SUMMARY OF BENEFITS

FOR

WINDSTREAM MEDICAL PLAN,
A COMPONENT OF THE WINDSTREAM SERVICES, LLC WELFARE BENEFIT PLAN

Benefits effective January 1, 2024

- **4000 Plan**

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INTRODUCTION

This document (the "Summary of Benefits") is a description of 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.

No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

The Plan Sponsor reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

At all times this Plan will comply with all applicable laws and regulations.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, Copayments, exclusions, limitations, definitions, eligibility and the like.

To the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care Provider who is acting within the scope of the Provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of Providers as an In-Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated or amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before the termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Open Enrollment. Explains enrollment events.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Coronavirus Pandemic. Explains temporary benefits related to COVID-19 through the public health emergency.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test, or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees who qualify under the requirements below, and Retired Employees (as defined in the Defined Terms section of this document) who qualify under the requirements below.

(1) **Regular Full-Time Employees:** Employees designated by the Employer as Regular Full-Time Employees who are scheduled to work at least 30 hours per week. Coverage for Regular Full-Time Employees becomes effective on the first day of the month following completion of the Waiting Period, subject to completion of enrollment requirements.

The Waiting Period is a period of 55 calendar days as an Active Employee beginning on the first day of employment, with coverage becoming effective on the first day of the following month.

An Active Employee also may be eligible if the Plan Administrator determines that the Employee worked at least 30 hours per week during a measurement period as defined in the applicable Affordable Care Act regulations. The Employee will be informed by the Plan Administrator if they are eligible for benefits under this provision.

(2) **Retired Employees:** Retired Employees who are under age 65, except as described herein.

Age 65 Exception: As of January 1, 2022, 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.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person with whom a covered Employee has established a valid marriage under applicable State law but does not include common law marriages. The term "Spouse" shall include an individual of the same sex as the covered employee if they were legally married under the laws of a State or other foreign or domestic jurisdiction. The Plan Administrator may require documentation proving a legal marital relationship. Spouses of Retired Employees who are subject to the age 65 limitation similarly are only eligible for coverage until age 65.

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

An Employee’s grandchild is also eligible for coverage only if the Employee’s Child (who is the parent and is an eligible family member) is enrolled in the Plan and the grandchild lives with the Employee and is dependent on the Employee for support. (The grandchild or the parent of the grandchild must be listed on the Employee’s federal tax return as a Dependent).

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(3) A covered Dependent Child who was enrolled in the Plan prior to reaching the limiting age and is Totally Disabled, unmarried, incapable of self-support because of intellectual or developmental disability or physical disability, and primarily dependent upon the covered Employee for support and maintenance. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both parents are Employees:

- Their eligible Dependent will be covered as the Dependent of one or the other, but not of both; and
- They cannot be simultaneously covered as an Employee and a Dependent.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. The Employer shares the cost of Active Employee and Dependent coverage under this Plan with the covered Active Employees. The enrollment application for Active Employee coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator. Retired Employees will make monthly premium payments via one of the methods provided by the Plan Administrator.

In some cases, the Employer shares the cost of Retired Employee and Dependent coverage under this Plan with the covered Retired Employees and their Dependents. However, in most cases, the Retired Employee and/or the Retired Employee’s Dependents must pay the full cost of coverage to participate.

The level of any Employee contributions is set by the Plan Sponsor. The Plan Sponsor reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee is responsible for enrolling in the manner and form prescribed by the Employer. 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 the Employee or their Dependents in order to make these determinations. The coverage choices offered will be the same choices offered to other similarly situated Employees.

Enrollment Requirements for Active Employees. An Active Employee may enroll for coverage online at www.windstreambenefits.com within 30 days after the employment records is loaded into the Windstream system (employment record date +30 calendar days).

Enrollment Requirements for Retired Employees. 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.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Newborn or newly adopted children are required to be enrolled within 60 days of the birth or adoption (birth or adoption date + 60 calendar days), or the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator within 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees who are married to each other are covered under the Plan, and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their eligible Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

Coverage begins on January 1 for individuals who elect to enroll during the open enrollment period.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her Dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days of the birth, marriage, adoption or placement for adoption (event date + 30 calendar days).

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information on these portability provisions, contact the Plan Administrator, Windstream Benefits Committee, 4005 N. Rodney Parham Road, Little Rock, Arkansas, 72212, 1-888-850-1712.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in this Plan within 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above.

If the above conditions are met, coverage will be effective as of the date of the event triggering the special enrollment right.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).

(b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) Acquiring a newly eligible Dependent may create a Special Enrollment right. If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent may be enrolled under this Plan. If the Employee is eligible to enroll but not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Special Enrollment Period for newly eligible Dependents is a period of 30 days that begins after the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective as of the date the event triggering the special enrollment right.

(4) Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan ("CHIP") under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage generally will become effective as of the date the event triggering the special enrollment right.

(5) Significant changes in cost or coverage.

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

(b) If the Employee or Dependent 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, he or she may elect coverage under another Plan option available in their geographic location that provides similar coverage.

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

EFFECTIVE DATE

Active or Retired Employee Requirement. An Employee must be an Active or Retired Employee (as defined by this Plan) and satisfy all enrollment requirements for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage generally will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes, but is not limited to, death or termination of Active Employment of the covered Employee (though Employees eligible as Retired Employees will be given the option to elect to continue coverage pursuant to the terms that apply to Retired Employees). (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(4) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

(5) The date the covered Employee’s Eligible Class is eliminated.

Continuation During Periods of Employer-Certified Disability or Leave of Absence. A person may remain eligible for a limited time if Active, full-time work ceases due to disability or leave of absence. This continuance will end on the date the Employer ends the continuance.

Continuation of coverage periods will run concurrently with any leave taken under the Family and Medical Leave Act. While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired within 13 weeks will be reinstated to the Plan with no Waiting Period, provided they had previously worked at least four weeks. A terminated Employee who is rehired after 13 weeks will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by the terms of the Plan.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA") under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's covered Dependents under such an election shall be the lesser of:

(a) The 24-month period beginning on the date on which the person's absence begins; or

(b) The period ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator, Windstream Benefits Committee, 4005 N. Rodney Parham Road, Little Rock, Arkansas, 72212, 1-888-850-1712. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death, except as described below with respect to Dependents of certain Retired Employees. (See the section entitled Continuation Coverage Rights under COBRA.)

Notwithstanding the above:

- If a Retired Employee’s coverage ends because such Retired Employee reaches the age limit for coverage, the Retired Employee’s covered Spouse under age 65 and/or covered Dependent Children may remain covered until they reach the applicable age limit, provided they remain otherwise eligible.
- 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.

(3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) Coverage will end on the last day of the month in which the Child ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

OPEN ENROLLMENT

Every year during the annual open enrollment period, eligible Active Employees and their eligible Dependents will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next December 31, unless there are circumstances that trigger mid-year enrollment rights or election change windows as described in the *Windstream Services, LLC Welfare Benefit Plan Summary Plan Description*.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

With regard to Employees who are Retired Employees, once a Retired Employee cancels coverage (voluntarily or due to non-payment of premiums) for him or herself or for his or her Dependent(s), the Retired Employee or his or her Dependent(s) may not re-enroll in the Plan at any time.

SCHEDULE OF BENEFITS
400 Plan

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the Claims Administrator's established Coverage Policy, Allowable Charge, and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is Medically Necessary; and the services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called In-Network Providers. Because these In-Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses an In-Network Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

A listing of In-Network Providers is available, free of charge, on the web at www.blueadvantagearkansas.com. A listing of In-Network Providers may be also found by accessing www.blueprintportal.com or by downloading the Blueprint Portal app available on Google Play or the App Store. Registration is required.

Deductibles Payable by Plan Participants, per Calendar Year
A deductible is an amount of money that is paid once a Calendar Year per Covered Person or Family Unit. On the first day of each Calendar Year, a new deductible amount is required.

In-Network Calendar Year Deductible	
Per Person	$4,000
Per Family Unit	$8,000
Out-of-Network Calendar Year Deductible	
Per Person	$8,000
Per Family Unit	$16,000

Deductible Accumulation.
In-Network Covered Charges will contribute to the In-Network Calendar Year Deductible. Out-of-Network Covered Charges will contribute to both the In-Network and Out-of-Network Calendar Year Deductibles.

For single coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge. For two-member or family coverages, each family member must meet his or her own individual deductible until the total amount of deductible expenses paid by all family members meets the overall Family Unit deductible.

The Calendar Year deductible is waived for the following Covered Charges:
- In-Network Standard and Routine Preventive Services
- In-Network Physician office visit and telemedicine and telephone consultations
- In-Network urgent care clinics

Annual Out-of-Pocket Limits
Unless stated otherwise in this document, the Plan will pay 70% of In-Network Covered Charges and 50% of Out-of-Network Covered Charges until the annual out-of-pocket limit is satisfied, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year.

In-Network Annual Out-of-Pocket Limit
Per Person.....$6,550
Per Family Unit $13,100

Out-of-Network Annual Out-of-Pocket Limit
Per Person.....$13,100
Per Family Unit $26,200

Out-of-Pocket Accumulation
In-Network Covered Charges will contribute to the In-Network out-of-pocket limit. Out-of-Network Covered Charges will contribute to both the In-Network and Out-of-Network out-of-pocket limit.

Pharmacy Benefit Plan expenses will contribute to the In-Network out-of-pocket limit.

For single coverage, the Covered Person must meet the individual out-of-pocket limit, at which point the Plan will pay Covered Charges at 100% for the Covered Person for the remainder of the Calendar Year. For two-member or family coverage, each family member must meet his or her own individual out-of-pocket limit until the overall Family Unit out-of-pocket limit has been met, at which point the Plan will pay Covered Charges at 100% for that Family Unit for the remainder of the Calendar Year.

The charges for the following do not apply to the annual out-of-pocket limit:
- Penalties for failure to obtain Prior Approval of an inpatient admission
- Amounts in excess of the Allowable Charge
- Non-covered services

HOSPITAL BENEFITS

Prior Approval is required for all inpatient admissions, except for a Hospital admission following a Medical Emergency.

The Covered Person is responsible for obtaining Prior Approval of any Out-of-Network inpatient admission.

NOTE: For inpatient admissions related to treatment of a Medical Emergency, the Covered Person or the treating Provider should notify the Plan of the admission within 48 hours of the admission.

Room and Board Allowances
Covered Charges for room and board during an inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan.

Inpatient and Outpatient Services
In-Network facility reimbursement rate .....70% of Covered Charges, after deductible
Out-of-Network facility reimbursement rate.....50% of Covered Charges, after deductible

Emergency Room Services
Copay, per visit $300
In-Network facility reimbursement rate ..... Copay, then 70% of Covered Charges, after deductible
Out-of-Network facility reimbursement rate ..... Copay, then 70% of Covered Charges, after deductible
- The Copay will be waived if the patient is admitted for an inpatient stay directly from the Emergency Room.

PHYSICIAN BENEFITS

Primary Care Physicians
Includes In-Network general practitioners, family practitioners, doctors of internal medicine, pediatricians, geriatricians, and obstetrician/gynecologists.

Covered Charges billed by physician assistants, registered nurse practitioners, certified nurse practitioners, and clinical nurse specialists that work under the direction of a Primary Care Physician will also be paid at the Primary Care Physician reimbursement rate.

In-Network PCP Reimbursement rates
Office visit charge ..... $40 Copay, then 100% of Covered Charges, deductible waived
Office services, other than an office visit charge .....70% of Covered Charges, after deductible
Inpatient and Outpatient services .....70% of Covered Charges, after deductible
Emergency room services .....70% of Covered Charges, after deductible

In-Network Specialist reimbursement rates
Office visit charge ..... $80 Copay*, then 100% of Covered Charges, deductible waived
Office services, other than an office visit charge .....70% of Covered Charges, after deductible
Inpatient and Outpatient services .....70% of Covered Charges, after deductible
Emergency room services .....70% of Covered Charges, after deductible
* $40 Copay office visit charge applies for Mental Health and Substance Abuse treatment.

Out-of-Network Physician reimbursement rates
Office visit charge .....50% of Covered Charges, after deductible
Office services, other than an office visit charge .....50% of Covered Charges, after deductible
Inpatient and Outpatient services .....50% of Covered Charges, after deductible
Emergency room services .....50% of Covered Charges, after deductible

TELEHEALTH BENEFITS AVAILABLE THROUGH A TELEHEALTH VENDOR
Telemedicine and telephone-based services reimbursement rate
Medical services..... $40 Copay, then 100% of Covered Charges, deductible waived
Behavioral health services..... …$40 Copay, then 100% of Covered Charges, deductible waived
Dermatology services……..$40 Copay, then 100% of Covered Charges, deductible waived

- Access to Telemedicine and telephone-based services for covered medical and behavioral health interventions are available through a third-party telehealth administrator. Covered Persons may call the customer service number on the back of their identification card for further information or visit the Windstream website at www.windstreambenefis.com for further information.

STANDARD PREVENTIVE CARE

Reimbursement rates
In-Network services.....100% of Covered Charges, deductible waived
Out-of-Network services .....50% of Covered Charges, after deductible

At all times, the Plan will comply with the Patient Protection and Affordable Care Act ("PPACA"). The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

www.HealthCare.gov/center/regulations/prevention.html and www.cdc.gov/vaccines/recs/.

Routine Preventive Care
In addition to the preventive services mandated by the ACA, the Plan also provides more generous coverage for the following services:

- Colonoscopies (Routine & Diagnostic) with related anesthesia & lab work, beginning at age 18 and not subject to frequency limitations. Diagnostic colonoscopies are subject to the standard reimbursement rate.
- Retinopathy screening
- Low-density Lipoprotein (LDL) testing
- International Normalized Ratio (INR) testing
- Blood pressure monitor when purchased from a Durable Medical Equipment Provider related to hypertension
- Glucometers

OTHER BENEFIT LIMITS AND MAXIMUMS
No benefits will be paid in excess of any listed limit.

Advanced Diagnostic Testing
- Advanced Diagnostic Testing, including MRIs, PET Scans, CT Scans and myocardial profusion scans, require prior approval. The Covered Person may call Carelon Health at the "High Tech" phone number on the back of their Health Plan Identification Card to receive Prior Approval. Failure to receive prior approval may result in a denial of benefits paid by the Plan. The Covered Person is responsible for reimbursing the Provider for the applicable penalty amount.

Acupuncture
Calendar Year limit ..... 12 visits

Ambulance Services
In-Network and Out-of-Network reimbursement rate ..... 70%, after deductible

Breast pumps
Electric breast pumps,
In-Network and Out-of-Network reimbursement rate .....100% of Covered Charges, deductible waived
- Manual breast pumps are included under Standard Preventive Care.

Chemotherapy and Radiation Therapy
In-Network office visit reimbursement rate ..... $80 Copay, then 100% of Covered Charges, deductible waived
In-Network services, other than an office visit charge, reimbursement rate .....70% of Covered Charges, after deductible
Out-of-Network reimbursement rate .....50% of Covered Charges, after deductible

Chiropractic Services
Calendar Year limit ..... 30 visits
In-Network office visit reimbursement rate ..... $80 Copay, then 100% of Covered Charges, deductible waived
In-Network services, other than an office visit charge, reimbursement rate ..... 70% of Covered Charges, after deductible
Out-of-Network reimbursement rate .....50% of Covered Charges, after deductible

Diabetes Management Services
Diabetes self-management training, Calendar Year limit ..... one program
- Calendar Year limit is in excess of mandated Standard Preventive Care benefits.

Dialysis Treatment
In-Network office visit reimbursement rate ..... $80 Copay, then 100% of Covered Charges, deductible waived
In-Network services, other than an office visit charge, reimbursement rate .....70% of Covered Charges, after deductible
Out-of-Network reimbursement rate .....50% of Covered Charges, after deductible

Eyeglasses or contact lenses following cataract surgery
Lifetime limit.....initial pair of glasses or contact lenses following surgery

Hearing Aids and Implantable Hearing Devices

Hearing aids and cochlear implant hardware
Calendar Year maximum.....$1,000 per ear

Cochlear Implants
Lifetime limit.....one per ear

Auditory Brain Stem Implant
Lifetime limit.....one implant

Hearing exams
Diagnostic exams
In-Network reimbursement .....70% of Covered Charges, after deductible
Out-of-Network reimbursement rate .....50% of Covered Charges, after deductible

- Routine screening exams are covered under Standard Preventive Care for individuals under age 21.

Home Health Care
Calendar Year limit ..... 120 visits

Infusion Therapy
In-Network office visit reimbursement rate ..... $80 Copay, then 100% of Covered Charges, deductible waived
In-Network services, other than an office visit charge, reimbursement rate ..... 70% of Covered Charges, after deductible
Out-of-Network reimbursement rate .....50% of Covered Charges, after deductible

Mental Health and Substance Abuse Treatment

- Inpatient admissions for Mental Health and Substance Abuse treatment require prior approval. The member may call Lucet Behavioral Health and Solutions at 877-801-1159 to receive Prior Approval.
- Prior Approval is required for repetitive transcranial magnetic stimulation for depression and applied behavioral analysis for autism. Failure to obtain Prior Approval may result in denial of reimbursement from the Plan. The member may call Lucet Behavioral Health and Solutions at 877-801-1159 to receive Prior Approval.

<u>Reimbursement Rates for Office Services</u>
In-Network PCP office visit charge..... $40 Copay, then 100% of Covered Charges, deductible waived
In-Network Specialist office visit charge .... $40 Copay, then 100% of Covered Charges, deductible waived
In-Network PCP and Specialist, other services in an office .....70% of Covered Charges, after deductible
Out-of-Network Physician, all services.....50% of Covered Charges, after deductible

<u>Reimbursement Rates for Inpatient and Outpatient Services</u>
In-Network Providers.....70% of Covered Charges, after deductible
Out-of-Network Providers.....50% of Covered Charges, after deductible

Morbid Obesity
Lifetime limit, surgical procedures .....one surgical procedure per Lifetime

- Gastric bypass and any other surgical procedure performed for the purpose of weight loss require prior written approval from the Claims Administrator.

Organ Transplants
All organ transplants require prior written approval from the Claims Administrator, acting on behalf of the Plan Administrator.

Blue Distinction Center reimbursement rate ..... 100% of Covered Charges, after deductible
In-Network, non-Blue Distinction Centers, reimbursement rate ..... 70% of Covered Charges, after deductible
Out-of-Network reimbursement rate ..... 50% of Covered Charges, after deductible

Private Duty Nursing
Calendar Year limit ..... 60 visits
- Coverage does not include Custodial Care or Private Duty Nursing on a 24-hour shift basis.

Reductive Mammoplasty
In-Network and Out-of-Network reimbursement rate ..... 50% of Covered Charges, after deductible
- Coverage subject to Medical Necessity.

Residential Treatment Facility
Calendar Year limit ..... 120 days

Routine Obstetrical Ultrasound
Benefit limit, per Pregnancy ..... one ultrasound

Skilled Nursing Facilities, Extended Nursing Care Facilities, Nursing Homes
Calendar Year limit ..... 120 days

Telehealth Benefits
Telehealth consultations
In-Network PCP reimbursement rate ..... $40 Copay, then 100% of Covered Charges, deductible waived
In-Network Specialist* reimbursement rate ..... $80 Copay, then 100% of Covered Charges, deductible waived
Out-of-Network reimbursement rate ..... 50% of Covered Charges, after deductible
* Covered In-Network behavioral health specialist office visits will be paid according to the standard reimbursement rate for an In-Network PCP office visit.

Therapy Benefits – Occupational, Physical and Speech Therapies
In-Network office visit charge reimbursement rate ..... $80 Copay, then 100% of Covered Charges, deductible waived
In-Network services, other than an office visit charge, reimbursement rate ..... 70% of Covered Charges, after deductible
Out-of-Network reimbursement rate ..... 50% of Covered Charges, after deductible

Travel and Lodging Expenses
Reimbursement rate ..... 70% of Covered Charges, after deductible
Organ transplant Travel and Lodging benefit limit ..... $10,000 per transplant
Calendar Year maximum for Travel and Lodging related to any combination of eligible services separate from organ transplant $5,000
- Lodging expenses that are eligible for reimbursement 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.
- If the patient is an enrolled Dependent minor child, the lodging expenses of two companions will be covered and expenses will be reimbursed at a per diem rate up to $150 per day.
- See "Travel and Lodging" in the Medical Benefits section for additional information.

Urgent Care Clinics

For treatment sought due to a Medical Emergency, as defined by the Plan:
Copay amount, per visit.....$100
In-Network reimbursement rate..... Copay, then 100% of Covered Charges, deductible waived
Out-of-Network reimbursement rate ..... Copay, then 100% of Covered Charges, deductible waived

- The Out-of-Network Urgent Care services will apply to the In-Network Out-of-Pocket Limit.

For urgent care services which are not related to a Medical Emergency, as defined by the Plan:
Copay amount, per visit.....$100
In-Network reimbursement rate..... Copay, then 100% of Covered Charges, deductible waived
Out-of-Network reimbursement rate .....60% of Covered Charges, after deductible

Wigs
Calendar Year maximum.....$500

- Eligible wig coverage includes services that follow a treatment of a covered medical condition, including but not limited to, gender dysphoria, chemotherapy, and diagnosis of alopecia.

INFERTILITY TREATMENT

Infertility treatment, artificial insemination, in-vitro fertilization, or any procedure performed for the purpose of achieving Pregnancy is administered by Progyny, a third-party Infertility administrator. Further information is available on the Windstream website at www.windstreambenefits.com. Eligible Infertility expenses are considered In-Network and will contribute to the applicable deductible and out-of-pocket limits.

PROVIDER NETWORK PROVISIONS AND COST SHARING PROCEDURES

The Plan may afford significant savings to members who obtain coverage from In-Network Providers. This Section describes how Covered Persons can maximize their benefits under the Plan by using In-Network Providers.

NETWORK PROCEDURES

Standard Benefits. All benefits described in this document are subject to the Claims Administrator's established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefits due under this Plan, the Allowable Charge (as defined herein), and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is or is not Medically Necessary and services, supplies and care are or are not Experimental and/or Investigational. A charge is incurred on the date that the service or supply is performed or furnished.

In-Network Services. This coverage is most effective and advantageous when the services of In-Network Providers are used. Claims associated with services provided by In-Network Providers may have a more advantageous deductible, coinsurance and Copayment than claims for services of Out-of-Network Providers. The In-Network deductible, coinsurance and any applicable Copayment cited in the Schedule of Benefits are applied to Allowable Charges for services and supplies received from an In-Network Provider, unless this document shows a different deductible, coinsurance or Copayment for the particular service.

Out-of-Network Benefits. Reimbursement for services by Out-of-Network Providers generally will be less than payment for the same services when provided by an In Network Provider and could result in substantial additional out-of-pocket expenses. The Out-of-Network deductible, coinsurance, and any applicable Copayment described in the Schedule of Benefits are applied to Allowable Charges for services and supplies received from an Out-of-Network Provider, except under the following circumstances:

(1) **Plan Provision.** If this document specifies elsewhere that a different deductible, coinsurance or Copayment is applicable to the particular service or supply that is the subject of the claim.

(2) **Emergency Services.** The Intervention is for a Medical Emergency, in which case the In-Network deductible, coinsurance and Copayment apply.

(3) **Continuity of Care, Change in the Plan's Claims Administrator.** A Covered Person may notify the Claims Administrator that prior to the effective date of the Plan's coverage with BlueAdvantage Administrators of Arkansas as the Claims Administrator, the Covered Person was engaged with an Out-of-Network Provider for a scheduled procedure or ongoing treatment covered under this Plan, that such procedure or treatment is for a condition requiring immediate care, and that the Covered Person requests In-Network benefits for such scheduled procedure or ongoing treatment. If the Claims Administrator approves In-Network coverage for the scheduled procedure or ongoing treatment, any applicable In-Network deductible, coinsurance, and any Copayment will apply to claims for eligible services and supplies rendered by the Out-of-Network Provider for such condition until the procedure or treatment ends or until the end of 90 days, whichever occurs first.

(4) **Continuity of Care, Pregnancy, Prior to Coverage.** A Covered Person may notify the Claims Administrator that prior to the effective date of coverage, the Covered Person was receiving obstetrical care from an Out-of-Network Provider for a Pregnancy covered under the terms of this Plan, and request In-Network benefits for continuation of such obstetrical care from the Out-of-Network Provider. If the Claims Administrator approves In-Network coverage for the requested obstetrical care, any applicable In-Network deductible, coinsurance and Copayment will apply to claims for services and supplies received from this Out-of-Network Provider and will continue to apply to claims for eligible services and supplies rendered by the Out-of-Network Provider until the completion of the Pregnancy, including two months of postnatal visits.

(5) **Provider Leaves Network.** A Covered Person may notify the Claims Administrator that their Out-of-Network Provider was formerly an In-Network Provider when ongoing treatment for an acute condition began, and request In-Network benefits for the continuation of such ongoing treatment. If the Claims Administrator approves In-Network coverage for the ongoing treatment, any applicable In-Network deductible, coinsurance and Copayment will apply to claims for eligible services and supplies rendered by the Out-of-Network Provider for such condition until the end of the current episode of treatment or until the end of 90 days, whichever occurs first.

(6) **Services Not Available or Accessible from In-Network Provider.** If a Covered Person notifies the Claims Administrator prior to receiving a Health Intervention and the Claims Administrator determines that the required covered services or supplies associated with such Health Intervention are not accessible or available from an In-Network Provider, the Claims Administrator may provide the Covered Person with written approval of In-Network coverage for such services or supplies, and any In-Network deductible, coinsurance and Copayment will apply to the claims for the eligible services that are received from the Out-of-Network Provider. In the event that a member fails to notify the Claims Administrator prior to receiving a Health Intervention from an Out-of-Network Provider, the Claims Administrator will determine whether or not an exception will be made to allow In-Network benefits due to potential inaccessibility or unavailability of an In-Network Provider.

PROVIDER DIRECTORY

The determination of whether a Physician or Hospital is an In-Network Provider is the responsibility of the Plan and Claims Administrator. The Claims Administrator can provide a list of In-Network Providers upon request. A Covered Person may also obtain a list of In-Network Providers on the web site www.blueadvantagearkansas.com. A Provider's status may change. A Covered Person can verify the Provider's status by calling Customer Service at the phone number on the back of their health plan identification card. If a Covered Person is informed incorrectly prior to receiving a Covered Service, either by accessing the directory or in response to a request for such information (via telephone, electronic, web-based or internet-based means), the Covered Person may be eligible for cost sharing that would be no greater than if the covered service had been provided by an In-Network Provider.

BlueCard PPO Program. The Plan includes access to the BlueCard PPO network. This benefit allows Covered Persons to receive In-Network benefits from Providers located outside of Arkansas, provided such Provider is in the BlueCard PPO network of the local Blue Cross or Blue Shield Company. A Covered Person may obtain a list of In-Network Providers in an out-of-Arkansas location or verify the status of an out of state Provider by calling Customer Service at the phone number on the back of their health plan identification card. A Covered Person may also obtain a list of In-Network Providers on the web site www.blueadvantagearkansas.com.

PROVIDER STATUS MAY CHANGE

It is possible that a Covered Person might not be able to obtain services from a particular In-Network Provider. The network of Providers is subject to change. A particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available, the Covered Person must choose another Provider to get In-Network benefits.

NO BALANCE BILLING FROM PREFERRED PROVIDERS AND CONTRACTING PROVIDERS

In-Network and Preferred Providers are Physicians or Hospitals who are paid directly by the Plan and have agreed to accept payment for covered services as payment in full except for the Covered Person's deductible, coinsurance, Copayment, and any specific benefit limitation, if applicable. In contrast, a Covered Person is responsible for billed charges in excess of the Plan's payment when Out-of-Network Physicians or Hospitals render services, except as provided in OUT-OF-NETWORK PROVIDERS AND BALANCE BILLING, subsection (2), below. These excess charges could amount to thousands of dollars in additional out of pocket expenses to the Covered Person.

OUT-OF-NETWORK PROVIDERS AND BALANCE BILLING

(1) **NOTICE: Certain Services may not be eligible for In-Network Benefits.** Additional costs, including balance billing, may be incurred for a covered Health Intervention provided by an Out-of-Network Provider, even if treatment is rendered in an In-Network Hospital, unless it meets the exception as provided in subsection 2 below. These additional charges may not count toward the In-Network Out-of-Pocket Limit. The Covered Person should not assume that an In-Network Provider's agreement includes all covered benefits or that all services provided at an In-Network Hospital are provided by In-Network Providers. Some Providers are contracted to provide only certain covered benefits, but not all covered benefits.

(2) **Balance billing by Out-of-Network Providers is prohibited in the following instances**:

(a) When Ancillary Services, as described in the No Surprises Act, are received at certain In-Network facilities on a non-emergency basis from Out-of-Network Providers.

(b) When Medical Emergency services are provided by an Out-of-Network Provider in an emergency room, a free-standing emergency department, or in an urgent care clinic which is licensed as a free-standing emergency department.

(c) When air Ambulance Services are provided by an Out-of-Network Provider.

(d) When a Provider leaves the network voluntarily, a Covered Person engaged with the Out-of-Network Provider for a scheduled procedure or ongoing treatment covered under this Plan, when such procedure or treatment is for a condition requiring immediate care, and the Covered Person's request is approved for continuity of care benefits until the end of the current episode of treatment or until the end of 90 days, whichever occurs first.

In these instances, when the services are eligible for coverage, the Out-of-Network Provider may not bill the Covered Person for amounts in excess of any In-Network Copayment, coinsurance or deductible (cost share). Except for air ambulance, the cost share is based on the Recognized Amount as described in the No Surprises Act and as set forth in the Defined Terms section. The cost share for air ambulance is based on the rates that would apply if the service was provided by an In-Network Provider.

When Covered Services are received from Out-of-Network Providers as stated above, Allowed Amounts are based upon one of the following as applicable:

(a) The initial payment made by the Plan or the amount subsequently agreed to by the Out-of-Network Provider.

(b) The amount determined by Independent Dispute Resolution ("IDR").

RELATION OF THE PLAN TO PROVIDERS

The decision about whether to use a particular Provider is the sole responsibility of a Covered Person. A treating Provider is not an agent of the Plan or the Claims Administrator. The Plan and the Claims Administrator makes no representations or guarantees regarding the qualification or experience of any Provider with respect to any service. The evaluation of such factors and the decision about whether to use any Provider is the sole responsibility of the Covered Person.

MEDICAL BENEFITS

All benefits described in this document are subject to the Claims Administrator's established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefits under this Plan, the Allowable Charge (as defined herein) and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is or is not Medically Necessary; or that services, supplies and care are or are not Experimental and/or Investigational. A charge is incurred on the date that the service or supply is performed or furnished.

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person under single coverage must meet the individual deductible, as applicable, shown in the Schedule of Benefits.. The Calendar Year deductible is waived for certain services as described in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Calendar Year.

PLAN ALLOWANCE

The Plan has defined an outer limit on Plan benefits that applies whether a Covered Person chooses to receive services from an In-Network Provider or an Out-of-Network Provider. This overall limit on the amount of Plan benefits available under the Plan is defined in this Summary of Benefits as the "Plan Allowance," and may also be referred to from time to time as the "Allowable Charge" or "Allowance" under the Plan. Benefits under the Plan will always be limited by the Plan Allowance that the Plan has adopted, as further defined in this section. Please note that the Plan does not pay either billed charges (unless they happen to be less than the Plan Allowance), nor based on the "usual, customary and reasonable" charges that all or a subset of health care providers may routinely or regularly charge for the same or similar services; the Plan has made an intentional decision not to pay Plan benefits based on such criteria, but, instead, to utilize the Plan Allowance as described and defined herein. This means that regardless of how much a health care Provider may bill for any service, drug, medical device, equipment or supplies, the benefits under the Plan will be limited to the Plan Allowance, as established in this section. The Plan Allowance may be established in the following ways:

(1) Covered In-Network Services

For covered In-Network services (those received from an In-Network Provider) received in Arkansas, the Plan Allowance is the Network Fee Schedule established by the terms of the Provider's contract with the Claims Administrator. For covered In-Network services received outside the state of Arkansas, the Claims Administrator may not have a direct contract with each Provider outside Arkansas; where that is the case, the Plan Allowance for covered In-Network services is determined by the allowance or fee schedule of the Provider's contract with the Blue Cross and Blue Shield plan in the state where services were provided (known as the "Host Plan").

(2) Covered Out-of-Network Services

For covered Out-of-Network services (those received from an Out-of-Network Provider), the Plan Allowance is the amount determined by the Claims Administrator, using the following standards:

(a) For services received in Arkansas, the Plan Allowance for covered Out-of-Network services of Physicians and other individual Providers, as well as Ambulatory Surgery Centers, Home Health Care Agencies, Hospice Agencies, and freestanding dialysis centers or imaging centers, will be the amount of the fee schedule that the Claims Administrator has contracted with Providers in Arkansas for its Preferred Payment Plan network ("PPP"); for Hospitals classified as acute care Hospitals, the Plan Allowance for covered Out-of-Network Inpatient and Outpatient Services will be the amount calculated using the Arkansas Blue Cross and Blue Shield Facility Pricing Guidelines.

(b) For services received outside of Arkansas, the Plan Allowance for covered Out-of-Network services will be either the amount provided to the Claims Administrator by the Host Plan in that state or, if no such amount is available to the Claims Administrator from a Host Plan, then the Plan Allowance will be the amount determined under the formulas for services received in Arkansas, as referenced in (a), above, or (c), below.

(c) For any services of any Provider that are not addressed in any of the existing Provider contracts or pricing guidelines referenced above, the Plan Allowance for covered Out-of-Network services will be the amount established by Claims Administrator using such pricing methods, benchmarks or sources as Claims Administrator may deem appropriate in the circumstances.

The Claims Administrator's calculation of a Plan Allowance shall be considered conclusive as to the amount that the Plan covers or will pay in Plan benefits for any covered service, treatment drug, supplies, equipment, or devices.

(3) Patient's Share of the Plan Allowance and Billed Charges of the Provider

The Plan calculates and pays Plan benefits on the basis of the Plan Allowance, an amount that may vary substantially from the amount a Provider chooses to bill. Once the Plan Allowance is determined with respect to any Provider's billed charges, the Covered Person may be responsible for a percentage or portion of the Plan Allowance, depending on the terms of the Plan with respect to copays, coinsurance and deductible. For example, if services are provided by an In-Network Provider, the Plan may pay 80% of the Plan Allowance, in which case the Covered Person would be responsible for the remaining 20% of the Plan Allowance, but not for the difference between the Plan Allowance and the Provider's billed charges. In this situation, the In-Network Provider contract protects the Covered Person from additional billing beyond the Plan Allowance. For an Out-of-Network Provider, the circumstances are substantially different. For example, if services are provided by an Out-of-Network Provider, the Plan may pay only 50% of the Plan Allowance, in which case the Covered Person would be responsible for the remaining 50% of the Plan Allowance. However, the Covered Person might also be held responsible by the Out-of-Network Provider for paying the difference between the Plan Allowance and the Provider's full, billed charges, leaving Plan participants or beneficiaries with "surprise" medical bills, in the form of so-called "balance billing" by Out-of-Network Providers.

COVERED CHARGES

Please note that although this section refers to "Covered Charges," none of the items listed below are *always* covered in all circumstances, and all of the items listed below may sometimes be non-covered or subject to coverage limitations or conditions, as otherwise outlined elsewhere in this document. (For example, if a Plan Participant ceases to be eligible for coverage under the Plan, or if a particular service, treatment, drug, supply, device or equipment is not Medically Necessary per the Plan's Medically Necessary standard, then an item listed as within the scope of "Covered Charges" will not, in fact, be covered under the Plan, due to specific coverage criteria that are not met in a particular instance).

All benefits described in this document are available for Covered Charges only and are subject to the Claims Administrator's established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefit due under this plan; Allowable Charge (as defined herein), and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is Medically Necessary or that services, supplies and care are not Experimental and/or Investigational. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center, Long Term Acute Care Hospital, or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Services before or after coverage. The care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan are not covered. However, if a Covered Person is hospitalized on the date of termination, dependent on the type of contractual agreement with the Hospital, the Plan may cover eligible Hospital facility charges through the date of discharge from the Hospital. Any charges other than those billed by the Hospital, which are incurred in conjunction with an inpatient hospitalization, are not covered after the individual's coverage is terminated.

(2) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

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

(3) **Skilled Nursing Facility Care.** The Inpatient care in a Skilled Nursing Facility, Extended Nursing Facility or Nursing Home, for patients who no longer need the full range of the acute care Hospital's services.

The facility must be approved by the Claims Administrator, the patient must be certified by the attending Physician as needing such care, and the care must be substantially more than seeing to the patient's day-to-day living activities.

Covered services include skilled care ordered by a Physician, room and board, general nursing care, and Prescription Medications during a covered admission.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) Coverage is provided for services of Physicians for surgery, either as an inpatient or outpatient. If coverage is provided for two or more surgical operations performed during the same surgical encounter or for bilateral procedures, payment for the secondary or subsequent procedure will be made at a reduced rate.

(b) Payment for a covered assistant surgeon shall be limited to a single Physician, qualified to act as an assistant for the surgical procedure. Covered Charges for assistant surgery services or minimum assistant surgery services will be paid at a reduced rate which will never exceed 20% of the surgeon's Allowable Charge.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to the extent that care is Medically Necessary or not custodial in nature. Care must be provided in a home setting to be eligible for coverage and is limited as shown in the Schedule of Benefits. Outpatient private duty nursing care of a custodial nature or private duty nursing care on a 24-hour shift basis is not covered.

(6) **Home Health Care Services.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. Covered services must be provided through and billed by a licensed Home Health Care Agency.

A Home Health Care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Bereavement counseling services are covered for the patient's immediate family (covered Spouse and/or covered Dependent Children) when rendered by a Hospice Care team.

Respite care is covered in an inpatient or home setting.

(8) **Diabetes Management Services.** The Plan will pay for one Diabetes Self-Management Training Program per Calendar Year per Covered Person, in excess of mandated Standard Preventive Care benefits. Such training program must be in compliance with the national standards for diabetes self-management education programs developed by the American Diabetes Association. If there is significant change in the Covered Person's symptoms or conditions which under the Coverage Policy makes it necessary to change the Covered Person's diabetic management process, the Plan will pay for an additional Diabetes Self-Management Training Program. This benefit is payable for training in or out of the Hospital that has been prescribed by a Physician.

The following services related to Diabetes Management are also covered by the Plan:

(a) Coverage is provided for glucometers and diabetic testing supplies purchased from a Durable Medical Equipment vendor. Diabetic testing supplies purchased from a Pharmacy may be covered under the Prescription Drug card program.

(b) Coverage is provided for insulin pumps and pump supplies.

(c) The Plan will cover eye examinations to screen for diabetic retinopathy for Covered Persons who are diagnosed with diabetes.

(d) Coverage of routine foot care, orthopedic shoes and custom foot orthotics is provided when required for prevention of complications associated with diabetes mellitus.

(9) **Mental Illness and Substance Abuse Disorder Services (Alcohol and Drug Abuse).** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Summary of Benefits, coverage is provided for Health Interventions to treat Mental Illness and Substance Abuse Disorders.

Inpatient, Partial Hospitalization Program and Intensive Outpatient Program Health Interventions

(a) Coverage for inpatient hospitalization, partial hospitalization programs or intensive outpatient programs for Mental Illness or Substance Abuse Health Interventions is subject to the following requirements.

(i) Inpatient hospitalization requires a patient to receive covered services 24 hours a day as an inpatient in a Hospital.

(ii) Partial hospitalization programs generally require the patient to receive covered services six to eight hours a day, five to seven days per week in a Hospital outpatient setting.

(iii) Intensive outpatient programs generally require the patient to receive covered services lasting two to four hours a day, three to five days per week in a Hospital outpatient setting.

(b) Inpatient Hospital admissions require Prior Approval. The Covered Person or Provider may call Lucet Behavioral Health and Solutions at 877-801-1159 to receive Prior Approval.

Non-Hospital Health Interventions

(a) Coverage is provided for a Health Intervention provided during an office visit with a psychiatrist, psychologist or other Provider licensed to provide psychiatric or Substance Use Disorder treatment.

(b) Coverage is provided for a Health Intervention at a licensed psychiatric or substance use disorder Residential Treatment Center and accredited by the Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF International).

(c) Coverage for counseling or treatment of marriage, family or child relationship dysfunction is only covered if the dysfunction is due to a condition defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(10) **Therapy Services.** Coverage is provided for inpatient and outpatient therapy services when performed or prescribed by a Physician. Such therapy services include physical, occupational, speech, aquatic, and massage therapy. Such therapy services shall include services provided for developmental delay, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy services must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate State Licensing Board. Coverage includes therapy for both rehabilitative and habilitative purposes.

(11) **Standard Preventive Care.** Standard Preventive Care shall be provided as required by applicable law. Standard Preventive Care includes services with an "A" or "B" rating from the United States Preventive Services Task Force. The Plan must provide coverage for USPSTF published recommendations for the Plan Year that begins on or after the date that is one year after the date a recommendation is published.

Examples of Standard Preventive Care for adults include:

(a) Screenings for: breast cancer (including 3-D mammograms), cervical cancer, colorectal cancer (including Cologuard testing), high blood pressure, Type 2 Diabetes Mellitus, cholesterol, bone density scans, and obesity.

(b) Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(c) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

-Women's contraceptives, sterilization procedures, and counseling.
-Breastfeeding support, supplies, and counseling.
-Gestational diabetes screening.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

www.HealthCare.gov/center/regulations/prevention.html and www.cdc.gov/vaccines/.

Examples of Standard Preventive Care for children include:

(a) Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:

-Diphtheria,
-Pertussis,
-Tetanus,
-Polio,
-Measles,
-Mumps,
-Rubella,
-Hemophilus influenza b (Hib),
-Hepatitis B,
-Varicella.

(b) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

www.HealthCare.gov/center/regulations/prevention.html and www.cdc.gov/vaccines/.

Charges for Routine Preventive Care. Routine Preventive Care is care by a Physician that is not for an Injury or Sickness. Covered Charges under Medical Benefits are payable for Routine Preventive Care as described in the Schedule of Benefits.

(12) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) **Abortions** including medical (abortifacient drugs), therapeutic, and elective.

(b) Treatment of **Acquired Immunodeficiency Syndrome (AIDS)** is covered as any other Illness.

(c) **Acupuncture** is covered and limited as shown in the Schedule of Benefits.

(d) Covered charges for services billed by **Advanced Practice Registered Nurses** and Physician Assistants.

(e) **Advanced Diagnostic Imaging Services.** Prior Approval is required for computed tomography scanning ("CT Scan"), Magnetic Resonance Angiography or Imaging ("MRA/MRI"), myocardial profusion scans, and positron emission tomography scans ("PET Scan") (collectively referred to as "Advanced Diagnostic Imaging"). The Covered Person may call AIM Specialty Health at the "High Tech" phone number on the back of their Health Plan Identification Card to receive Prior Approval. Failure to receive Prior Approval may result in a denial of benefits paid by the Plan. The Covered Person is responsible for reimbursing the Provider for the applicable penalty amount.

(f) **Allergy-related services,** including testing, extracts and injections.

(g) **Ambulance Services.** Coverage for Ambulance Services is provided as described below, and payable as specified in the Schedule of Benefits.

Benefits are provided under the Plan for ground Ambulance Services to treat a Covered Person in place; for local transportation to the nearest Hospital in the event Medical Emergency care is needed; or to the nearest neonatal special care unit for newborn infants for treatment of Injuries, Illnesses, congenital birth defects or complication of premature birth that require that level of care.

Benefits for air Ambulance Services are provided under the Plan but are limited to transportation to the nearest Hospital capable of providing Medical Emergency care. The Plan's coverage of air ambulance is limited to those situations in which:

(i) The Covered Person is in a location that cannot be reached by ground ambulance due to weather or road conditions or other circumstances exist that make it impossible for ground Ambulance Services to be obtained; or

(ii) Transportation by ground ambulance poses a threat to the Covered Person's survival or seriously endangers the Covered Person's health due to the time or distance involved.

NOTE: The Plan excludes benefits for any air ambulance transport between or among different Hospitals unless the first Hospital to which a Covered Person is transported is not capable of providing Medical Emergency care that will stabilize the Covered Person; in such circumstances, the Plan covers one additional air ambulance transport to the nearest alternative Hospital that is capable of providing Medical Emergency care. If the Covered Person's medical condition is capable of being stabilized at any Hospital to which the Covered Person has been transported, the Plan excludes coverage for any air ambulance transfer to another Hospital. In addition, the Plan excludes coverage of air ambulance or ground ambulance for transfer of a Covered Person to any private residence or to any facility that will not furnish further medical treatment to the Covered Person.

Non-emergent medical transportation. Coverage of non-emergent Ambulance Services is limited to situations when all of the following conditions apply:

(i) The Covered Person is confined to a bed or requires monitoring during transportation from a trained medical professional and cannot be safely transported by any other means; and

(ii) Transportation is needed to a different location in order to access Medically Necessary treatment that cannot be safely and adequately provided at the Covered Person's location.

Additional Specific Ambulance Service Exclusions (applicable to both air and ground Ambulance Services). No benefits will be paid for:

(i) Expenses incurred for Ambulance Services covered by a local governmental or municipal body, unless otherwise required by law;

(ii) Non-emergency Ambulance Service, except as stated above;

(iii) Ambulance Services that originate:

a) Outside the 50 United States and the District of Columbia; or

b) From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or

c) From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States; or

(iv) Ambulance Services provided for comfort or convenience for a Covered Person, their family, caregiver, Provider, or any facility; or

(v) That portion of any Ambulance Services ride that is farther from the point of origin than the nearest Hospital capable of providing Medical Emergency care.

(h) **Anesthetic**; oxygen; blood and blood derivatives; intravenous injections and solutions. Administration of these items is included.

(i) **Autism Spectrum Disorder.** Coverage is provided for Covered Persons with autism spectrum disorder, including applied behavioral analysis when ordered by a medical doctor or psychologist and provided by a Board-Certified Behavioral Analyst (BCBA). Coverage of applied behavioral analysis requires Prior Approval from the Claims Administrator, acting on the Plan's behalf, and is subject to established Coverage Policy and limits set forth. Failure to obtain Prior Approval may result in denial of reimbursement from the Plan. The member may call New Directions Behavioral Health at 877-801-1159 to receive Prior Approval.

(j) **CardioMEMS Champion Heart Failure Monitoring System** is covered based on the Claims Administrator review and recommendation.

(k) **Cardiac rehabilitation** services are covered when the services are ordered by a Physician.

(l) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(m) Initial **contact lenses** or glasses required following cataract surgery. A single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery is covered. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. The Allowable Charge is based on the cost for basic glasses or contact lenses.

(n) **Craniofacial Anomaly Services**. Coverage for related Health Interventions for a Covered Person who is diagnosed as having a craniofacial anomaly provided the Health Interventions are determined to be Medically Necessary and to improve a functional impairment that results from the craniofacial anomaly as determined by a surgical member of a nationally accredited cleft-craniofacial team, approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina. A nationally accredited cleft-craniofacial team for cleft-craniofacial conditions shall evaluate Covered Persons with craniofacial anomalies and coordinate a treatment plan for each Covered Person. Coverage includes corrective surgery, dental care, and vision care in a manner consistent with Coverage Policy.

(o) **Dietitian services** for treatment of a covered medical condition.

(p) Coverage is provided for **Durable Medical Equipment ("DME")** when prescribed by a Physician according to the guidelines specified below.

(i) Durable Medical Equipment is equipment which:

a) Can withstand repeated use; and

b) Is primarily and customarily used to serve a medical purpose; and

c) Generally is not useful to a person in the absence of an Illness or Injury; and

d) Is appropriate for use in the home.

(ii) Coverage for Durable Medical Equipment and Medical Supplies is provided when the Durable Medical Equipment is provided in accordance with Coverage Policy. Examples of Durable Medical Equipment include, but are not limited to, oxygen equipment, wheelchairs and crutches.

(iii) Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. The Plan will pay for DME replacement batteries as needed. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Covered Person.

(iv) When it is more cost effective, the Plan, in its discretion will purchase rather than lease equipment. In making such purchase, the Plan may deduct previous rental payments from its purchase Allowance.

(q) **Eye exams** are covered when ordered by a Physician during treatment of a medical condition or Injury. Routine eye exams are covered under Standard Preventive Care for children under age six.

(r) Benefits for the treatment of **Gender Dysphoria**, limited to the following services:

(i) Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described in the Mental Health Benefits section of this SPD.

(ii) 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.

(iii) Puberty-suppressing medication injected or implanted by a medical Provider in a clinical setting.

(iv) Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.

(v) Surgical field and facial electrolysis to eliminate hair in the specified area.

(vi) Treatment of speech, language, voice, communication and/or auditory processing disorder.

(vii) 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

(viii) Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation in the form of 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.

(s) A limited number of specific **genetic tests** may be covered when the Plan has determined that the particular genetic test:

(i) Is the only way to diagnose the disease or condition;

(ii) Has been scientifically proven to improve outcomes when used to direct treatment; and

(iii) Will affect the individual's treatment plan. Any published Coverage Policy regarding a genetic test will control whether or not benefits are available for that genetic test.

Coverage includes, but is not limited to, testing of the products of an amniocentesis, 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.

(t) **Hearing exams** are covered when ordered by a Physician during treatment of a medical condition or Injury. Routine hearing exams are covered under Standard Preventive Care as shown in the Schedule of Benefits.

(u) **Hearing aids and implantable Prosthetic Devices.** In accordance with established Coverage Policy, coverage may be provided for the following:

(i) Hearing aids;

(ii) Cochlear implant (an implantable hearing device inserted into the modiolus of the cochlea and into cranial bone) and its associated speech processor;

(iii) Auditory brain stem implant; and

(iv) implantable osseointegrated hearing aids.

Benefits for covered hearing aids and hearing devices are payable as described in the Schedule of Benefits.

(v) **Laboratory services.**

(w) **Morbid obesity** treatment coverage, including gastric bypass surgery or any other procedure performed for the purpose of weight loss, is subject to prior written approval from the Claims Administrator, acting on behalf of the Plan Administrator. Coverage includes Physician-supervised weight control programs. Benefits for approved treatment will be limited as described in the Schedule of Benefits. Reversal of a prior weight loss surgery will be covered, contingent on Medical Necessity.

Additionally, Blue Distinction Centers are available as sites of care for bariatric surgery. Blue Distinction Centers are medical facilities and Providers that are recognized for their expertise in delivering specialty care. For a complete list of Blue Distinction Centers nationwide, visit the BCBSAR website at https://www.bcbs.com/blue-distinction-center/facility or contact the Customer Service number on the back of the Member's identification card. Travel and lodging are covered as described under "Travel and Lodging Expenses" located later in this section and limited as shown in the Schedule of Benefits.

(x) **Oral Surgery, Dental Care and Orthodontic Services.** Oral Surgery, Dental Care and orthodontic services are generally not covered. However, coverage is provided for the following specific conditions.

(i) **Benefits for Oral surgery.** The Plan will pay only for the following non-dental oral surgical procedures:

a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required.

b) Surgical procedures required to treat an Injury to jaws, cheeks, lips, tongue, roof and floor of the mouth. Treatment of an injury to a tooth or teeth incurred while eating is not covered.

c) Excision of exostoses of jaws and hard palate.

d) External incision and drainage of abscess.

e) Incision of accessory sinuses, salivary glands or ducts.

f) Removal of impacted teeth is not covered; however, Hospital and ambulatory surgery center services and anesthesia charges related to the surgical extraction of impacted teeth are covered.

(ii) **Benefits for Injury.** If a Covered Person has an Injury, benefits will be provided for Dental Care and x-rays necessary to correct damage to a Non-Diseased Tooth or surrounding tissue caused by the accidental Injury. The Covered Person must seek treatment within seven days of the accidental Injury for services to be covered.

a) Only the non-diseased tooth or teeth avulsed or extracted as a direct result of the Injury and the non-diseased tooth or teeth immediately adjacent will be considered for replacement.

b) 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.

c) This benefit is limited to the first 12 months immediately following the Injury. 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,
- Under standard dental practices the treatment could not have been provided within such 12-month period, and
- Coverage for the injured Covered Person is in force when the treatment is rendered.

d) Injury to teeth while eating is not considered an accidental Injury.

e) Any Health Intervention related to dental caries or tooth decay is not covered.

(iii) **Benefits for dental services required in connection with Covered Services.**

a) Dental services in connection with radiation treatment for any malignancy of the head or neck are covered.

b) Dental services perioperative to organ transplant when dental infection precludes listing for a transplant are covered.

c) Dental services perioperative to valve replacement or surgery when dental infection precludes surgery are covered.

d) Dental services perioperative for hematopoietic stem cell transplant when dental infection precludes listing for a transplant are covered.

(iv) **Benefits for anesthesia services.** Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures, including services to children, are covered in connection with treatment for a complex dental condition provided to: (i) a Participant under seven years of age who is determined by two dentists (in separate practices) to require the dental treatment without delay; (ii) a Participant with a diagnosis of serious mental or physical condition; or (iii) a Participant, certified by his or her primary care physician to have a significant behavioral problem.

(v) **Benefits for dental reconstructive surgery.** Dental implants of titanium osseointegrated fixtures, or of any other material, are not covered regardless of the diagnosis, medical condition, accident or injury.

(y) **Organ transplant** limits. Coverage is provided for organ or tissue transplants in accordance with the following specific conditions:

(i) Not all transplants are covered. There must be a specific Coverage Policy which allows benefits for the transplant in question, and the Covered Person must meet all of the required criteria necessary for coverage set forth in the Coverage Policy and in this Summary of Benefits.

(ii) Except for corneal transplants, coverage for transplant services requires prior approval from the Claims Administrator. A request for approval must be submitted to the Claims Administrator prior to receiving any transplant services, including transplant evaluation.

(iii) The transplant benefit is subject to the deductible, coinsurance and any applicable Copays or maximums specified in the Schedule of Benefits.

(iv) Notwithstanding any other provisions, the Allowable Charge for an organ transplant, including any charge for the procurement of the organ, Hospital services, Physician services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) 90% of the billed charges or (b) the global payment determined as payment in full by a Blue Cross and Blue Shield Association Blue Distinction Centers for Transplant participating facility, if the Covered Person chooses to use that facility. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network, but is contracted with a local Blue Cross and/or Blue Shield Plan, the Allowable Charge shall be the price contracted by such Blue Cross and/or Blue Shield Plan. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network and does not contract with the local Blue Cross and/or Blue Shield plan, the Allowable Charge for the transplant services provided in the Transplant Global Period is 80% of the average usual and reasonable charge authorized by participating facilities in the Blue Distinction Centers for Transplant network located in the geographic region where the transplant is performed.

(v) Please note that payments for any transplant (whether performed within the transplant network or by a non-participating facility) are limited to a global payment that applies to all covered transplant services; payment will not be made for any amounts in excess of the global payment for services the facility or any Physician or other Health Care Provider or supplier may bill or attempt to bill separately, because the global payment is deemed to include payment for all related necessary services (other than non-covered services). If a Covered Person uses a facility participating in the Blue Distinction Centers for Transplant network, that facility has agreed to accept the global payment as payment in full, and should not bill for any excess amount above the global payment, except for applicable deductible, coinsurance or non-covered services; however, a non-participating facility may bill the Covered Person for all amounts it may charge above the global payment. These charges above the global payment could amount to thousands of dollars in additional out-of-pocket expenses.

(vi) When the Covered Person is the potential transplant recipient, a living donor's Hospital costs for the removal of the organ are covered with the following limitations:

a) Allowable Charges are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less; and

b) Donor testing is covered only if the tested donor is found compatible.

(vii) Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. Benefits under this Plan will be payable only if there is no coverage available under the donor's plan. Donor charges include those for evaluating the organ or tissue, removing the organ or tissue from the donor, and transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

(viii) Travel and lodging are covered as described under "Travel and Lodging" later in this section and limited as shown in the Schedule of Benefits.

(z) The initial purchase, fitting, and repair of **Orthotic Devices** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(aa) Covered charges billed by a p**harmacist** will be paid at the Primary Care Physician's benefit level provided the Pharmacist is acting within the scope of their license.

(bb) **Podiatry services** are limited to surgical services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or débridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot. Coverage includes custom-molded foot orthotics. Coverage includes routine foot care to treat podiatric conditions associated with diabetes mellitus, metabolic (e.g. diabetes, gout, etc.), neurologic (peripheral neuropathy of any etiology), and peripheral vascular disease.

(cc) **Prescription Medications** (as defined) are covered under the Prescription Drug program administered by the pharmacy benefits manager. Coverage under Medical Benefits is available for injectable medications while confined as an inpatient, or when provided and administered by a Physician in a clinic setting.

(dd) The initial purchase, fitting and repair of fitted **Prosthetic Devices** which replace body parts.

(ee) **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:

(i) 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

(ii) 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

(iii) 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

(iv) 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:

(i) Covered health services (i.e., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;

(ii) 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

(iii) 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:

(i) The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial;

(ii) 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;

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

(iv) 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.

(i) 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: (a) It is comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and (b) It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(ii) The study or investigation is conducted under an Investigational new drug application reviewed by the *U.S. Food and Drug Administration*;

(iii) The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;

(iv) 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

(v) 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.

(ff) Reconstructive Surgery. Cosmetic Services are not covered. Coverage is provided for the following reconstructive surgery procedures:

(i) Treatment provided for the correction of defects incurred in an accidental Injury sustained by the Covered Person. The Covered Person must seek treatment within seven days of accidental Injury for services to be covered. Unless Prior Approved by the Claims Administrator, no benefits are provided after 12 months from the accidental Injury.

(ii) Removal of a port-wine stain or hemangioma (on the head, neck, or face).

(iii) Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery.

(iv) In connection with a mastectomy eligible for coverage under this document, services for:

a) Reconstruction of the breast on which the surgery was performed;

b) Surgery to reconstruct the other breast to produce a symmetrical appearance; and

c) Prostheses and services to correct physical complications for all stages of the mastectomy, including lymphedemas.

(v) Reduction mammoplasty, if such reduction mammoplasty meets coverage criteria, is covered.

NOTE: Reconstructive surgery for any craniofacial anomaly is NOT covered under this subsection; the only Plan coverage for any services related to a craniofacial anomaly is outlined elsewhere in the Medical Benefits Section, under the heading "Craniofacial Anomaly Services." All coverage of such services is limited to the terms, conditions and limitations outlined and also limited by all other generally applicable terms, conditions and limitations of this Plan Document (e.g., eligibility, Medically Necessary, Experimental and Investigational standards, etc.).

(gg) **Sleep apnea treatment** and **sleep studies** is covered in accordance with established Coverage Policy.

(hh) **Spinal Manipulation/Chiropractic services** by a Provider acting within the scope of his or her own license. Coverage is limited as shown in the Schedule of Benefits when performed by a licensed D.C.

(ii) **Sterilization** procedures (tubal ligation and vasectomy).

(jj) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(kk) **Telehealth benefits.** Coverage is provided for Telehealth services performed by a person licensed, certified, or otherwise authorized to administer health care in the ordinary course of the practice of his or her profession at the same rate as if it had been performed in-person provided the Telehealth service is comparable to the same service provided in person.

Coverage also includes communications made by a Physician responsible for the direct care of a Covered Person in Case Management with involved health care Providers.

Audio-only communication is covered if it is real-time, interactive, and substantially meets the requirements for a covered service that would otherwise be covered by the Plan.

However, electronic consultations such as, but not limited to fax; email; or for services, which are, by their nature, hands-on (e.g., surgery, interventional radiology, coronary, angiography, anesthesia, and endoscopy) are not covered.

(ll) Treatment of **Temporomandibular Joint (TMJ) Disorder and Cranial Mandibular Disharmony** consistent with established Coverage Policy.

(mm) **Travel and Lodging Expenses**. Travel and lodging are covered when services are not available within 50 miles each way of the member's home for organ transplants and within 100 miles each way 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 transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $150 per day.

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

(ii) 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.blueadvantagearkansas.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. 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.

(nn) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Allowable Charges for nursery care for the first five days after birth while the newborn child is Hospital confined as a result of the child's birth or until the mother is discharged, whichever is less.

Charges for covered routine nursery care will be applied toward the Plan of the mother. If the mother is not covered under this Plan, charges will be applied toward the Plan of the newborn child.

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

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician for routine pediatric care for the first five days after birth while the newborn child is Hospital confined, or until the mother is discharged, whichever is less.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

(oo) **Wigs** following chemotherapy, radiation therapy, or diagnosis of alopecia, are covered and limited as shown in the Schedule of Benefits.

(pp) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES

PRIOR APPROVAL OF MEDICAL SERVICES

The Plan has a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

To request Prior Approval, please call the Customer Service phone number on the back of the health plan identification card.

The program consists of:

(1) Prior Approval of the Medical Necessity for the following services before Medical and/or Surgical services are provided:

Inpatient Admissions
Emergency Inpatient Admissions (call must be made within 48 hours of admission)
Specific Medical Services
Specific Outpatient Surgical Procedures

(2) Retrospective review of the Medical Necessity of the listed services provided;

(3) Concurrent review, in consideration of extended services; and,

(4) Discharge planning.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan may not pay for the charges or the Plan may not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

Prior Approval requirements are waived for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works:

The responsible party must call the appropriate telephone number on the Covered Person's health plan identification card.

Through the Prior Approval process, the number of days of Medical Care Facility confinement authorized for payment will be determined. ***Failure to follow this procedure may result in a reduction or denial of benefits from the Plan.***

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the Prior Approval program. The Covered Person's Medical Care Facility stay or use of other medical services will be monitored and either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services will be coordinated with the attending Physician, Medical Care Facility and Covered Person.

Responsibility for Obtaining Prior Approval
The following table identifies some services which are subject to Prior Approval. If the service or procedure is provided by an In-Network Provider, in some cases the Provider may be held financially responsible for failure to obtain Prior Approval. However, it is always in the Covered Person's best interest to verify that the treating Provider did obtain Prior Approval in order to avoid any potential penalties that could result in additional out-of-pocket expenses. If the service or procedure is provided by an Out-of-Network Provider, it is always the Covered Person's responsibility to obtain Prior Approval.

SERVICES REQUIRING PRIOR APPROVAL
NOTE: THIS IS NOT A COMPLETE LIST. Information regarding whether or not a specific service or procedure is subject to Prior Approval may be obtained by calling BlueAdvantage Administrators customer service. All benefits described in this document are subject to the Claims Administrator's established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefits due under this Plan.
Inpatient admissions, including emergency admissions and concurrent care extension, at a Hospital and similar facilities, such as: Acute Care Facility — Skilled Nursing Facility Inpatient Rehabilitation (Physical) — Long Term Acute Care (LTAC) Residential Treatment Facility Please refer to the health plan identification card for the Customer Service phone number or, in the case of a Residential Treatment Facility admission, the "Behavioral Health" phone number. **NOTE:** For inpatient admissions related to treatment of a Medical Emergency, the Covered Person or the treating Provider should notify the Plan of the admission within 48 hours of the admission.
Specific Medical Services Genetic Testing
Certain Outpatient Surgeries, including, but not limited to: Neurostimulators — Bone stimulators Gastric procedures — Breast surgeries Cochlear implants — Joint surgeries Spine surgeries — Maxillofacial surgeries Facial surgeries
Outpatient radiological imaging services, such as Magnetic Resonance Angiography or Imaging ("MRA/MRI"), Computed Tomography Scanning ("CT Scan"), Nuclear Cardiology, Echo Cardiography and positron emission tomography scans ("PET Scan"), collectively referred to as "Advanced Diagnostic Imaging." Please refer to the health plan identification card for the Carelon Health "High-Tech" phone number.
Behavioral health services, including repetitive transcranial magnetic stimulation (rTMS) for treatment of depression and applied behavioral analysis related to autism therapy. The member may call Lucet Behavioral Health and Solutions at 877-801-1159 to receive Prior Approval.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

PREADMISSION TESTING SERVICE

Diagnostic lab tests and x-ray exams will be reimbursed according to standard Plan benefit levels when:

(1) Performed on an outpatient basis within seven days before a Hospital confinement;

(2) Related to the condition which causes the confinement; and

(3) Performed in place of tests while Hospital confined.

Covered charges for this testing will be paid even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

INCLUDED HEALTH (FORMERLY GRAND ROUNDS), A PERSONAL HEALTH CARE ASSISTANT

At no cost to the Covered Person and their covered dependents, Included Health can help with understanding their medical Plan coverage, tracking progress towards meeting their Deductible, finding trusted, In-Network doctors and specialists that match their preferences, and getting personalized health care recommendations for any new or existing condition.

Windstream members and their covered dependents have the support they need to address any health care concern with Included Health. Members can call or message Included Health, available as a no-cost benefit from Windstream when a Covered Person needs:

- Information. Get questions answered about their medical plan, including what’s covered.
- Guidance. Manage claims, track progress towards meeting their deductible, and fix billing errors.
- Answers. Get personalized health care recommendations for any new or existing condition.
- Doctors. Find trusted, In-Network doctors and specialists that match their preferences.
- Clarity. Understand their health benefits and when to use them.
- Support. Receive high-touch support to remove any obstacle in their health care journey, including care logistics.

How does Included Health work?
Included Health is made up of a team of multidisciplinary health care experts, ready to provide a Covered Person with personalized support. A Covered Person can contact their care coordinator over the phone, or via live message on the app.

Who can use Included Health?
Included Health is available to all Employees enrolled in a Windstream sponsored medical Plan and their covered dependents.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

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

Allowable Charge when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Claims Administrator, in its sole discretion, to be reasonable. The customary allowance is the basic Allowable Charge. However, Allowable Charge may vary, given the facts of the case and the opinion of the Claims Administrator.

Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan. Please note that all benefits under this Plan are subject to and shall be paid only by reference to the Allowable Charge as determined at the discretion of the Plan. This means that regardless of how much a health care Provider may bill for a given service, the benefits under this Plan will be limited by the established Allowable Charge. If services are rendered by a participating Provider, that Provider is obligated to accept the established rate as payment in full, and should only bill the member for Deductible, Coinsurance and any non-covered services; however, if services are rendered by a non-participating Provider, the member will be responsible for all amounts billed in excess of the Allowable Charge.

Ambulance Service means surface or air transportation in a regularly equipped ambulance licensed by an appropriate agency and where the use of any other means of transportation is not medically indicated.

Ancillary Services means services provided by Out-of-Network Providers at an In-Network facility such as: related to emergency medicine – anesthesiology, pathology, radiology and neonatology; provided by assistant surgeons, hospitalists and intensivists; diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the Secretary (as that term is applied in the No Surprises Act); provided by such other specialty practitioners as determined by the Secretary; and provided by an Out-of-Network Physician when no other In-Network Physician is available.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Child (Children) means any of the following individuals with respect to an Employee: biological Children; stepchildren; adopted Children; a legal ward; Children lawfully placed with the Employee for adoption, a grandchild or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Claims Administrator means a vendor to whom the Plan Administrator has delegated responsibility and authority to process claims for benefits under the Plan, applying the terms, conditions, limitations, and exclusions of the Plan as set forth in this document. The Claims Administrator and its address are identified in the General Plan Information section of this document. The Claims Administrator is not the Plan Administrator and does not act as a fiduciary of the Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Copay or Copayment is the amount of money that is paid each time a particular service is used before the Plan pays. Typically, there may be copays on some services and other services will not have any copays. Copay amounts for eligible services rendered by In-Network Providers accrue toward the In-Network annual out-of-pocket limit

Cosmetic Surgery means any surgical procedure, including corrective plastic or reconstructive plastic surgical procedures, having the primary purpose of improving physical appearance. Cosmetic Surgery also includes any procedure required in order to correct complications caused by or arising from prior Cosmetic Surgery. However, Cosmetic Surgery does not include in connection with a mastectomy, (a) reconstruction of the breast on which the mastectomy has been performed, and (b) surgery and reconstruction of the other breast to produce a symmetrical appearance.

Coverage Policy - With respect to certain drugs, treatments, services, tests, equipment or supplies, the Claims Administrator has developed specific Coverage Policies, which have been put into writing, and are available upon request from the Claims Administrator. If the Claims Administrator has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment or supply that a Covered Person received or seeks to have covered under the Plan, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service, test, equipment or supply meets the coverage criteria; however, the absence of a specific Coverage Policy with respect to any particular drug, treatment, service, test, equipment or supply shall not be construed to mean that such drug, treatment, service, test, equipment or supply meets the coverage criteria.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

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

Dental Care means the treatment or repair of the teeth, bones and tissues of the mouth and defects of the human jaws and associated structures and shall include surgical procedures involving the mandible and maxilla where such is done for the purpose of correcting malocclusion of the teeth or for the purpose, at least in part, of preparing such bony structure for dentures or the attachment of teeth, artificial or natural. Dental Care shall include any related supplies or oral appliances used in the treatment, diagnosis or prevention of any defects in the teeth or supporting tissues of the mouth. Expenses for such treatment or repair are considered Dental Care regardless of the reason for the services. Generally, hospital services and administration of anesthetic in connection with Dental Care are not covered except in limited circumstances, as specifically outlined elsewhere in this document.

Durable Medical Equipment means equipment which:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of an Illness or Injury; and

(4) Is appropriate for use in the home.

Employee means a person who is classified by his Employer as an Active or Retired, common law employee.

Employer is 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 is the Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational. The Plan shall have full discretion to determine whether a drug, device or medical treatment is experimental or investigational. Any drug, device or medical treatment may be deemed experimental or investigational, in the Plan's discretion, if:

(1) The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and final regulatory approval for marketing has not been announced to the public at the time the drug or device is furnished; or

(2) The drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval;

(3) Reliable Evidence (as defined below) shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II or III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;

(4) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

(5) Reliable Evidence (as defined below) shows that a majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure neither supports nor denies its use for a particular condition or disease.

(6) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that it should not be used as a first line therapy for a particular condition or disease.

"Reliable Evidence" shall mean only the following sources:

(a) The patient's medical records or other information from the treating Physician(s) or from a consultant(s) regarding the patient's medical history, treatment or condition;

(b) The written protocol(s) under which the drug, device, treatment or procedure is provided to the patient;

(c) Any consent document the patient has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;

(d) Published reports and articles in the authoritative medical and scientific literature, signed by or published in the name of a recognized medical expert, regarding the drug, device, treatment or procedure at issue as applied to the Injury, Illness or condition at issue; or

(e) The written protocol(s) used by another facility studying substantially the same drug, device, medical treatment or procedure.

Explanation of Benefit (EOB) means the explanation of benefit determination, provided by the Claims Administrator to the Participant as a result of the submission of a Claim by the Claimant or of a bill for service rendered by a health care Provider.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Full-Time Employees are Employees who are scheduled to work at least 30 hours per week.

Health Intervention or Intervention means an item or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital means an acute general care Hospital, a psychiatric Hospital and a rehabilitation Hospital licensed as such by the appropriate state agency. It does not include any of the following, unless required by applicable law: Hospitals owned or operated by state or federal agencies, convalescent homes or Hospitals, homes for the aged, sanitariums, long term care facilities, infirmaries, or any institution operated mainly for treatment of long-term chronic diseases.

Illness means a bodily disorder, disease, physical Sickness or Mental Illness. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Independent Dispute Resolution is the process that Out-of-Network or non-participating Providers may use following the end of an unsuccessful open negotiation period to determine the Out-of-Network rate for certain services. More specifically, the Federal IDR process may be used to determine the Out-of-Network rate for certain emergency services, non-emergency items and services furnished by non-participating Providers at participating health care facilities, and air ambulance services furnished by non-participating Providers of air Ambulance Services where an All-Payer Model Agreement or specified state law does not apply. Additionally, a party may not initiate the Federal IDR process if, with respect to an item or service, the party knows or reasonably should have known that the Provider or facility provided notice and obtained consent from a participant, beneficiary, or enrollee to waive surprise billing protections consistent with PHS Act sections 2799B-1(a) and 2799B-2(a) and the implementing regulations at 45 CFR 149.410(b) and 149.420(c)-(i).

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury (not an intentionally self-inflicted injury) sustained by a Covered Person while eligible for coverage under the Plan, and which is the direct cause of the loss, independent of disease or bodily infirmity. Injury to a tooth or teeth while eating is not considered an accidental Injury.

In-Network Provider means a health care Provider who has entered into a network participation contract with either the Claims Administrator or, outside the state of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided ("Host Plan").

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the Lifetime of the Covered Person.

Long Term Acute Care means the medical and nursing care treatment of medically stable but fragile patients over an extended period of time, anticipated to be at least 25 days. Long Term Acute Care includes, but is not limited to, treatment of chronic cardiac disorders, ventilator dependent respiratory disorder, post-operative complications and total parenteral nutrition (TPN) issues.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that a condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:

(1) Placing the patient's health in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

Medically Necessary, or sometimes referred to as Medical Necessity, means care and/or treatment that is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Illness means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to, schizophrenic spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma and stressor-related disorders, dissociative disorders, somatic symptom and related disorders, feeding and eating disorders, elimination disorders, sleep-wake disorders, sexual dysfunctions, gender dysphoria, disruptive, impulse-control and conduct disorders, substance-related and addictive disorders, neurocognitive disorders, personality disorders, paraphilic disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include only illnesses classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)

Morbid Obesity is a diagnosed condition in which the patient has a BMI of 40 or greater, or a BMI of 36-39 with the presence of other high-risk co-morbid conditions.

Orthotic Device means a support, brace, or splint used to support, align, prevent, or correct the function of movable parts of the body.

Out-of-Network Provider means a health care Provider who does not have a network participation contract with either the Claims Administrator or, outside the state of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided ("Host Plan"). Out-of-Network Providers are free to bill and collect from members any charges for Covered Charges which are in excess of the Plan's Allowance or Allowable Charge except when prohibited by law.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

Outpatient Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Physician means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place a claimed Intervention is rendered. Physician also means a Doctor of Podiatry (D.P.M.), a Chiropractor (D.C.), a Psychologist (Ph.D.), an Oral Surgeon (D.D.S.) or an Optometrist (O.D.) duly licensed and qualified to perform the claimed Health Intervention at the time and place such Intervention is rendered.

Plan means Windstream Medical Plan, a component of the Windstream Services, LLC Welfare Benefit Plan, which is a benefits plan for certain Employees of the Employer and is described in this document. 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.

Plan Allowance means the maximum amount the Plan will cover or pay for any health care services, drugs, medical devices, equipment, supplies or benefits covered by the Plan, regardless of how much a Provider may bill for services, drugs, medical devices, equipment, supplies or benefits. This overall limit on the amount of Plan benefits available under the Plan may also be referred to as the "Allowable Charge or "Allowance" under the Plan.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Sponsor means Windstream Services, LLC.

Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Medication means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Prior Approval means a health plan coverage management feature which requires that an approval be obtained from the Claims Administrator or from a subcontractor engaged by the Claims Administrator, acting on behalf of the Plan, before incurring expenses for certain covered services. The Plan's procedures and timeframes for making decisions on Prior Approval requests may differ depending on when the request is received, and the type of service involved. Ongoing therapy of a prior authorized medication may require periodic assessments that could include an efficacy measure intended to demonstrate positive outcomes for continuation of therapy.

Please note that Prior Approval does NOT guarantee coverage for, or the payment of, the service or procedure reviewed. The sole effect and meaning of receiving Prior Approval is simply that, if Prior Approval is given, coverage for the specific service will not be denied for lack of Medical Necessity, including length of stay in a facility. All other Plan coverage criteria, including but not limited to, eligibility, premium payments, if any, Coverage Policies, exclusions, and limitations shall continue to apply, and must be satisfied in order to receive Plan coverage for the Prior Approved services. In other words, if a Covered Person or their treating Provider receives Prior Approval, that Prior Approval takes care of the Medical Necessity issue for the particular admission or service that is Prior Approved, but there may be other Plan coverage standards that still must be reviewed, and if any of those standards are not also met, coverage for the Prior Approved service still could be denied upon further review of the Plan benefits claim. Prior Approval does not in any way control or attempt to control whether or not a Covered Person receives any particular medical service, drug, supply, equipment, device, or treatment – the decision on whether to undergo any particular course of treatment is entirely up to the Covered Person and their treating health care Providers. The only effect of a denial of Prior Approval is that a Covered Person may not receive Plan benefits for the service, drug, supply, equipment, device, or treatment in question. Accordingly, if the Covered Person and their treating health care provider believe that a particular service, drug, supply, equipment, device, or treatment is essential or in the Covered Person's best interests, even though Prior Approval has been denied, the Covered Person should make their own decision regarding such matters, without regard to the Prior Approval decision. In other words, Prior Approval will only affect the Plan's coverage of medical care or treatment; it does not prevent a Covered Person and their doctors or other health care Providers from doing whatever they believe necessary in the best interests of the Covered Person's health and safety.

Prosthetic Device means a device used to replace, correct, or support a missing portion of the body, to prevent or correct a physical deformity or malfunction, or to support a weak or deformed portion of the body. Prosthetic Devices do not include dentures or other dental appliances that replace either teeth or structures directly supporting the teeth.

Provider means a Hospital or a Physician. Provider also means a certified registered nurse anesthetist; certified nurse practitioner; clinical nurse specialist; certified nurse midwife; a licensed audiologist; a chiropractor; a dentist; a licensed certified social worker; a licensed Durable Medical Equipment Provider; an optometrist; a pharmacist; a physical therapist; a podiatrist; a psychologist; a respiratory therapist; a speech pathologist and any other type of health care Provider which the Plan Administrator, in its sole discretion, approves for reimbursement for services rendered.

Recognized Amount is the amount which a Covered Person's cost sharing is based on for the following Covered Services when provided by Out-of-Network Providers: Out-of-Network Emergency Care; non-Emergency Care received at certain In-Network facilities by Out-of-Network Providers, when such services are Ancillary Services. For the purpose of this provision, "certain In-Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary. The Recognized Amount is based on the qualifying payment amount as determined under applicable law.

NOTE: Covered Services that use the Recognized Amount to determine a Covered Person's cost sharing may be higher or lower than if cost sharing for these Covered Services were determined based upon an Allowed Amount.

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.

Sickness is a Covered Person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, custodial or educational care.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse Disorder means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

Substance Use Disorder Residential Treatment Center means a facility that provides treatment for Substance (alcohol and drug) Use Disorders to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drug and supplies, psychological testing, and room and board.

Telehealth means the use of information and communication technology to deliver health care services, including without limitation to the assessment, diagnosis, consultation, treatment, education, care management, and self-management. Telehealth includes store-and-forward technology, remote patient monitoring, and audio only communication, **but does not include** a facsimile machine, text messaging, or electronic mail systems.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Transplant Global Period means a period of time that begins on or prior to the day of the transplant procedure and extends for a number of days after the transplant procedure. The length of the Transplant Global Period varies, depending upon the type of transplant involved.

Urgent Care Services means care and treatment for an Illness, Injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

Waiting Period means the number of days established by the Group that must pass before a new Employee who is an eligible Plan Participant can commence coverage for benefits.

PLAN EXCLUSIONS

This Section describes the conditions, Provider services, Health Interventions and miscellaneous fees or services for which coverage is excluded. However, please note that some additional exclusions are also stated elsewhere in this document, including the Medical Benefits section.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Active Duty.** Charges for an Injury sustained or an Illness contracted while on active duty or military service, unless payment is legally required.

(2) **Administrative Fees.** Fees incurred for acquiring or copying medical records, sales tax, preparation of records for other insurance carriers or insurance agencies, medical evaluation for life, disability or any type of insurance coverage.

(3) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol. The following must be present for there to be sufficient evidence for the purpose of this exclusion: (1) the results of a valid blood, breath or urine test performed by a qualified Provider indicating the Covered Person's alcohol level exceeds the legal limit in the state where the Injury or Sickness occurred or (2) a written citation from a law enforcement officer, in attendance where the Injury or Sickness occurred, indicating the Covered Person was under the influence of alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(4) **Appointments.** Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider.

(5) **Bed wetting.** Charges for the treatment of Nocturnal Enuresis Alarm (Bed wetting).

(6) **Bereavement services.** Medical social services and outpatient family counseling and/or therapy for bereavement, except if provided as Hospice Care.

(7) **Biofeedback.** Biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered for any diagnosis or medical condition.

(8) **Blood typing.** Blood typing for paternity testing.

(9) **Childbirth classes.** Lamaze Classes or other Childbirth classes

(10) **Clinical Trials.** Services or supplies provided in connection with a phase I, II, III or IV clinical trial or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. This exclusion will not apply to routine items and services that (a) would have been Covered Expenses had they not be incurred during an approved clinical trial, and (b) are provided during an approved clinical trial, as required and defined under PHSA Section 2709.

(11) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

(12) **Cosmetic Surgery.** Cosmetic Surgery, care and treatment provided for cosmetic reasons. This exclusion will not apply if services are for reconstructive procedures following surgical treatment of an Illness or accidental Injury, or correction of an abnormal congenital condition. Reconstructive mammoplasty will be covered after Medically Necessary surgery.

(13) **Custodial Care.** Services or supplies for custodial, convalescent, domiciliary or support care and non-medical services to assist a Covered Person with activities of daily living.

(14) **Custodial Care Facility.** Services or supplies furnished by an institution which is primarily a place of rest or a place for the aged. Youth homes, schools, or therapeutic wilderness, ranch or camp programs, or any similar institution are not covered.

(15) **Delivery Charges.** Charges for shipping, packaging, handling or delivering Medications are not separately covered.

(16) **Dental Care or orthodontic services.** Dental Care and orthodontic services are generally not covered. Limited dental care and orthodontic services are described in the Medical Benefits Section.

(17) **Diabetic Supplies.** Charges for diabetic supplies and equipment are not covered under Medical Benefits but instead are covered under the Prescription Drug Card Program. Insulin pumps and insulin pump supplies are covered under Medical Benefits, subject to the Durable Medical Equipment benefit limits.

(18) **Dietary and nutritional services.** Services or supplies provided for dietary and nutritional services, unless such services are for the sole source of nutrition for a Covered Person. Also, special foods such as meals, shakes, or supplements, prescribed in association with a weight control program are not covered.

(19) **Duplicate Charges**. Duplicate services and charges or inappropriate billing including the preparation of medical reports and itemized bills.

(20) **Educational or vocational testing.** Services for educational or vocational testing or training.

(21) **Environmental change.** Charges for environmental change including Hospital or Physician charges connected with prescribing an environmental change.

(22) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.

(23) **Exercise programs.** Exercise programs for treatment of any condition, including but not limited to physical education programs in a group setting, health club memberships, athletic training, back schools, or work hardening. This exclusion does not apply to Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(24) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(25) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, including refractions, lenses for the eyes and exams for their fitting. A procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic Injury or corneal disease, infectious or non-infectious, and (2) the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered.

(26) **Foreign travel.** Care, treatment or supplies out of the United States if travel is for the sole purpose of obtaining medical services. Services received outside of the United States must be Medically Necessary to be considered eligible for coverage.

(27) **Genetic testing.** In general, genetic testing to determine: (1) the likelihood of developing a disease or condition, (2) the presence of a disease or condition in a relative, (3) the likelihood of passing an inheritable disease, condition or congenital abnormality to an offspring, (4) genetic testing of the products of amniocentesis to determine the presence of a disease, condition or congenital anomaly in the fetus, (5) genetic testing of a symptomatic Covered Person's blood or tissue to determine if the Covered Person has a specific disease or condition, and (6) genetic testing to determine the anticipated response to a particular pharmaceutical, are not covered. However, a limited number of specific genetic tests may be covered for situations (4) or (5) referenced above when the Plan has determined that the particular genetic test (a) is the only way to diagnose the disease or condition, (b) has been scientifically proven to improve outcomes when used to direct treatment, and (c) will affect the individual's treatment plan. A limited number of specific genetic tests may be covered for situation (6) referenced above if criteria (b) and (c) above are met. The Plan has full discretion in determining which particular genetic tests may be eligible for benefits as an exception to this exclusion. Any published Coverage Policy regarding a genetic test will control whether or not benefits are available for that genetic test as an exception to this exclusion.

(28) **Growth hormones.** Charges related to growth hormones.

(29) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician. However, the Plan will allow charges associated with the purchase of a wig following chemotherapy, radiation therapy, or a diagnosis of alopecia.

(30) **Hippotherapy.** Charges associated with hippotherapy.

(31) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(32) **Hypnotherapy.** Hypnotherapy is not covered for any diagnosis or medical condition.

(33) **Illegal Acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(34) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness resulting from that Covered Person’s voluntary taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person illegally using the controlled substances. A written citation from a law enforcement officer, in attendance where the Injury or Sickness occurred, indicating the Covered Person was under the influence of a controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician must be present for there to be sufficient evidence for the purpose of this exclusion. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(35) **Impacted teeth.** Charges for impacted teeth are not covered; however, Hospital and ambulatory surgery center services and anesthesia charges related to the surgical extraction of impacted teeth are covered.

(36) **Infertility Treatment**. Artificial insemination in-vitro fertilization, and procedures performed for the purpose of achieving Pregnancy are not covered under the Medical Plan. Further details regarding infertility treatment by Progyny, a third-party administrator, are available on the Windstream website at www.windstreambenefits.com.

(37) **Learning Disabilities.** Services or supplies provided for learning disabilities, i.e., reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty, and other learning difficulties.

(38) **Nicotine replacement products.** Charges for nicotine replacement products, including lozenges, nasal sprays, inhalers, nicotine gum and transdermal nicotine patches purchased over the counter or with a prescription, are not covered under Medical Benefits.

(39) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(40) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(41) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(42) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(43) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(44) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. All treatment for Morbid Obesity is subject to prior approval by the Claims Administrator, acting on behalf of the Plan Administrator.

(45) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(46) **Orthopedic shoes**. Charges for orthopedic shoes (except when they are an integral part of the leg brace and the cost is included in the orthotist's charge), or the purchase of orthotic services or appliances. This exclusion does not apply to orthopedic shoes prescribed during the treatment of a metabolic or peripheral-vascular disease.

(47) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(48) **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.

(49) **Prescription Medications** are not covered under Medical Benefits, but are covered under the Prescription Drug Card program administered by the pharmacy benefits manager.

(50) **Private duty nursing.** Outpatient private duty nursing care of a custodial nature or private duty nursing care on a 24-hour shift basis is not covered.

(51) **Provider Not Defined.** Services or supplies provided by an individual or entity that is not a Provider as defined in this Summary of Benefits.

(52) **Recreational therapy.** Services or supplies provided by a recreational therapist.

(53) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, or grandchild, whether the relationship is by blood or exists in law.

(54) **Replacement Durable Medical Equipment, Prosthetic and Orthotic Devices.** Replacement of Durable Medical Equipment, or a prosthetic or orthotic device is covered no more frequently than once per three-year period except when necessitated by normal growth or when the age of the DME, Prosthetic or Orthotic Device exceeds the useful life. Maintenance and repair resulting from misuse or abuse of DME or a Prosthetic or Orthotic Device, are the responsibility of the Covered Person.

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

(56) **Room and Board Fees.** Room and board fees when surgery is performed other than at a Hospital or Surgical Center.

(57) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition, which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(58) **Seasonal Affective Disorder (SAD).** Use of photo therapy or light therapy to treat seasonal affective disorder or depression is not covered.

(59) **Self-Administered Services.** Charges for procedures that can be done by the Covered Person without the presence of medical supervision.

(60) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(61) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan. However, if a Covered Person is hospitalized on the date of termination, dependent on the type of contractual agreement with the Hospital, the Plan may cover eligible Hospital facility charges through the date of discharge from the Hospital. Any charges other than those billed by the Hospital, which are incurred in conjunction with an inpatient hospitalization, are not covered after the individual’s coverage is terminated.

(62) **Snoring.** Devices, procedures or other Health Interventions to treat snoring are not covered.

(63) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization

(64) **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.

(65) **Third party recommended treatment**. Services required or recommended by third parties, including physicals and/or vaccines/immunizations for employment, overseas travel, camp, marriage licensing, insurance, unless otherwise covered by this Plan are not covered.

(66) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for expenses related to an organ transplant or ambulance charges, as defined as a covered expense.

(67) **Unlicensed Provider.** Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not include within its scope the treatment, procedure or service provided.

(68) **War.** Any loss that is due to a declared or undeclared act of war.

(69) **Weekend pass.** Charges for room and board in a facility for days on which the Covered Person is permitted to leave (a weekend pass, for example).

(70) **Workers' Compensation.** Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Worker's Compensation law, employer's liability law, or occupational disease law, even though the Covered Person fails to claim rights to such benefits or fails to enroll or purchase such coverage.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Claims Administrator, acting on behalf of the Plan Administrator, in its discretion, interprets the Plan to provide such benefits to the Covered Person.

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described later in this section.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures, both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If the Covered Person has any questions regarding these procedures, they should contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Claims Administrator must decide whether to approve or deny the Claim. The Claims Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Claims Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Claims Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Claims Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Claims Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of Claim determination .....72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing .....24 hours

Response by claimant, orally or in writing .....48 hours

Benefit determination, orally or in writing .....48 hours

Notification of Adverse Benefit Determination on Appeal .....72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction.....Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal

Notification to claimant of rescission.....30 days

Notification of determination on Appeal of
Urgent Care Claims ..... 24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)

Notification of Adverse Benefit Determination
on Appeal for non-Urgent Claims ..... 15 days

Notification of Adverse Benefit Determination
on Appeal for Rescission Claims ..... 30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits, pre-certification or mandatory second opinions. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination ..... 15 days

Extension due to matters beyond the control of the Plan ..... 15 days

Insufficient information on the Claim:
Notification of ..... 15 days
Response by claimant ..... 45 days

Notification, orally or in writing, of failure to follow
the Plan's procedures for filing a Claim ..... 5 days

Notification of Adverse Benefit Determination on Appeal ..... 30 days

Reduction or termination before the end of the treatment ..... 15 days

Request to extend course of treatment ..... 15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination ..... 30 days

Extension due to matters beyond the control of the Plan ..... 15 days

Extension due to insufficient information on the Claim ..... 15 days

Response by claimant following notice
of insufficient information ..... 45 days

Notification of Adverse Benefit Determination on Appeal.....60 days

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Claims Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the health care Provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures, incorporating any voluntary appeal procedures offered by the Plan. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

PREFERRED PAYMENT PLAN AND HOSPITAL REIMBURSEMENT PROGRAM PARTICIPATING PROVIDERS

The Plan participates in the Preferred Payment Plan ("PPP") and the Hospital Reimbursement Program ("HRP") with BlueAdvantage Administrators of Arkansas. Participating Providers agree to accept the allowances of BlueAdvantage Administrators of Arkansas and not charge the Covered Person more than that amount. No Assignment of Benefits by the Covered Person shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to the Covered Person.

A list of participating Providers is available on the web at www.blueadvantagearkansas.com.

The Claim Process

This Plan uses a direct claims administration system. Under this approach, the PPP or HRP Provider submits the claims directly to the Claims Administrator.

Any payment due for eligible services rendered by Preferred Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-Preferred Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person

PREFERRED PROVIDER ORGANIZATION (PPO)

The Plan participates in a Preferred Provider Organization ("PPO"). Participating Providers agree to accept the PPO allowances and not charge the Covered Person more than that amount.

No Assignment of Benefits by the Covered Person shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to the Covered Person.

A list of participating Providers is available on the web at www.blueadvantagearkansas.com.

The Claims Process

The Plan uses a direct claims administration system. Under this approach, the PPO Provider submits the claims directly to the Claims Administrator.

Any payment due for eligible services rendered by PPO Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-PPO Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

BLUECARD® PROGRAM

Out-of-Arkansas Services. The Plan participates in a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever a Covered Person obtains health care services outside of the State of Arkansas ("the service area"), the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Health Plan and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the service area, a Covered Person will obtain care from health care Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield

Licensee in that other geographic area ("Host Blue"). In some instances, a Covered Person may obtain care from nonparticipating health care Providers. The Health Plan's practices for consideration of payment in both instances are described below.

(1) BlueCard® Program.

(a) Under the BlueCard® Program, when a Covered Person accesses covered health care services within the geographic area served by a Host Blue, the Health Plan will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers. Whenever a Covered Person accesses covered health care services outside the service area and the claim is processed through the BlueCard Program, the amount a Covered Person pays for covered health care services is calculated based on the lower of:

- The billed covered charges for the covered services; or
- The negotiated price that the Host Blue makes available to the Health Plan.

(b) Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with the health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

(c) Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price used for a Covered Person's claim because the adjustments will not be applied retroactively to claims already paid.

(d) Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Health Plan would then calculate the Covered Person's liability for any covered health care services according to applicable law.

(2) Non-Participating Health Care Providers Outside the Service Area

(a) When covered health care services are provided outside of the service area by non-participating health care Providers, the amount a Covered Person pays for such services will generally be based on either the Host Blue's nonparticipating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, a Covered Person may be liable for the difference between the amount that the non-participating health care Provider bills and any payment made for the covered services as set forth in this paragraph.

(b) In certain situations, the Health Plan may use other payment bases, such as billed covered charges, the payment the Health Plan would make if the health care services had been obtained within the service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Health Plan will pay for services rendered by non-participating health care Providers. In these situations, a Covered Person may be liable for the difference between the amount that the non-participating health care Provider bills and the payment the Health Plan will make for the covered services as set forth in this paragraph.

BLUE CROSS BLUE SHIELD GLOBAL CORE

If the Covered Person is outside the United States (hereinafter "BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Medically Necessary Covered Services available under the medical benefits of the Plan. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists individuals with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when a Covered Person receives care from Providers outside the BlueCard service area, they will typically have to pay the Provider directly. If a Covered Person needs medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, they may contact customer service at the number on the back of their health plan identification card or additional information can be found at www.bcbsglobalcore.com.

(1) **Inpatient Services.** In most cases, if the Covered Person contacts Blue Cross Blue Shield Global Core for assistance, Hospitals will not require a Covered Person to pay for covered inpatient services, except for applicable cost-share amounts (deductibles, coinsurance, etc.). In such cases, the Hospital will submit claims to the service center to begin claims processing. However, if the Covered Person paid in full at the time of service, they must submit a claim to receive a benefit determination. Contact the Claims Administrator to obtain prior approval for non-emergency inpatient services.

(2) **Outpatient Services.** Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require the Covered Person to pay in full at the time of service. A claim must be submitted to receive a benefit determination.

(3) **Submitting a Blue Cross Blue Shield Global Core Claim.** When the Covered Person pays for services outside the BlueCard service area, a claim must be submitted to receive a benefit determination. For institutional and professional claims, a Blue Cross Blue Shield Global Core claim form should be completed and sent with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from the service center or online at www.bcbsglobalcore.com.

ALL OTHER PROVIDERS

When a Covered Person has a Claim to submit for payment that person must:

- Obtain a Claim form from the Windstream Benefits Department or the Claims Administrator.
- Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- . For Plan reimbursements, attach bills for services rendered or itemized receipts for travel and lodging. ALL BILLS MUST SHOW:

  Name of Plan
  Employee's name
  Name of patient
  Name, address, telephone number of the Provider of care
  Diagnosis
  Type of services rendered, with diagnosis and/or procedure codes
  Date of services
  Charges

Send the above to the Claims Administrator at this address:

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas
72203

WHEN CLAIMS SHOULD BE FILED

The Plan has established and will enforce a 365-day timely filing deadline for all claims for benefits under the Plan, meaning that the Covered Person, the treating Provider, or an Authorized Representative acting on the Covered Person's behalf, must submit the claim to the Claims Administrator within 365 days from the date of service. However, In-Network Providers must submit claims within the time limits provided in their applicable Provider contract, if shorter than 365 days. Claims are not payable if they are not submitted to the Claims Administrator within the applicable time limit.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

INFORMAL CLAIM REVIEW

In cases where a claim for benefits payment is denied or reduced in whole or in part, the Plan Participant or the Authorized Representative may request an informal claim review. An informal claim review is not an appeal. In a situation where the determination, after informal review, remains adverse, the Plan Participant or the Authorized Representative may request an appeal of the denial.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits. If a lawsuit is brought, it must be filed within two years after the final determination of an appeal.

Requests for review may be submitted in writing, email, or by telephone to the Claims Administrator. The request should provide the patient's name, Plan identification number and the specific claim(s) to be reviewed. Additional relevant documentation may also be provided to the Claims Administrator to assist in the review. A request for an informal claim review must be submitted within 180 days after notice is received of the denial or reduction in benefits.

A determination shall be rendered with a reasonable period of time, but notification of the determination will be provided not later than 60 days after received. A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60-day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

EXPLANATION OF BENEFITS (EOB)

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. For post-service claims, a Plan Participant will be notified within 30 days of receipt of the completed and properly submitted claim as to the acceptance or denial of a claim and if not notified within 30 days, the claim shall be deemed denied. Upon making a determination of a claim, the Claims Administrator will deliver to the Covered Person an Explanation of Benefit Determination ("EOB") containing the following information:

(1) The specific reason or reasons for the determination;

(2) Specific reference to those Plan provisions on which the denial is based;

(3) A description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

(4) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 45 days from the receipt of a completely and properly submitted claim.

CLAIMS REVIEW PROCEDURE

The Plan Participant will receive an EOB explaining the claim determination, and if applicable, the reason or reasons for any denial or reduction of benefits. In cases where a claim for benefits payment is denied or reduced in whole or in part, the Plan Participant or the Authorized Representative may request an informal claim review.

In a situation where the determination, after informal review, remains adverse, the Plan Participant or the Authorized Representative may request an appeal of the denial. This appeal provision will allow the Plan Participant to:

(1) Request from the Claims Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

(2) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Claims Administrator within 180 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Claims Administrator and the Claims Administrator will provide the Plan Participant with a written response within 60 days of the date the Claims Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Claims Administrator is unable to complete the review process within 60 days, the Claims Administrator shall notify the Plan Participant of the delay within the 60-day period and shall provide a final written response to the request for review within 120 days of the date the Claims Administrator received the Plan Participant's written request for review.

The Claims Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits. If a lawsuit is brought, it must be filed within two years after the final determination of an appeal.

The following describes the informal review and appeals processes:

(1) **Informal Claim Review**

Requests for review may be submitted in writing, email, or by telephone to the Claims Administrator. The request should provide the patient’s name, Plan identification number and the specific claim(s) to be reviewed. Additional relevant documentation may also be provided to the Claims Administrator to assist in the review. A request for an informal claim review must be submitted within 180 days after notice is received of the denial or reduction in benefits.

A determination shall be rendered with a reasonable period of time, but notification of the determination will be provided not later than 60 days after received.

If the review is in regard to a Pre-Service Claim, response will be provided within 30 days of received.

If the review is in regard to an Urgent Care Pre-Service Claim, response will be provided within 24 hours of receipt.

(2) Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. A claimant may submit written comments, documents, records, and other information relating to the Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Claims Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(a) Was relied upon in making the benefit determination;

(b) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(c) Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Claims Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Claims Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a manner calculated to be understood by the claimant:

(a) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the health care Provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(b) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, which was used in denying the Claim.

(c) Reference to the specific Plan provisions on which the determination was based.

(d) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(e) A description of the Plan's internal and external review procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(f) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(g) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(h) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(i) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. This request must be filed in writing within four months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll-free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the four-month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating Provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Appeals Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the plan.

AUTHORIZED REPRESENTATIVE

One Authorized Representative. A Covered Person may have one representative, and only one representative at a time, to assist in submitting a claim or appealing an Adverse Benefit Determination.

Authority of Authorized Representative. An Authorized Representative shall have the authority to represent the Covered Person in all matters concerning the Covered Person’s claim or appeal of a claim determination. If the Covered Person has an Authorized Representative, references to “Covered Person” in the provision of this document entitled “How to Submit a Claim” refer to the Authorized Representative.

Designation of Authorized Representative. Except to the extent mandated by the U.S. Department of Labor claims rules in the case of a treating health care professionals and urgent care claims, the Plan does not permit appeals on your behalf by any other person or entity not properly designated as your “authorized representative” in the manner specified in this section.

One of the following persons may act as a Covered Person's Authorized Representative:

(1) An individual designated by the Covered Person in writing in a form approved by the Claims Administrator. A “Designation of Authorized Appeal Representative” form is available from the Claims Administrator or the Plan Administrator;

(2) The treating Provider, if the claim is a claim involving urgent care, or if the Covered Person has designated the Provider in writing in a form approved by the Claims Administrator. A “Designation of Authorized Appeal Representative” form is available from the Claims Administrator or the Plan Administrator;

(3) A person holding the Covered Person's durable power of attorney;

(4) If the Covered Person is incapacitated due to Illness or Injury, a person appointed as guardian to have care and custody of the Covered Person by a court of competent jurisdiction; or

(5) If the Covered Person is a minor, the Covered Person's parent or legal guardian, unless the Claims Administrator is notified that the Covered Person's claim involves health care services where the consent of the Covered Person's parent or legal guardian is or was not required by law and the Covered Person shall represent himself or herself with respect to the claim.

Term of the Authorized Representative. The authority of an Authorized Representative shall continue for the period specified in the Covered Person's appointment of the Authorized Representative or until the Covered Person is legally competent to represent him or herself and notifies the Claims Administrator in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative.

(1) If the Authorized Representative represents the Covered Person because the Authorized Representative is the Covered Person's parent or legal guardian or attorney in fact under a durable power of attorney, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

(2) If the Authorized Representative represents the Covered Person in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

(3) If the Authorized Representative represents the Covered Person in connection with the submission of a post-service claim, the Claims Administrator will send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Covered Person, but the Claims Administrator will provide copies of such correspondence to the Authorized Representative upon request.

(4) The Covered Person understands that it will take the Claims Administrator at least 30 days to notify all its personnel about the termination of the Covered Person's Authorized Representative and it is possible that the Claims Administrator may communicate information about the Covered Person to the Authorized Representative during this 30-day period.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan, or the couple's Covered Children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Eligible Charge. For a charge to be eligible it must be an Allowable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network Provider has agreed to accept as payment in full.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

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, Sickness 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 Auto 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's 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, Sickness 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.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), certain Employees and their families covered under the Windstream Medical Plan component of the Windstream Services, LLC Welfare Benefit Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA continuation coverage under the Plan is administered by the COBRA Administrator. The COBRA Administrator is Businessolver, PO Box 850512, Minneapolis, MN 55485-0512, 1-888-850-1712, https://mywindstreambenefits.com. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the Employer (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care Provider. An individual may want to check to see if their current health care Providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication - and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the Employer, the former Employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Medicare Eligibility:** Individuals should be aware of how COBRA coverage coordinates with Medicare eligibility. If an individual is eligible for Medicare at the time of the Qualifying Event, or if he or she will become eligible soon after the Qualifying Event, he or she has eight months to enroll in Medicare after employment -related health coverage ends. Electing COBRA coverage does not extend this eight-month period. For more information, see https://www.medicare.gov/sign-up-change-plans/.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay Copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher Copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. More information about these options is available at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

NOTE: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) The end of employment or reduction of hours of employment,

(2) Death of the Employee,

(3) Commencement of a proceeding in bankruptcy with respect to the employer, or

(4) Entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), the Covered Person or someone on their behalf must notify the Plan Administrator at 4005 N. Rodney Parham Road, Little Rock, Arkansas, 72212, 1-888-850-1712 within 60 days after the later of (1) the date the Qualifying Event occurs or (2) the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Qualifying Event, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. The notice must be mailed, faxed or hand-delivered to the Plan Administrator or the COBRA Administrator, as applicable.

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice provided must state:

- the **name of the plan or plans** under which coverage has been lost or is being lost,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event (or second Qualifying Event or disability determination, as discussed below)** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, the notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the COBRA Administrator receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If an individual does not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage may terminate if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the date that coverage would otherwise be lost due to the Qualifying Event. The maximum coverage period increases to 29 months if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(b) 18 months (or 29 months, if there is a disability extension) after the date that coverage would otherwise be lost due to the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the date that coverage would otherwise be lost due to the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date that coverage would otherwise be lost due to the first Qualifying Event. The COBRA Administrator must be notified of the second Qualifying Event within 60 days of the later of the second Qualifying Event or the date on which the Qualified Beneficiary would have lost coverage under the terms of the Plan as a result of the second Qualifying Event. This notice must be sent to the **COBRA Administrator, Businessolver, at PO Box 850512, Minneapolis, MN 55485-0512** (call 1-888-850-1712 or visit https://mywindstreambenefits.com for additional information) in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the COBRA Administrator with notice of the disability determination on a date that is both:

- Within 60 days after the later of the date of the disability determination, the date the Qualifying Event occurs, or the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Qualifying Event, and
- Before the end of the original 18-month maximum coverage.

This notice should be sent to the COBRA Administrator, Businessolver, at PO Box 850512, Minneapolis, MN 55485-0512 (call 1-888-850-1712 or visit https://mywindstreambenefits.com for additional information), in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

For More Information

If an individual has questions about COBRA continuation coverage, they should contact the Plan Administrator at 4005 N. Rodney Parham Road, Little Rock, Arkansas, 72212, 1-888-850-1712. For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (“EBSA”). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep The Plan Administrator Informed of Address Changes

In order for an individual to protect his or her family's rights, they should keep the Plan Administrator informed of any changes in the addresses of family members. The individual should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR

The Windstream Services, LLC Welfare Benefit Plan is the benefit plan of Windstream Services, LLC, the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by Windstream Services, LLC to be Plan Administrator and serve at the convenience of the Plan Sponsor.
The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan Sponsor’s general assets through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

ASSIGNMENT OF BENEFITS

Assignment of benefits due under the Plan is prohibited as stated elsewhere in this document, although the Plan, acting through the Claims Administrator, may choose to accept or honor some assignments, in its sole discretion.

Any payment due for eligible services rendered by Preferred Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-Preferred Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

Any payment due for eligible services rendered by PPO Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-PPO Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Plan Sponsor reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA specifies that all Plan Participants shall be entitled to:

> Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
>
> Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
>
> Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.
>
> Review this Summary of Benefits and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has 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 a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (“HIPAA”), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (“EBSA”) 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.)

GENERAL PLAN INFORMATION

TYPE OF PLAN AND ADMINISTRATION

The Plan is a welfare benefits plan. The benefits described in this document are self-funded group health benefits, the administration of which is provided through a Third-Party Claims Administrator.

SOURCE OF CONTRIBUTIONS AND FUNDING

Both the Employer and the Employees make contributions to pay for coverage elected by Active Employees and their Dependents. Except in limited circumstances (as discussed in greater detail in the *Windstream Services, LLC Welfare Benefit Plan Summary Plan Description*), Retired Employees and their Dependents are responsible for paying 100% of the cost of coverage under the Plan.

Benefits are paid from the Employer's general assets. The Plan is not insured.

PLAN NAME: Windstream Services, LLC Welfare Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 85-2049794

PLAN YEAR ENDS: December 31

PLAN SPONSOR INFORMATION

Windstream Services, LLC
4005 N. Rodney Parham Road
Little Rock, Arkansas 72212
1-888-850-1712

Participating employers listed on Addendum A.

PLAN ADMINISTRATOR

Windstream Benefits Committee
4005 N. Rodney Parham Road
Little Rock, Arkansas 72212
1-888-850-1712

NAMED FIDUCIARY

Windstream Benefits Committee
4005 N. Rodney Parham Road
Little Rock, Arkansas 72212

AGENT FOR SERVICE OF LEGAL PROCESS

Windstream Benefits Committee
4005 N. Rodney Parham Road
Little Rock, Arkansas 72212

CLAIMS ADMINISTRATOR

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas 72210
1-844-662-2279

BlueAdvantage Administrators of Arkansas is an independent licensee of the Blue Cross and Blue Shield Association.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy. This benefit applies to any covered Employee or Dependent, including you, your Spouse, and your Dependent Child(ren).

If the Covered Person receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending Physician and the Covered Person. Coverage may apply to:

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

Benefits for breast reconstruction are subject to annual Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Plan.

ADDENDUM A

Participating Employers

Windstream Services, LLC
Windstream North Carolina, LLC
Windstream Mississippi, LLC
Windstream Florida, LLC
Windstream Western Reserve, LLC
Windstream Pennsylvania, LLC
Windstream New York, Inc.
Windstream Nebraska, Inc.
Windstream Ohio, LLC
Windstream Kentucky East, LLC
Valor Communications of TX LLC
Windstream Comm Kerrville, LLC
D&E Communications, LLC
Windstream Iowa Comm, LLC

Mailing address for all Participating Employers:
4005 N. Rodney Parham Road
Little Rock, Arkansas 72212