducing Modifiers,** if Medically Necessary. These terms apply to services and procedures performed on the same day and may be applied to surgical, radiological, and other diagnostic procedures. For a provider participating with a primary or secondary network, claims will be paid according to the network contract. For a provider who is not participating with a network, where no discount is applied, the industry guidelines are to allow the Usual and Customary fee allowance for the primary procedure and a percentage of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

50. **Morbid Obesity Treatment** includes only the following treatments if those treatments are determined to be Medically Necessary and appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.

    - Bariatric surgery, including, but not limited to:
        - Gastric or intestinal bypasses (Roux-en-Y; biliopancreatic bypass; biliopancreatic diversion with duodenal switch).
        - Stomach stapling (vertical banded gastroplasty, gastric banding, gastric stapling).
        - Lap band (laparoscopic adjustable gastric banding).
        - Gastric sleeve procedure (laparoscopic vertical gastrectomy, laparoscopic sleeve gastrectomy).
    - Physician supervised weight loss programs at a medical facility.
    - Charges for diagnostic services.
    - Nutritional counseling by registered dieticians or other Qualified Providers.

    This Plan does not cover diet supplements, exercise equipment, or any other items listed in the General Exclusions of this SPD. Reversal of bariatric procedures are a covered benefit if determined to be Medically Necessary.

51. **Nursery and Newborn Expenses Including Circumcision** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

    Expenses for the covered newborn will be processed under the mother's benefits until the mother is discharged from the Hospital following the delivery. If the covered newborn needs to stay in the Hospital longer than the mother following the delivery, those charges will be processed under the newborn's benefits subject to the Deductible and other Plan provisions, including HIPAA Special Enrollment.

52. **Nutritional Supplements, Vitamins and Electrolytes** which are prescribed by a Physician and administered through enteral feedings, provided they are the sole source of nutrition. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings) provided the feedings are prescribed by a Physician, and are the sole source of nutrition.

53. **Occupational Therapy.** (See Therapy Services below)

54. **Oral Surgery** includes:

    - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
    - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
    - Reduction of fractures and dislocations of the jaw.
    - External incision and drainage of cellulitis.
    - Incision of accessory sinuses, salivary glands or ducts.
    - Excision of exostosis of jaws and hard palate.

55. **Orthotic Appliances, Devices and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic Appliances and Devices include supports, trusses, elastic compression stockings, braces and foot orthotics when required for prevention of complications associated with diabetes mellitus.

56. **Oxygen and Its Administration.**

57. **Pharmacological Medical Case Management** (Medication management and lab charges).

58. **Pharmacist Billing/Coding**: Covered charges billed by a pharmacist will be covered provided the Pharmacist is acting within the scope of their license.

59. **Physical Therapy.** (See Therapy Services below)

60. **Physician Services** for covered benefits.

61. **Pre-Admission Testing:** The testing must be necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

62. **Prescription Medications** excluding injectables dispensed at a medical facility that are covered under the Specialty Injectable Program. This does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit. See the Prescription Benefits section of this SPD for more details.

63. **Preventive / Routine Care** as listed under the Schedule of Benefits.

    The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility, or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes, and include the following as required under applicable law:

    - Evidence-based items or services that have in affect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
    - With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
    - Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
    - Well-Woman Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-woman visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

        - Screening for gestational diabetes;
        - Human papillomavirus (HPV) DNA testing;
        - Counseling for sexually transmitted infections;
        - Counseling and screening for human immune-deficiency virus;
        - Screening and counseling for interpersonal and domestic violence; and.
        - Breast cancer genetic test counseling (BRCA) for women at high risk.

    Please visit the following links for additional information:

    https://www.healthcare.gov/preventive-care-benefits/
    https://www.healthcare.gov/preventive-care-children/
    https://www.healthcare.gov/preventive-care-women/

64. **Private Duty Nursing Services:** Charges are covered only when care is Medically Necessary and not custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. Outpatient private duty nursing care on a 24-hour shift basis is not covered.

65. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

    - Due to the growth or development of a Dependent Child; or
    - When necessary because of a change in the Covered Person's physical condition; or
    - Because of deterioration caused from normal wear and tear.

    The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

66. **Qualifying Clinical Trials** as defined below, including routine patient care costs as defined below Incurred during participation in a Qualifying Clinical Trial for the treatment of:

    - Cancer or other Life-Threatening Disease or Condition. For purposes of this benefit, a Life-Threatening Disease or Condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and
    - Cardiovascular disease (cardiac/stroke) that is not life threatening, for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below; and
    - Surgical musculoskeletal disorders of the spine, hip and knees, that are not life threatening, for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below; and
    - Other diseases or disorders that are not life threatening for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below.

    Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a Qualifying Clinical Trial.

    Benefits are available only when the Covered Person is clinically eligible for participation in the Qualifying Clinical Trial as defined by the researcher.

    Routine patient care costs for Qualifying Clinical Trials may include:

    - Covered health services (i.e., Physician charges, lab work, x-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
    - Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
    - Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

    Routine costs for clinical trials do not include:

    - The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial;
    - Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
    - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
    - Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Diseases or Conditions, a Qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health* (NIH), including the *National Cancer Institute* (NCI);
  - *Centers for Disease Control and Prevention* (CDC);
  - *Agency for Healthcare Research and Quality* (AHRQ);
  - *Centers for Medicare and Medicaid Services* (CMS);
  - A cooperative group or center of any of the entities described above or the *Department of Defense* (DOD) or the Veteran's Administration (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
  - The *Department of Veterans Affairs*, the *Department of Defense,* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - It is comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
    - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

67. **Radiation Therapy and Chemotherapy.**

68. **Radiology and Interpretation Charges.**

69. **Reconstructive Surgery** is provided for the following Reconstructive Surgery procedures when prescribed or ordered by a Physician:

- Treatment provided for the correction of defects Incurred in an accidental Injury sustained by the Covered Person.
- Surgery performed on a Child for the correction of a cleft palate or cleft lip, removal of a port-wine stain or hemangioma (only on the face), or correction of a congenital abnormality. In order to be covered, such corrective surgery for a congenital defect must be performed when the Child is 12 years of age or younger, unless it is determined that due to the complexity of the procedure, such surgery could not be performed prior the Child's 12th birthday. Dental care to correct congenital defects is not a covered benefit.
- Treatment provided when it is incidental to disease or for Reconstructive Surgery following neoplastic (cancer) surgery.
- Following a mastectomy (Women's Health and Cancer Rights Act) the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
- Surgery to restore a bodily function that has been impaired by a congenital Illness or anomaly, or by an Accident, or from an infection or other disease of the involved part.

70. **Respiratory Therapy.** (See Therapy Services below)

71. **Second And Third Surgical Opinion** must be given by a board-certified Specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second and third opinion must not be affiliated in any way with the Physician who rendered the first opinion.

72. **Sleep Disorders** if Medically Necessary.

73. **Sleep Studies.**

74. **Speech Therapy.** (See Therapy Services below)

75. **Sterilizations (Voluntary).**

76. **Substance Use Disorder Services** (Refer to Substance Use Disorder section of this SPD)

77. **Surgery and Assistant Surgeon Services** (See Modifiers or Reducing Modifiers above).

78. **Taxes:** Sales taxes, shipping and handling unless covered elsewhere in this SPD.

79. **Telehealth:** Consultations made by a Covered Person's treating Physician to another Physician. Consultations made by a Covered Person to a Physician.

80. **Telemedicine.** (Refer to the Teladoc Services section of this SPD for more details.)

81. **Temporomandibular Joint Disorder (TMJ) Services** includes**:**

    - Diagnostic services.
    - Surgical treatment.
    - Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).

    This does not cover orthodontic services.

82. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    - **Occupational therapy** by a Qualified occupational therapist (OT), or other Qualified Provider, if applicable.
    - **Physical therapy** by a Qualified physical therapist (PT), or other Qualified Provider, if applicable.
    - **Respiratory therapy** by a Qualified respiratory therapist (RT), or other Qualified Provider, if applicable.
    - **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or Autism Spectrum Disorder.

    The Plan allows coverage for occupational and/or physical therapy for Developmental Delays due to Accidents or Illnesses such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome, and cerebral palsy when performed by a Qualified Provider. The Plan allows coverage for the treatment of disorders of speech, language, voice, communication, and auditory processing only when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular Accident.

83. **Travel and Lodging Expenses**. Travel and lodging are covered when services are not available within 50 miles of the member's home for organ transplants and within 100 miles for all other eligible treatments and services. Coverage is available to the following extent:

    (i) Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of an eligible covered service.

    (ii) Eligible expenses for lodging for the patient (while not a Hospital inpatient) and one companion are paid at a per diem (per day) rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion.

    (iii) If the patient is an enrolled Dependent minor child, the lodging expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $150 per day.

    (iv) Travel and lodging expenses are only available if the patient is not covered by Medicare.

    (v) The Covered Person must submit valid receipts with a travel and lodging claim form for such charges. Travel and lodging claim form is available at www.umr.com.

    Examples of travel expenses may include airfare at coach rate, taxi or ground transportation. Mileage reimbursement at the IRS rate for the most direct route between the patient's home and the facility. Benefit limits apply per Covered Person for all travel and lodging under this Plan in connection with all eligible treatments and services during the entire period that a person is covered under this Plan as described in the Schedule of Benefits section.

84. **Tobacco Addiction:** Preventive / Routine benefits as required by applicable law.

85. **Transplant Services** (Refer to Transplant Benefits section of this SPD).

86. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

87. **Walk-In Retail Health Clinics** Charges associated with medical services provided at a Walk-In Retail Health Clinic.

88. **X-Ray Services** for covered benefits.

TELADOC SERVICES

Note: Teladoc Services described below are subject to state availability. Access to telephonic or video-based consultations may be restricted in some states.

This Plan has a special benefit allowing Covered Persons of all ages to receive telephone or web-based video consultations with Physicians for routine primary medical diagnoses.

Teladoc may be used:

- When immediate care is needed.
- When considering the ER or urgent care center for non-Emergency issues.
- When You are on vacation or on a business trip.

Teladoc can be used for the following types of conditions:

- General medicine, including, but not limited to:
  - Colds and flu
  - Allergies
  - Bronchitis
  - Pink eye
  - Upper respiratory infections
- A refill of a recurring Prescription.
- Pediatric care.
- Non-Emergency medical assistance.

In order to obtain this benefit, a Covered Person must complete a medical history disclosure form that will serve as an electronic medical record for consulting Physicians. This form can be completed via the Teladoc website, via the call center, or via the Teladoc mobile app. Once enrolled, a Covered Person may phone 1-800-TELADOC (1-800-835-2362) and request a consultation with a Physician. A Physician will then return the Covered Person's phone call. If a Covered Person requests a web-based video consultation, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time. If necessary, the Physician will write a Prescription. The Prescription will be called in to a pharmacy of the Covered Person's choice. Benefits for this service are shown in the Schedule of Benefits.

Teladoc may not be used for:

- Drug Enforcement Agency-controlled Prescriptions.
- Charges for telephone or online consultations with Physicians and/or other providers who are not contracted through Teladoc.
- Consultations in states/jurisdictions where not available due to regulations or interpretations affecting the practice of Telemedicine for medical or dermatology or behavior health conditions.

Dermatology Services Program

In addition to receiving care for general medical conditions, Covered Persons may receive access to dermatology services, as described below.

Dermatologists provide dermatology consultations to Covered Persons through an online message center using store-and-forward technology in the dermatology service area. The dermatology program offers Covered Persons the ability to upload photographs of their dermatological conditions to licensed dermatologists, who provide treatment and Prescription medication, when appropriate. The dermatologists are selected and engaged to provide dermatological assessments in accordance with standard dermatology protocols and guidelines that are tailored to the Telehealth industry.

In order to receive dermatology consultations, the Covered Person must have completed Teladoc's requirement for access to the general medicine program, including the medical history disclosure form. The Covered Person must also complete a comprehensive Dermatology Intake Form prior to receiving a dermatology consultation. The Dermatology Intake Form consists of a Dermatology History section and an intake form for the condition for which the Covered Person is seeking treatment describing the area of concern. This medical history and intake form may be completed either online or by telephone with a designated dermatology representative. Additionally, the Covered Person must upload at least three images of his or her condition prior to communicating with a dermatologist. If the Covered Person fails to complete the Dermatology Intake Form or upload the required number of images, the Covered Person will not have access to the dermatologists.

Covered Persons will be allowed to request more than one dermatology consultation at any given time. Dermatology consultations are not intended to be provided in Emergency situations.

Initial Consultation: The Covered Person will be required to upload a minimum of three images and a maximum of five images for the dermatologist to review. A dermatologist will respond to the Covered Person's consultation submission via the Teladoc Message Center within two business days of such submission. The dermatologist will either:

- determine that no additional information is required and provide a diagnosis and Prescription, if appropriate; or
- request additional information from the Covered Person before making a diagnosis.

Covered Person Follow-Up: The Covered Person will have seven days after diagnosis to respond to the dermatologist with follow-up questions via the message center. The Covered Person will be able to respond only once and may upload up to five additional images in the response. The Covered Person will not be charged for a one-time follow-up.

Subsequent Consultations: A Covered Person will have the option of selecting the same dermatologist with whom he or she had a prior consultation or with a new dermatologist licensed in his or her state.

Behavioral Health Program

The Behavioral Health Program includes access to behavioral health Providers who provide behavioral health consultations to Covered Persons by telephone or video conference. The Behavioral Health Program offers Covered Persons ongoing access to behavioral diagnostic services, talk therapy, and Prescription medication management, when appropriate. The behavioral health Providers are selected and engaged to provide behavioral health clinical intake assessments in accordance with behavioral health protocols and guidelines that are tailored to the Telehealth industry.

Behavioral Health Consultations: In order for a Covered Person to receive a behavioral health consultation under this program, the Covered Person must complete a Medical History Disclosure and an assessment that is specific to the Behavioral Health Program. This disclosure may be completed either online or by telephone with a designated Behavioral Health Program representative. In addition, the Covered Person must also agree to Teladoc's Informed Patient Consent and Release Form confirming an understanding that the behavioral health Provider is not obligated to accept the Covered Person as a patient. If the Covered Person fails to complete the Medical History Disclosure, the Covered Person will not have access to the behavioral health providers through the Behavioral Health Program.

Scheduling: Teladoc will provide the Covered Person with information identifying each behavioral health provider's licensure, specialties, gender, and language, and will provide sufficient biographical information on each behavioral health provider to allow the Covered Person to choose the provider from whom he or she wishes to receive treatment. The Covered Person may schedule consultations through either Teladoc's website or the mobile platform. When scheduling a subsequent consultation, the Covered Person may choose to receive the consultation from the same provider or from a different behavioral health provider. There are no limitations on the number of behavioral health consultations a Covered Person may receive under the Behavioral Health Program.

Individual Sessions: The initial behavioral health consultation is expected to be 45 minutes in length, on average followed by subsequent psychiatric visits that will be shorter in length. At the beginning of the behavioral health consultation, the Covered Person will be required to complete a brief intake assessment before proceeding with the session. A behavioral health provider may determine that the treatment of a Covered Person's particular behavioral health issue would be managed more appropriately through in-person therapy. In such a case, the behavioral health provider will encourage the Covered Person to make an appointment for an in-person visit.

Clarifications: Unlike the consultations provided under the general medicine program, the behavioral health consultations under the Behavioral Health Program:

- Are not accessible 24 hours per day, 365 days per year. Rather, a Covered Person must schedule a behavioral health consultation with a behavioral health provider and the consultation must occur within a time period for which the behavioral health provider is scheduled to support the Behavioral Health Program.
- Are not intended to be cross-coverage consultations. Rather, the Behavioral Health Program is designed to make behavioral health providers available by telephone or video conference even when another behavioral health counselor is available to the Covered Person for an in-person visit.
- Are not intended to be provided in Emergency situations.
- Are currently not available to Covered Persons under the age of 13.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients when Medically Necessary as determined by the Utilization Review Organization.

Prior-Authorization may be required before receiving services. Please refer to the UMR CARE section of this SPD for more details. Covered services can include:

- Home visits instead of visits to the provider's office that do not exceed the maximum allowable under this Plan.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a Qualified dietician or other Qualified Provider, if applicable.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a Qualified therapist, or other Qualified Provider, if applicable.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports or transportation.
- Expenses for the normal necessities of living such as food, clothing and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS

Refer to the UMR CARE section of this SPD for Prior-Authorization requirements

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing and Ancillary Services.

Designated Transplant Facility means a facility which has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Organ and Tissue Acquisition / Procurement means the harvesting, preparation, transportation and the storage of human organ and tissue which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells and may include chimeric antigen receptor T-cell therapy (CAR-T).

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated Transplant Facility for an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary charge or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain Prior-Authorization for all transplant related services. If Prior-Authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated Transplant Facility for Organ and Tissue Acquisition / Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition / Procurement from a living human or cadaver will be included as part of the Covered Person’s Covered Expenses when the donor’s own plan does not provide coverage for Organ and Tissue Acquisition / Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor related complications during the transplant period, as per the transplant contract, if the recipient is a Covered Person under this Plan.

Benefits are payable for the following transplants:

- Kidney.
- Kidney/Pancreas.
- Pancreas, which meets the criteria as determined by care management.
- Liver.
- Heart.
- Heart/Lung.
- Lung.
- Bone Marrow or Stem Cell transplant (allogeneic and autologous) for certain conditions.
- Small Bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the transplant facility, the Plan will allow them to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS (Applies to Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to a Covered Person who is a recipient or to a covered or non-covered donor if the recipient is a Covered Person under this Plan)

If the Covered Person or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for the travel and housing, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility including:
  - Airfare.
  - Tolls and parking fees.
  - Gas/Mileage.
- Lodging at or near the transplant facility including:
  - Apartment rental.
  - Hotel rental.
  - Applicable tax.

  Lodging for purposes of this Plan does not include private residences.

  Lodging reimbursement that is greater than $50 per person per day, may be subject to IRS codes for taxable income.

Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Note: This Plan will only pay travel and housing benefits for a non-covered living donor after any other coverage that the living donor has is exhausted.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.

- Expenses for Organ and Tissue Acquisition / Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.

- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.

- Transplants considered Experimental, Investigational or Unproven.

- Transplants not listed as covered by Medicare.

- Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for five (5) years or considered cured. Exceptions, which will require additional review for Medical Necessity, include: diagnoses of squamous cell and basal cell carcinoma of the skin and hepatocellular carcinoma.

- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the NCCN compendium.

- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION BENEFITS
Administered by **Express Scripts**

NOTE: UMR (the claims administrator) does not administer the benefits within this provision. Please contact the Pharmacy Benefit Manager or Plan Administrator with any questions related to this coverage.

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. Medicare eligible individuals generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to get Prescription coverage under this Plan. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay an additional monthly penalty if they change their mind and sign up later. Medicare eligible individuals should have received a Notice informing them whether their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage and explaining whether election of Medicare Part D will affect coverage available under this Plan. For a copy of this notice, please contact the Plan Administrator.

DEFINITIONS

Generic Drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This 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.

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.

Pharmacy Benefits Administrator is an organization that manages payment for Prescriptions and services under the Plan.

Prescription Drug means any drug that under Federal Drug Administration (FDA) or state law requires a written Prescription by a Physician. Drugs that are available without a Prescription are considered non-legend drugs.

Drugs and medicines prescribed by a licensed Physician and dispensed by a licensed pharmacist are covered by the Plan, except as otherwise provided by the Plan. Outpatient Prescription Drugs will be covered subject to the applicable Co-pay amounts and any limitations as stated in the Schedule of Benefits.

A Covered drug must be approved for use by the Food and Drug Administration for the purpose for which it is prescribed and dispensed by a licensed pharmacist or Physician.

Note: FDA approval of a drug does not guarantee inclusion as a covered item under the Prescription Drug program. Newly approved drugs may be subject to review by the Plan Sponsor before being covered or may be excluded altogether. In addition, the level of coverage for some Prescriptions may vary depending on the medication's therapeutic classification. As a result, some medications (including, but not limited to, newly approved Prescriptions) may be subject to quantity limits or may require Pre-Authorization before being dispensed.

For a specific up-to-date list of covered and/or excluded Prescription Drugs, contact Express Scripts.

The following are **excluded** through the Prescription Drug program (this list is **not** all-inclusive):

- Applicable exclusions listed under General Exclusions section of this SPD.
- Prescription products if a Pre-Authorization was necessary but not received or denied.
- Prescription products that are available over-the-counter.
- Prescription products that do not have Food and Drug Administration (FDA) approval for the purpose for which prescribed.
- All illegal drugs or supplies, even if prescribed by a duly licensed individual.
- Prescriptions that are in excess of the number of refills specified or dispensed more than one year after the order was written.
- Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation law, or any municipal, state or Federal program.

The Covered Person has a right to purchase an excluded product at his or her own cost if the product is excluded under this Plan.

This Plan does not coordinate Prescription benefits.

For any Prescription Drug questions, please contact Express Scripts at the following:

EXPRESS SCRIPTS
ONE EXPRESS WAY
ST. LOUIS, MO 63121
Phone: 1-866-769-0052

HEARING AID BENEFITS

This Plan includes a benefit that allows Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by UnitedHealthcare Hearing.

UnitedHealthcare Hearing provides a full range of hearing health benefits that deliver value, choice, and a positive experience.

UnitedHealthcare Hearing offers:

- Name-brand and private-labeled hearing aids from major manufacturers at discounted prices.
- Access to a network of credentialed hearing professionals at more than 5,000 locations nationwide.
- Convenient ordering with hearing aids available in person or through home delivery.

How To Use This Hearing Benefit:

- Contact UnitedHealthcare Hearing at 1-855-523-9355, between 8:00 a.m. and 8:00 p.m. Central Time Monday through Friday, or visit uhchearing.com to learn more about the ordering process and for a referral to a UnitedHealthcare Hearing provider location (if a hearing test is needed).
- Receive a hearing test by a UnitedHealthcare Hearing provider. During the appointment, You will decide if You would like to have Your hearing aids fitted in person with Your hearing provider or to have Your hearing aids delivered directly to Your home (for select hearing aid models only). A broad selection of name-brand and private-labeled hearing aids is available.
- If You choose to purchase hearing aids through the UnitedHealthcare Hearing provider, the hearing aids will be ordered by the provider and sent directly to the provider's office. You will be fitted with the hearing aid(s) by the local provider. If You choose home delivery, the hearing aids will be sent directly to Your home within 5-10 business days from the order date.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, contact UnitedHealthcare Hearing at 1-855-523-9355 or visit uhchearing.com.

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial and prevocational modalities. Such programs must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active Medically Necessary treatment for the Covered Person's condition is not being provided.

- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.

- Services provided for conflict between the Covered Person and society which is solely related to criminal activity.

- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification manual (most recent revision) (ICD-CM) in the following categories:

  - Personality disorders; or
  - Behavior and impulse control disorders; or
  - "V" codes (including marriage counseling).

- Services for biofeedback.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of substance use disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions or substance-related disorders. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g. therapeutic boarding schools, half-way houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such programs must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include: the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE USE DISORDER EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Treatment or care considered inappropriate or substandard as determined by the Plan.

- Inpatient charges for the period of time when full, active Medically Necessary treatment for the Covered Person's condition is not being provided.

UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER

Effective: 01-01-2022

Utilization Management

Utilization Management is the process of evaluating whether services, supplies, or treatment are Medically Necessary and the appropriate level of care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons are responsible for ensuring the provider calls the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact-gathering and independent medical review, if necessary.

Special Notes: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. Covered Persons who have received care on this basis are responsible for ensuring the provider contacts the Utilization Review Organization (see below) as soon as possible by phone or fax within 24 hours, or by the next business day if on a weekend or holiday, from the time coverage information is known. If notice is provided past the timeframe shown above, the extenuating circumstances must be communicated. The Utilization Review Organization will then review the services provided.

This Plan complies with the Newborns' and Mothers' Health Protection Act. Prior Authorization is not required for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR**

DEFINITIONS

The following terms are used for the purpose of the UMR CARE section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Prior Authorization is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for drugs, supplies, tests, procedures, and other services that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay.

Utilization Management is the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits Plan. This management is sometimes called "utilization review." Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization **before** receiving services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Organ and tissue transplants.
- Medical Specialty Drug Program. To encourage safe and cost-effective medication use, prior authorization may be required for some specialty drugs. Please visit https://fhs.umr.com/print/UM1428.pdf for a list of Medical Specialty Drugs that may require prior authorization, including Site of Care when applicable (including select gene therapy drugs, orphan drugs, and CAR-T drugs). To request a copy of the Medical Specialty Drug list, call the toll-free number on the back of Your member identification card and the list will be provided free of charge. Prior authorization does not guarantee benefit payment. This Plan may exclude specific drugs on this list from coverage. Refer to the General Exclusions section of this SPD for possible Medical Specialty Drug exclusions.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Hospice Care.
- MRI/MRA/PET Scans.
- Outpatient Surgeries not performed in a Physician's office.
- CardioMEMS.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above). If permitted by the No Surprises Act, a Covered Person who receives treatment at an Out-of-Network facility may be transferred to an In-Network facility after the Covered Person's condition is stabilized.

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not however, apply to Prescription benefits**. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and the Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies. See order of benefit determination rules (below) for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. See below. This does not include Medicaid.
- This Plan does not, however, coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule to use:

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

- Where an individual is covered under one plan as a dependent and another plan as an employee, member or subscriber, the plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) is considered primary. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan.

- The plan that covers a person as a dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent (see continuation coverage below). (Also see the section on Medicare, below, for exceptions).

- If an individual is covered under a spouse's plan and also under their parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.

- If one or more plans cover the same person as a dependent child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
    - If both parents have the same birthday, the plan that covered either of the parents longer is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or dependent of a retired or laid off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule in paragraph 3 (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See exception in the Medicare section)

- Longer or Shorter Length of Coverage: The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and the Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

When this Plan is not Primary and a Covered Person is receiving Part A Medicare but has chosen not to elect Part B, this Plan will reduce its payments on Part B services as though Part B Medicare was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:

  - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.

  - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through Your spouse's former employer. In this case, this Plan will be primary for You and Your covered spouse, Medicare pays second, and the retiree plan would pay last.

  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.

- Medicare generally pays first under the following circumstances:

  - You are no longer actively employed by an employer; and

  - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also have COBRA continuation coverage through the Plan; or

  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first, however an exception is that COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or

- You or Your covered spouse have retiree coverage plus Medicare coverage; or

- Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).

- Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

Note: If a Covered Person is eligible for Medicare as the primary plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether the Covered Person is enrolled in Medicare.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's health insurance plan.

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess payments from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

THIRD PARTY RECOVERY PROVISION

Effective: 01-01-2022

Reimbursement

This section applies when a Covered Person, or the legal representative, estate or heirs of the Covered Person (sometimes collectively referred to as the "Covered Person") recovers damages, by settlement, verdict or otherwise, for an Injury, Sickness or other condition. If the Covered Person has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an Injury or Illness or the treatment of such an Injury or Illness. These benefits are specifically excluded.

However, if the Plan does advance moneys or provide care for such an Injury, Illness, or other condition, the Covered Person shall promptly convey moneys or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by the Covered Person (or by the legal representative, estate or heirs of the Covered Person), to the Plan for the reasonable value of the medical benefits advanced or provided by the Plan to the Covered Person, regardless of whether or not [1] the Covered Person has been fully compensated, or "made-whole" for his/her loss; [2] liability for payment is admitted by the Covered Person or any other party; or [3] the recovery by the Covered Person is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over the Covered Person, or any other party, to receive reimbursement of the benefits advanced on the Covered Person's behalf. This reimbursement shall be from any recovery made by the Covered Person, and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties.

In order to secure the rights of the Plan under this section, and because of the Plan's advancement of benefits, the Covered Person hereby [1] acknowledges that the Plan shall have first priority against proceeds of any such settlement, arbitration award, verdict, or any other amounts received by the Covered Person; and [2] assigns the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. The Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, the Covered Person acknowledges that any proceeds of settlement of judgment, including a Covered Person's claim to such proceeds held by another person, held by the Covered Person or by another, are being held for the benefit of the Plan under these provisions.

The Covered Person shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided. The Covered Person shall not take any action that prejudices the Plan' rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this section, and/or to set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of Covered Person, whether under comparative negligence or otherwise.

SUBROGATION

This section applies when another party is, or may be considered, liable for a Covered Person's Injury, Illness, or other condition (including insurance carriers who are so financially liable) and the Plan has advanced benefits.

In consideration for the advancement of benefits, the Plan is subrogated to all of the rights of the Covered Person against any party liable for the Covered Person's Injury or Illness, or is or may be liable for the payment for the medical treatment of such Injury or occupational Illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person. This right includes, but is not limited to, the Covered Person's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Covered Person's rights under the Plan to bring an action to clarify his or her rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on behalf of the Covered Person, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that the Covered Person fails to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Covered Person shall be borne solely by the Covered Person.

GENERAL EXCLUSIONS

Effective: 01-01-2022

Exclusions, including complications from excluded items are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below or as otherwise required to be covered by the No Surprises Act. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of an Injury if the Plan has information that the Injury is due to a medical condition (including physical and mental health conditions and Emergencies) or domestic violence.

1. **Abdominoplasty.**

2. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

3. **Alternative / Complementary Treatment** includes: Treatment, services or supplies for holistic or homeopathic medicine, hypnosis, or other alternate treatment that is not accepted medical practice as determined by the Plan.

4. **Appointments Missed:** An appointment the Covered Person did not attend.

5. **Assistance With Activities of Daily Living.**

6. **Assistant Surgeon Services,** unless determined Medically Necessary by the Plan.

7. **Augmentation Communication Devices** and related instruction or therapy**.**

8. **Automobile Limitations:** When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan Deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

9. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.

10. **Blood:** Blood donor expenses.

11. **Blood Pressure Cuffs / Monitors.**

12. **Cardiac Rehabilitation** beyond Phase II including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

13. **Chelation Therapy**, except in the treatment of conditions considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.

14. **Chemical Ecology:** Diagnostic studies and treatment of multiple chemical sensitivities, environmental Illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology.

15. **Claims** received later than 12 months from the date of service.

16. **Contraceptive Products and Counseling** (including injectables) unless covered elsewhere in this document. Contraceptives covered under the Windstream Prescription Drug Program administered by Express Scripts are also excluded.

17. **Cosmetic Treatment**, **Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

18. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan shall enforce this exclusion based upon reasonable information showing that this criminal activity took place.

19. **Custodial Care** as defined in the Glossary of Terms of this SPD.

20. **Custom-Molded Shoe Inserts,** including the exam for required Prescription and fitting.

21. **Dental Services,** unless covered elsewhere in this SPD.

22. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.

23. **Education:** Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

24. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.

25. **Examinations:** Examinations for employment, insurance, licensing or litigation purposes.

26. **Excess Charges:** Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, the Negotiated Rate, or the fee schedule. This exclusion does not apply to payments that may be required under the No Surprises Act.

27. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatment. This does not include Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD.

28. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.

29. **Family Planning:** Consultation for family planning.

30. **Financial Counseling.**

31. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.

32. **Genetic Counseling** other than based on Medical Necessity unless covered elsewhere in this SPD.

33. **Genetic Testing** unless covered elsewhere in this SPD.

34. **Growth Hormones.**

35. **Hearing Services:**

    - Purchase or fitting of hearing aids.

36. **High Frequency Chest Wall Oscillators:** Charges associates with high frequency chest wall oscillators.

37. **Hippotherapy:** Charges associated with Hippotherapy.

38. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steambaths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

39. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

40. **Lamaze Classes** or other child birth classes.

41. **Liposuction** regardless of purpose.

42. **Low Vision Enhancement System (LVES):** Charges associated with LVES.

43. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

44. **Mammoplasty or Breast Augmentation** unless covered elsewhere in this SPD.

45. **Marriage Counseling.**

46. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

47. **Military:** A military related Illness or Injury to a Covered Person on active military duty, unless payment is legally required.

48. **Nocturnal Enuresis Alarm** (Bed wetting).

49. **Non-Custom-Molded Shoe Inserts**.

50. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

51. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy, above.

52. **Nutrition Counseling** unless covered elsewhere in this SPD.

53. **Nutritional Supplements, Vitamins and Electrolytes** except as listed under the Covered Benefits.

54. **Orthognathic, Prognathic and Maxillofacial Surgery** except as covered under Temporomandibular Joint Dysfunction.

55. **Over-The-Counter Medication, Products, Supplies or Devices** unless covered elsewhere in this SPD.

56. **Palliative Foot Care.**

57. **Panniculectomy** unless determined by the Plan to be Medically Necessary.

58. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

59. **Pharmacy Consultations.** Charges for or relating to consultative information provided by a pharmacist regarding a Prescription order, including but not limited to information relating to dosage instruction, drug interactions, side effects, and the like.

60. **Prescription Medication** which is administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility and that require a Physician's Prescription.

    (Covered Persons with a written Physician's Prescription who obtain medication from a pharmacy should refer to the Prescription Benefits section of this SPD for coverage).

61. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

62. **Recreational Therapy** services or supplies provided by a recreational therapist.

63. **Return to Work / School:** Telephone or Internet consultations or completion of claim forms or forms necessary for the return to work or school.

64. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.

65. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

66. **Seasonal Affective Disorder.**

67. **Self-Administered Services** or procedures, including self-administered or self-infused medications, that can be performed by the Covered Person without the presence of medical supervision. This exclusion does not apply to medications that, due to their characteristics (as determined by the claims administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an Outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to members for self-infusion.

68. **Services at no Charge or Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

69. **Services** that should legally be provided by a school.

70. **Services Provided by a Close Relative.** See Glossary of Terms of this SPD for definition of Close Relative.

71. **Sex Therapy.**

72. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence.

73. **Standby Surgeon Charges.**

74. **Subrogation.** Charges for Illness or Injuries suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.

75. **Surrogate Parenting and Gestational Carrier Services**. Any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.

76. **Tobacco Addiction:** Diagnoses, services, treatment or supplies related to addiction to or dependency on nicotine unless covered elsewhere in this SPD.

77. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

78. **Travel:** Travel costs, unless covered elsewhere in this SPD.

79. **Treatment of speech, language, voice, communication and auditory processing disorder in a group setting.**

80. **Vision Care** unless covered elsewhere in this SPD.

81. **Vitamins, Minerals and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

82. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

83. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency, or for care related to pregnancy that is expected to result in childbirth.

84. **Weight Control:** Treatment, services or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling. This does not include specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.

85. **Wigs, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this SPD.

86. **Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment for wage or profit, not including self-employment, for which the Covered Person was or could have been entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force.

87. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. Covered Persons or providers may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore cannot be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as <u>required</u> by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person or provider, when applicable, is required to obtain approval from the Plan ***before*** obtaining medical care, such as in the case of prior authorization of health care items or services that the Plan requires. If a Covered Person or provider calls the Plan for the sole purpose of learning whether or not a claim will be covered, that call is not considered a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization. (See "Pre-Determination" above.) The fact that the Plan may grant prior authorization does not guarantee that the Plan will ultimately pay the claim.

  Note that this Plan does not require Prior-Authorization for urgent or Emergency care claims, however Covered Persons may be required to notify the Plan following stabilization. Please refer to the UMR CARE section of this SPD for more details. A claim is considered to be an urgent or Emergency care claim if the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for benefits is urgent. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. Minor Dependents must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant their Personal Representative access to their Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, then the Covered Person will need to send the claim to the Plan within the timelines discussed below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

Covered Persons who receive services in a country other than the United States are responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person/patient ID number, name, sex, date of birth, Social Security number, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, auto Accident, or other Accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. Where Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly follow the Plan's procedures for requesting Prior-Authorization, the Plan will notify the person to explain proper procedures within five calendar days (or within 24 hours, in the case of an urgent care claim) following receipt of a Pre-Service claim request, as long as:

- The claim is received by a person or unit of the Plan Administrator or Claims Administrator that is generally responsible for handling benefit matters; and
- The claim submission names the claimant, a specific medical condition or symptom, as a specific treatment, service, or product for which approval is requested.

The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for services that have been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If it is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If it is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to the billed charges, a Negotiated Rate, or the Protection from Balance Billing allowed amount, or based on the Usual and Customary amounts, minus any Deductible, Plan Participation rate, Co-pay, or penalties that the Covered Person is responsible for paying. Refer to the Protection from Balance Billing section of this SPD for covered benefits that are payable in accordance with the Protection from Balance Billing allowed amount.

Fee Schedule: Generally, providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Co-pay or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's allowable charge used in the calculation of the payable benefit.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care Facility treatment or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's Negotiated Rate.

When covered health services are received from a non-network provider as a result of an Emergency or as arranged by Your Plan Administrator, eligible expenses are amounts negotiated by Your claims administrator or amounts permitted by law. Refer to the Protection from Balance Billing section of this SPD for more information. Please contact Your Plan Administrator if You are billed for amounts in excess of Your applicable Plan Participation, Co-pays, or Deductibles. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- Pre-Service Claim: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.

- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination before the benefit is reduced or terminated.
- Emergency and/or Urgent Care Claim: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with Prior-Authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Usual and Customary fee limits, fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial, including any denial code applicable to a medical claim and its corresponding meaning.
- Include information to confirm the identity of the claim at issue, including the date of service, provider's name and claim amount.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.

- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review), as well as details regarding any available external review and the right to sue in federal court under Section 502(a) of ERISA.
- Include a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or other entity established by federal law to assist individuals with the claims and appeals process.

Additionally:

- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.
- For urgent care claims, the EOB will include a description of the expedited review process applicable to such claims.
- Upon the Covered Person's request and free of charge, the Claims Administrator will also provide the Covered Person with the diagnosis and treatment codes (and their corresponding meanings) applicable to the Covered Person's claim.

The denial of an urgent care claim may be given orally, provided that a written or electronic notification is furnished to the Covered Person no later than 3 days after the oral notification.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before any outside action is taken.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person.

The notification will:

- Explain the specific reasons for the denial, including any denial code applicable to a medical claim and its corresponding meaning.
- Include information to confirm the identity of the claim at issue, including the date of service, provider's name and claim amount.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- State that the Covered Person is entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination.
- Provide appropriate information as to:
    - Any voluntary appeal procedures offered by the Plan and the Covered Person's right to obtain information about those procedures;
    - The external review process and instructions on how to request an external review; and
    - The right to sue in federal court under Section 502(a) of ERISA.
- Include a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or other entity established by federal law to assist individuals with the claims and appeals process.

Additionally:

- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.
- Upon the Covered Person's request and free of charge, the Claims Administrator will also provide the Covered Person with the diagnosis and treatment codes (and their corresponding meanings) applicable to the Covered Person's claim.

Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- Covered Persons who are not satisfied with the decision following the first appeal have the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 60 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume that the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.

- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "First Level of Appeal" section above, to the extent applicable.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on their rights to any other benefits under the Plan. For any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (Personal Representative) or other details, please contact the Plan. Refer to the ERISA Statement of Rights section of this SPD for details on a Covered Person's additional rights to challenge the benefit decision under section 502(a) of ERISA.

Appeals should be sent within the prescribed time period as stated above to the following address(es):

This Plan contracts with various companies to administer different parts of this Plan. Covered Persons who want to appeal a decision or a claim determination that one of these companies made, should send appeals directly to the company that made the decision being appealed. The names and addresses of the companies that the Plan contracts include:

Send Post-Service Claim Medical appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

Appeals regarding ANY Medical Management decisions or Referral Appeals should be sent to:
CLAIM APPEALS
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-054

Send Pharmacy appeals to:
EXPRESS SCRIPTS
ATTN: PHARMACY APPEALS
6625 WEST 78TH STREET
MAIL ROUTE BL0390
BLOOMINGTON, MN 55439
PHONE: 1-888-804-7613

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide it to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

The timelines below will only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days (or 72 hours in the case of an urgent care claim) after the Plan receives the request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven Services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:
  - Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
  - Whether a claim for items and services was furnished by a non-network provider at a network facility;
  - Whether an individual gave informed consent to waive the protections under the No Surprises Act;
  - Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
  - Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or
- Other matters, to the extent required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or the Plan fails to respond to Your appeal within the time lines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR or the Plan Administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or the Employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to UMR or the Plan Administrator.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or the Plan Administrator with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, Covered Persons have the right to further appeal Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the ERISA Statement of Rights section of this SPD for more details. **No such action may be filed against the Plan after thirty-six months from the date on which the claim was Incurred.**

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that effects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

These actions will result in denial of the Covered Person's claim or termination from the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Covered Persons must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on Your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under Your identity. If Your Plan identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of Your knowledge.
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your coverage will continue under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid (by pre-paying for Your coverage on a pre-tax basis and/or catching up with pre-tax contributions upon Your return from leave); and
- The Employee has written approved leave from the employer.

Coverage will be continued during the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders. If the Plan Administrator receives an order that requires another individual other than You to provide coverage, You may request to cancel that Child's coverage under the Plan.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for a 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain precertification. For information on precertification, contact Your plan administrator.

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- The Americans with Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Coverage of Dependent Children in cases of adoption or Placement for Adoption as required by ERISA.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Non-discrimination Act (GINA).
- Patient Protection and Affordable Care Act (PPACA).

STATEMENT OF ERISA RIGHTS

Under the Employee Retirement Income Security Act of 1974 (ERISA), all Covered Persons shall have the right to:

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as at work sites) all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

CONTINUE GROUP HEALTH COVERAGE

Covered Persons have the right to continue health care coverage if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "Fiduciaries" of this Plan, have a duty to do so prudently and in the interest of all Plan participants.

NO DISCRIMINATION

No one, including Your employer, Your union, or any other person, may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

ENFORCING COVERED PERSON'S RIGHTS

If a claim for a benefit is denied or ignored, in whole or in part, Covered Persons 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 an Employee can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

If there are any questions about this Plan, contact the Plan Administrator. For any questions about this statement or about a Covered Person's rights under ERISA, or for assistance in obtaining documents from the Plan Administrator, Covered Persons should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the Plan Sponsor reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or Third Party Administrator within 75 days of the effective date of termination of this Plan due to bankruptcy will, to the extent permitted by law, be excluded from any benefit consideration.

The Plan will assume that the Covered Person received the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the Plan Sponsor.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and an Employer.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body.

Active Employee is an Employee who is on the regular payroll of an Employer and who has begun to perform the duties of his or her job with the Employer on a full time basis.

Activities of Daily Living (ADL) means the following, with or without assistance: Bathing, dressing, toileting and associated personal hygiene; transferring (which is to move in and out of a bed, chair, wheelchair, tub or shower); mobility, eating (which is getting nourishment into the body by any means other than intravenous), and continence (which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, or for treating condition of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic or therapeutic services.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation or when deemed Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Refer to the Protection from Balance Billing section of this SPD for the No Surprises Act requirements specific to air ambulance.

Ancillary Services means services rendered in connection with care provided to treat a medical condition whether scheduled or unscheduled, including, but not limited to: surgery, anesthesia, diagnostic testing, and imaging or therapy services. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency. With respect to the Protection from Balance Billing section, Ancillary Services means items and services provided by out-of-network Physicians at network facilities that are related to Emergency medicine, anesthesiology, pathology, radiology, neonatology, laboratory services, or diagnostic services; provided by assistant surgeons, hospitalists, and intensivists; or provided by an out-of-network Physician when a network Physician is not available.

Birthing Center means a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24 hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) – see Eligibility and Enrollment section of this SPD.

Close Relative means a member of the immediate family. Immediate family includes You, Your spouse, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, Children, step Children and grandchildren.

Co-pay is the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits if applicable.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expenses means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan. Details regarding Covered Expenses that are health care services subject to the federal No Surprises Act protections are provided in the Protection from Balance Billing section of this SPD.

Covered Person means an Employee or Dependent who is enrolled under this Plan.

Custodial Care means nonmedical care given to a Covered Person to administer medication and to assist with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible is the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see Eligibility and Enrollment section of this SPD.

Developmental Delays are characterized by impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills. Developmental Delays may not always have a history of birth trauma or other Illness that could be causing the impairment such as a hearing problem, mental Illness or other neurological symptoms or Illness.

Durable Medical Equipment means equipment which meets all of the following criteria:

- Can withstand repeated use.
- Is primarily used to serve a medical purpose with respect to an Illness or Injury.
- Generally is not useful to a person in the absence of an Illness or Injury.
- Is appropriate for use in the Covered Person's home.

Effective Date means the first day of coverage under this Plan as defined in this SPD.

Emergency means a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – means a person who is classified by his Employer as an Active or Retired, common law employee.

Employer means Windstream Services, LLC and any subsidiary or otherwise affiliated employer and any successor which, with the approval of the Windstream Services, LLC and subject to such conditions as Windstream Services, LLC may impose, adopts the Plan.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time and the applicable regulations.

Experimental, Investigational or Unproven means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility includes, but is not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-a-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

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

Gender Dysphoria means a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

Home Health Care means a formal program of care and intermittent treatment that is: Performed in the home; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician which is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours a day, seven days a week; is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; services of a Physician; physical or occupational therapist; home health aide services; pharmacy services; and Durable Medical Equipment.

Hospital means:

- A facility that is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- It is accredited by a recognized Credentialing Entity approved by CMS and/or a state or federal agency or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- It continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

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.

Incurred means the date the service or treatment is given, the supply is received or the facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

Injury means a physical harm or disability to the body which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special enrollment date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: Basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation and mathematical reasoning. Specific learning disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling and level of intelligence.

Legal Guardianship / Guardian means the individual is recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Manipulation means the act, process, or instance of manipulating a body part by manual examination and treatment such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

Maximum Benefit means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

Medical Specialty Medications (including gene therapy and CAR-T therapy) means Prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Medical Specialty Medications often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, substance use disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with Generally Accepted Standards of Medical Practice; and
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, disease, or symptoms; and
- Clinical factors used when reviewing Medical Necessity for specialty drugs may include review of the progress in use or therapy as compared to other similar products or services, Site of Care, relative safety or effectiveness of specialty drugs, and any applicable prior authorization requirements.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on Your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

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

Mental Health Disorder means a syndrome that is present in an individual and that involves clinically significant disturbance in behavior, emotion regulation, or cognitive functioning. These disturbances are thought to reflect a dysfunction in biological, psychological, or developmental processes that are necessary for mental functioning.

Morbid Obesity means a condition in which an individual 18 years of age or older has a Body Mass Index (BMI) of 40 or more, or 35 or more if experiencing health conditions directly related to his or her weight, such as high blood pressure, diabetes, sleep apnea, etc.

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

Negotiated Rate means the amount that providers have contracted to accept a payment in full for Covered Expenses of the Plan.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliances means braces, splints, casts and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventative maintenance care or debridement, such as cleaning and soaking of the feet, and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT). Subject to the limitations below, the term 'Physician' shall also include the following practitioner types: a physician's assistant (PA), a nurse practitioner (NP), a certified nurse midwife (CNM), a certified registered nurse anesthetist (CRNA), or advanced practice registered nurses (APRN) when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Placed or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means WINDSTREAM MEDICAL PLAN, a component of the Windstream Services, LLC Welfare Benefit Plan, which is a benefit plan for certain Employees of the Employer and is described in this document. References to the "Plan" in this Summary of Benefits means the Windstream Medical Plan component benefits described in this document or the entire Windstream Services, LLC Welfare Benefit Plan, as applicable depending on the context.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means Windstream Services, LLC.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug, that could be a medication or supply for the person for whom prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom prescribed. It must also identify the name, strength, quantity and the directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive / Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventative / Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive / Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Primary Care Physician means a Physician engaged in family practice, general practice, non-specialized internal medicine (i.e., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology, or treatment of mental health/substance use disorder providers. Generally, they provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat Children.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered and/or in accordance with the applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

Recognized Amount means, in the Plan's determination of the allowed amount payable for covered services subject to Protection from Balance Bills, the amount on which Co-pays, Plan Participation, and applicable Deductibles are based for the below covered health services when provided by non-network providers:

- Non-network Emergency health services.
- Non-Emergency covered health services received at certain network facilities by non-network Physicians, when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, the term "certain network facility" is limited to a Hospital (as defined in section 1861(e) of the Social Security Act), a Hospital Outpatient department, a critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act), and any other facility specified by the Secretary of Health and Human Services.

The amount is based on either:

- an All Payer Model Agreement if adopted,
- state law, or
- the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for air ambulance services provided by a non-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered health services that use the Recognized Amount to determine Your cost-sharing may be higher or lower than if cost-sharing for these covered health services was determined based upon a Covered Expense.

Retired Employee is: (a) a person who retired on or before December 31, 2020 and is designated by the Plan Sponsor as an eligible Retired Employee under the Plan or (b) subject to any applicable collective bargaining agreement, a person who retires from employment with an Employer on or after January 1, 2021 and:

- is covered under the Plan immediately before retirement;
- Is not reemployed by an Employer in a benefits-eligible position subsequent to retirement, and
- Meets the Plan Sponsor's eligibility rules for continued health benefits at the time of retirement, specifically:
  - Has attained age 55 with at least 20 years of Windstream service; or
  - Has attained age 60 with at least 15 years of Windstream service; or
  - Has attained age 65 with at least 5 years of Windstream service.

Years of Windstream service may include credited service with the Plan Sponsor and/or a related employer. The Plan Administrator shall have the discretionary authority to determine whether an individual has met the years of service requirement.

Site of Care means the treatment location where services are rendered, for example, Outpatient Hospital, community office, ambulatory infusion site, or home-based settings.

Specialist means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians that are not considered Specialists include, but are not limited to, family practitioners, non-specializing internists, pediatricians, obstetricians/gynecologists, and mental health/substance use disorder providers.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever the patient is in the center:

- Provides drug services as needed for medical operations and procedures performed;
- Provides for the physical and emotional well-being of the patients;
- Provides Emergency services;
- Has organized administration structure and maintains statistical and medical records.

Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications.

Telemedicine means the clinical services provided to patients through electronic communications utilizing a vendor.

Temporomandibular Joint Disorder (TMJ) shall mean a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) is a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Urgent Care is the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have an Injury or Illness that requires immediate care but is not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. 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. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

Waiting Period means the period of time that must pass before coverage can become effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan.

Walk-In Retail Health Clinics means health clinics located in retail stores, supermarkets, or pharmacies that provide a limited scope of preventive and/or clinical services to treat routine family Illnesses. Such a clinic must be operating under applicable state and local regulations and overseen by a Physician where required by law.

You, Your means the Employee.